

ANNUAL  
& REPORT  
& accounts  
2013/2014



The future of your healthcare

*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

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## Welcome from the Chief Executive

Hello and welcome to 2013/14 Annual Report and Accounts.

In taking stock of the last 12 months one necessarily looks for the themes which have defined our year. This year I think there have been two; first, steady improvements to the quality of our services and second a very difficult financial position which culminated in a £40m deficit at year end.

The contrast between those two statements is not lost on me or my colleagues. I will now look a little more closely at each in turn.

We launched our “Quality Commitment” in June, the aim of the Commitment being to leave no one - staff, patients, public - in any doubt that the overriding priority for this Trust is the delivery of safe, high quality care. This focus has delivered results; infection rates have reduced, pressure ulcers have reduced, patient falls have reduced. At the same time, as a result of the nearly £6m we invested in ward staffing, we have more nurses and health care assistants out on the wards than at any other time in our history. Partly as a response to this and partly as a consequence of our focus on staff engagement we have also seen a significant improvement in both our staff and patient satisfaction surveys. I am pleased that under the leadership of our Chief Nurse, Rachel Overfield we have employed over 900 new nurses and healthcare assistants in the last year.

The arbiters of quality and safety in the NHS are the Care Quality Commission, (CQC). Their inspectors, more than 40 of them, spent a week in the Trust in early January 2014. Their Chief Inspector, Professor Sir Mike Richards, had this to say following the inspection:

*“We found that the University Hospitals of Leicester NHS Trust was providing services that were safe, effective, responsive, caring and well-led. Staff we spoke to were positive, and patients we spoke to were positive about the care that they had received at the Trust.”*

*“There are improvements that could be made at the trust to improve the care delivered to local people, but overall we judge this to be a good trust.”*

We think that the CQC got their assessment pretty much spot on, especially regarding our staff who they described as ‘overwhelmingly caring’. However, we also note that, as did the CQC, that there are still improvements to be made and we think that these improvements, particularly around the quality of the emergency care pathway are absolutely essential. Over the past few months we have redoubled our efforts in this area, led by our senior doctors, and this is starting to pay dividends. To support this, during the year we committed to investing the greater part of £50m to create a new Emergency Floor at the Royal Infirmary. The original Emergency Department was built to manage 100,000 patients a year and we are now seeing 160,000 patients and rising. It is a classic case of quart and pint pot. In recognition of the urgency of this work we have ‘proceeded at risk’ with some of the enabling schemes for the Emergency Floor which means that when we finally get the go ahead and the funds to commence construction there will be no delay.

Turning to the issue of money....we were in deficit for all of last year; put simply we spent more on providing services than we were paid to cover the costs of those services. By the year end the deficit stood at £39.8m. This did not prevent us from making the necessary investments in quality and safety, not least the millions we spent on increasing nurse numbers

but for the avoidance of doubt, a deficit of this size is a very significant issue which we must tackle.

How we go about that has, as you would imagine, been the subject of many discussions within the Trust and throughout the wider health economy. Essentially the diagnosis is that there is an over reliance on expensive hospital care, especially out of hours which is draining the local NHS of resources. That combined with inefficiencies in the way that some of our services are structured and the expense of maintaining three acute hospital sites in the City means that things have to change and this time at a pace which is in keeping with the size of the problem.

The vehicle for this change is the Better Care Together programme. Previously this has had a stop start existence, now with the backing and leadership of clinical and managerial colleagues across the system we have set out, at a high level, the five year plan which will return the whole health economy and ourselves to financial balance and most importantly make the necessary quality improvements which are required to create a local NHS which we can all be proud of.

Finally, I wanted to say thank you to the thousands of staff who work for these hospitals. There can be very few employers anywhere in the world that are so constantly under the spotlight from the media, the public and politicians. On the whole the attention is positive and reflects the fact that the NHS is 'owned' by the taxpayer who of course, have every right to hold us to account. But I know that when we make mistakes the scrutiny is at times difficult and our staff bear the brunt of that. In short, they do a terrific job for their patients under the kind of scrutiny that would make lesser people quake. The CQC made a point of saying that the staff in Leicester's Hospitals were always prepared to 'go the extra mile' for their patients... I know that to be the case and I want to thank them for that on behalf of us all.



**John Adler**, Chief Executive

## Welcome from the Chairman

It is my great pleasure to introduce you to our Annual Report and Accounts for 2013/14.

As John has said in his introduction the year was defined by the improvements in quality and the struggle with our finances. I don't intend add anything to those themes already explored by John.

Instead, I wanted to pick out a couple of examples of what I think makes the NHS, despite all its problems, the envy of the developed world.

The first example illustrates a point that I soon learnt when I first became involved in Leicester's Hospitals namely that everyday someone in the Leicester's Hospital team performs a major or minor miracle and it is more often than not, overlooked.

The one I want to share with you relates to our 'Meaningful Activity Co-ordinators'. They are a small team, just three people, funded through our charity but the work they do is extraordinary. Many of our patients are older and sadly with age for some people comes chronic confusion and dementia. Nurses will tell you that it is often very difficult to reach out to a person suffering from severe dementia. Hospitals are confusing places at the best of times so people who are already confused as a consequence of their illness become frightened and variously withdrawn, uncommunicative and even violent. Our meaningful activities co-ordinators support our ward staff by working with these patients to find a way through their fear and confusion and establish a link to the person inside. Earlier this year we heard about one such instance. An elderly patient had been with us for a number of days and from their arrival it was clear that they had dementia. The patient became increasingly agitated and our nursing staff were unable to comfort them with kind words. The Meaningful Activity Co-ordinators intervened and over a few hours were able to establish that the patient had once worked in Leicester's hosiery industry and used to untangle yarn in the knitting machines. One of the co-ordinators had an idea and brought a ball of wool onto the ward, purposefully tangled it and then asked the patient to help untangle the wool... the effect was immediate, the patient found some focus out of their confusion, became less agitated and began to reminisce about the good old days. This simple therapy helped establish a point of reference with the patient and meant that ward staff were able to reminisce with the patient as part of their care.

The second example is brief but speaks to the point that Leicester's Hospitals benefit from tremendous support from other partners and stakeholders. I've already made reference to the fact that many of our patients are old and unfortunately for some of these patients and their families the reason that they are rushed to hospital, for example a fall, also marks the end to their previous way of life. As such the patient and family have to think about on-going care needs, whether they can still cope in their own home and if not what the alternatives are. I think we would all recognise that the choices and decisions required can be bewildering, especially when we have to make these decisions at a time when a loved one is poorly. Thankfully there are experts in this area in the guise of AGE UK LeicesterShire and Rutland. We have always worked with their team but this year we went one step further and created a permanent base for AGE UK in the Royal Infirmary. From here relatives can find information about the benefits available to them and their loved one; how to navigate the system and what support is on offer to ensure that they and their mum/ dad or husband/ wife get the maximum support they can. The Advice Centre has been a success from day one, leading one of our team to comment that AGE UK are the fourth emergency service; I agree.

Before I sign off I wanted to say thank you to staff, stakeholders and our partners for the support they have shown to the Trust and to me over the last 12 months. As you will know with the departure of our previous Chairman I agreed to become acting chairman in October and I am about to stand aside in order to welcome our new Chairman, Karamjit Singh CBE who will join the Trust on 1 October 2014. It has been an honour and a privilege to lead the Board in recent months and I would like to thank my executive and non-executive colleagues for their fortitude and resilience over what has been a challenging period for the Trust.

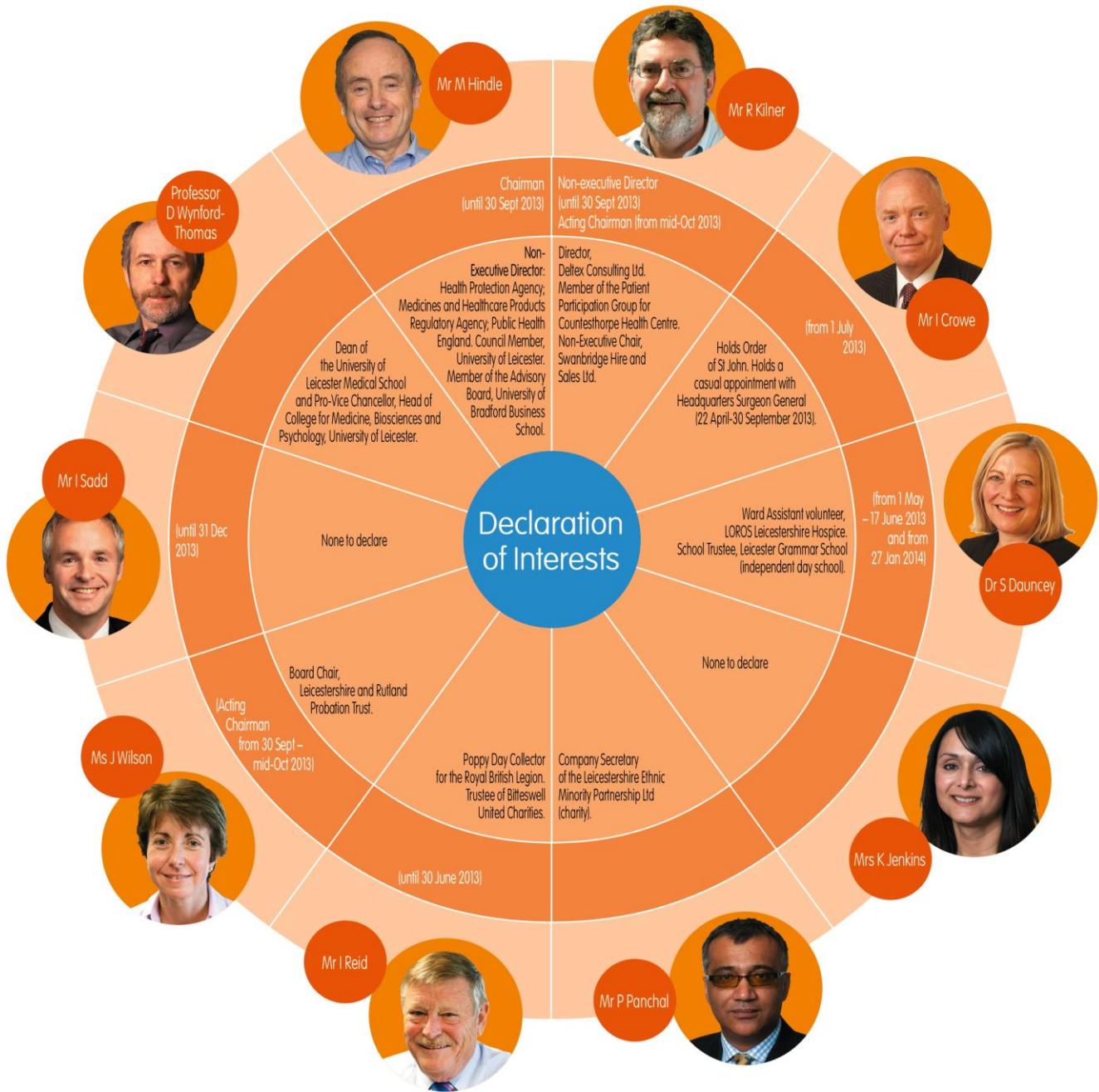
A handwritten signature in black ink, appearing to read 'R. Kilner', with a long horizontal flourish extending to the right.

**Richard Kilner**, Acting Chairman



# Our Trust Board

## Non-executive Directors



## What is a non-executive director?

The role of non-executive directors is different to that of an executive director. They do not have responsibility for the day to day management of the Trust but share the Board's corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. They will scrutinise the executive management's performance in meeting agreed goals and objectives and monitor the reporting of performance. They must satisfy themselves on the integrity of financial information and that financial controls and a sound system for the management of risk are in place. They will seek to establish and maintain public confidence in the Trust, and must be independent in judgement and constructively challenge and help develop decisions and strategy for which they bear equal responsibility. To be effective a NED needs to be well-informed about the Trust and have a good grasp of the relevant issues.

Our non-executive directors bring independence, external perspectives, skills and challenge to strategy development and hold our Executive Team to account for the delivery of the strategy. They actively support and promote a healthy culture for the organisation and this reflects in their own behaviour. It is imperative that they provide visible leadership in developing a healthy culture so that staff believe non-executive directors provide a safe point of access to the Board for raising their concerns.

Some of the non-executive directors chair or participate as members of key committees that support accountability. These are the roles that our non-executive directors carried out over the last 12 months:

**Martin Hindle** chaired Trust Board, Charitable Funds Committee, Research and Development Committee (all until end September 2013) (NB: R&D Committee became the R&D Executive in May 2013). He was also a member of Remuneration Committee (until end September 2013).

**Richard Kilner** chairs Trust Board (from mid-October 2013) and Finance and Performance Committee (from July 2013) and is a member of Finance and Performance Committee (until July 2013 when he became its Chair), Remuneration Committee, Audit Committee (until mid-October 2013 when he became Trust Chair)

**Ian Crowe** is a member of the Finance and Performance Committee, Audit Committee, Remuneration Committee

**Sarah Dauncey** is a member of the Quality Assurance Committee, Remuneration Committee

**Kiran Jenkins** chaired the Audit Committee and was a member of Charitable Funds Committee, Remuneration Committee, Quality Assurance Committee (from November 2013)

**Prakash Panchal** chairs the Charitable Funds Committee (from October 2013) and is a member of Audit Committee (from September 2013), Remuneration Committee, Finance and Performance Committee (end August 2013 – October 2013 only)

**Ian Reid** chaired the Finance and Performance Committee (until end June 2013) and was a member of Audit Committee and Remuneration Committee (both until the end of June 2013)

**Ian Sadd** was a member of Audit Committee, Remuneration Committee, and Finance and Performance Committee (all between October – end December 2013)

**Jane Wilson** chairs the QAC (and was Acting Trust Chair for 2 weeks from end September 2013 – mid-October 2013). She is also a member of Finance and Performance Committee and Remuneration Committee

**D Wynford-Thomas** is a member of Research and Development Committee/Research and Development Executive, Remuneration Committee, Quality Assurance Committee.

# Our Trust Board

## Executive Directors



## Trust Board meetings

Our Trust Board meetings are held in public and details of dates are on our public website. The meetings move between our three hospital sites, and both staff and members of the public are welcome to attend the public session of each meeting. We held our Annual Public Meeting on Thursday 19 September 2013 at 'The Big Shed' on Freeman's Common in Leicester presenting our 2012/13 annual report and accounts and answering questions from the public. There was also a health and wellbeing fair for members of the public.

## Partners on our Trust Board



### Dr Tony Bentley

Dr Bentley is a nominee of the City CCG (as lead Commissioner) who attends and contributes at our monthly public Trust Board meetings as a non-voting/ co-opted member. The idea behind having such a person at our Board meetings is to help forge more collaborative working between the Trust and Commissioners on matters of mutual interest for the benefit of our patients.



### Eric Charlesworth

Mr Charlesworth's role was as a 'participating observer' at our monthly public Board meetings as a non-voting/co-opted member. We hope that by having a representative from the Leicester, Leicestershire and Rutland Healthwatch at the Board table it opens up the Board to a different perspective - that of the patient/public voice - which serves to enrich the Board's deliberations and decisions.

Mr Charlesworth has now been succeeded by Mr David Henson.

*"It has been an absolute privilege to be the Patient and Public observer on Leicester's Hospitals Trust Board. In line with NHS England's expectation that patients are to be at the heart of decision making and care provision, the Chair of the Board needs commending for the manner he has embraced patient representation at the highest level of decision making. This role has allowed me open access to represent the population of Leicester, Leicestershire and Rutland, contribute, challenge, co-ordinate and act as a conduit with many other NHS services, Boards, and working groups. This provided the wider, unique view and understanding of issues, priorities and planning, whilst at the same time ensuring the patient journey and voice was heard and acted upon."*

*"My greatest sadness is that conveying to patients, public and other key players the complexities of running an Acute Trust has often been seen negatively without recognition of the enormous commitment and dedication of the staff at all levels. Partnership working has a long way to go, blame culture removed and a unified approach to achieving service provision at its best. As patients we ALL have a role to assist and influence the changes. I strongly believe that working together with the Board of Leicester's Hospitals will achieve great things."* **Eric Charlesworth**

## Openness and accountability

We have adopted the NHS Executive's code of conduct and accountability, and incorporated them into our corporate governance policies (Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation, and Code of Business Conduct for Staff).

## About us

**Our patients are the most important thing to us and we are constantly striving to improve the care they receive, through looking at the ways we work, ensuring our staff are highly trained and encouraging research which allows us to offer our patients the latest technologies, techniques and medicines – and attract and retain our enviable team of more than 10,000 highly skilled staff.**

**We are one of the biggest and busiest NHS Trusts in the country**, serving the one million residents of Leicester, Leicestershire and Rutland – and increasingly specialist services over a much wider area. Our nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

Spread over the General, Glenfield and Royal Infirmary hospitals, we also have our very own Children's Hospital and work closely with partners at the University of Leicester and De Montfort University providing world-class teaching to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with us.

We continue to work with many different organisations throughout the world to push the boundaries of research and new surgical procedures for the benefit of our patients. Areas of world-renowned expertise include diabetes, genetics, cancer and cardio-respiratory diseases. We are now home to three NIHR (National Institute of Health Research) Biomedical Research Units and during the year we carried out more than 800 clinical trials, involving thousands of our patients who are among the first to try the latest medicines and techniques.

Our heart centre at the Glenfield hospital continues to lead the way in developing new and innovative research and techniques, such as surgery with a Robotic Arm, TAVI (Trans-Catheter Aortic Valve Insertion) and the use of the suture less valve in heart surgery. It has also become one of the world's busiest ECMO (extra corporeal membrane oxygenation) centres and the only hospital in the UK to provide ECMO therapy for both adults and children.

We have one of the best vascular services nationally, with more patients surviving longer after following an aneurysm repair (to fix a life threatening bulge in a blood vessel). And we are proud to continue to have some of the lowest rates of hospital-acquired infections, such as C.Difficile and MRSA, in the country.

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

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

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

## Our values and the NHS Constitution

We created our values with staff over two years ago and made sure that they were in line with, and supported, the [NHS Constitution](#), which was put in place by the Government on 1 April 2010.

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions.

The Constitution will be renewed every ten years, with the involvement of the public, patients and staff. It is accompanied by the [Handbook to the NHS Constitution](#) that is renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

In March 2012 the NHS Constitution was updated and strengthened in a new commitment to support whistle blowing and tackle poor patient care. Then on 26 March 2013 as part of the Government's response to the Francis Enquiry into the events at the Mid Staffordshire NHS Trust, the Government strengthened the Constitution by including an expectation that staff will raise concerns and that their employers will support them. All NHS organisations will have 'whistle blowing' policies and procedures which allow staff to raise concerns about issues that are in the public interest without the risk of suffering at work – for example, victimisation or losing the chance to be promoted.

In March 2014 the Expert Advisory Group to the NHS Constitution (a group of clinicians, patient representatives' voluntary sector representatives' and others from the health field, including frontline staff) wrote to the Minister of State for Care and Reform with their feedback following a request from the Minister on how the NHS Constitution might be strengthened. The Expert Advisory Group suggested: *To be of real practical use, the Constitution needs much greater visibility and ownership across the health world. It should be the framework for the values and behaviours expected and against which those delivering NHS-funded services are recruited, trained, managed and held to account. Effort is needed to track whether and to what extent the rights and commitments in the Constitution are delivered in practice. Significant levers of accountability – such as the NHS Outcomes Framework, the Department of Health's mandate to NHS England and the CQC's new fundamental standards – must reinforce and be aligned with the Constitution.* You can read their report and recommendations [here](#).

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

## Our year in numbers

We have **967** beds at the Royal Infirmary, **416** beds at the Glenfield and **408** at the General

Last year we spent **£474.1m** on wages for our **10,166** staff; that is 59 per cent of our total budget

We earned **£770.4m** and spent **£809.9m**, leaving us with a deficit of **£39.7m**

We have **7,957 females** and **2,209 men** working for our Trust

We spent **£73.6m** on drugs for our patients

Between 1 April 2013 and 31 March 2014 we treated **151,600** patients were treated in our emergency department and eye casualty; **22,400** patients had elective operations; and **85,200** patients had a day case procedure

We admitted **80,100** patients in an emergency

Last year **288,700** patients had a new outpatient appointment and **566,000** patients had follow-up outpatient appointments

Our **445 midwives** delivered **10,400 babies** born in our maternity units; that's **28** babies every day

We spent **£14.3m** on research and development

Every month **19,000** patients have their blood taken by one of our phlebotomists

There were **1.2m** requests from staff for patient records

We have **1,028** volunteers working across our hospitals

Our volunteers made **20,906** buggy journey's helping **34,506** patients get around our hospitals

## Our year at a glance

### April 2013

#### Fracture clinic opens

A new Fracture Liaison Service devised to speed up the diagnosis of osteoporosis opened at the rheumatology department at the Royal.

The referral service, set up by Dr Peter Sheldon, consultant rheumatologist and his team at Leicester's hospitals, works with the Royal's Fracture Clinic and local GPs to ensure that patients are offered a specialist scan to measure bone density.

Since November 2012, the Fracture Clinic has been identifying patients over the age of 40 who have been treated for a fragility fracture of the forearm, a break that occurs when the bones are weak.

#### National appointment

Anne de Bono, consultant occupational physician and head of the Occupational Health

Service at our hospitals has been elected Chair of the national NHS Health at Work Network Board from April 2013.

The Network consists of NHS occupational health services from across England and aims to influence national policy and contribute to a robust evidence base for the speciality, collaboratively working to promote best clinical and business practice of health and work services to all NHS staff.

#### Leicester's Hospitals pledges its support to Speak Out Safely campaign

We pledged our support to the principles set out in the Nursing Times Speak Out Safely campaign.

We already actively encourage any member of our staff to raise genuine concerns they might have about patient safety or quality of care through our own internal campaign, but were proud to also add our support to the Nursing Times and their national campaign.

We understand how important it is that staff feel safe and supported to raise concerns in an honest and transparent environment, and that they feel protected when they have come forward.

We want all of our staff to know it is safe for them to speak up when they feel something is wrong.

We will continue to encourage staff to raise their concerns with their line manager, or another member of our management team or through our anonymous 3636 concerns hotline.

We know our staff are often best placed to identify where care may be falling below the standard our patients deserve. They can ensure concerns are addressed so that we continue to deliver high quality and safe care to our patients as part of our pledge to deliver caring at its best.

#### Reports show Glenfield has one of lowest child heart death rates in the country

Report confirm that Glenfield Hospital has one of the lowest mortality rates for children's heart operations in the country

Two independent reports, one by Professor Brian Jarman, from Imperial College London, and, more recently, the National Institute for Cardiovascular Outcomes Research (NICOR) show the East Midlands Congenital Heart Centre at Glenfield Hospital has one of the lowest mortality rates in England. The NICOR data released on Friday 12 April 2013 does not show a safety problem in any of the 10 centres for the period 2009 to 2012.

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### May 2013

#### Dementia champions

To support National Dementia Awareness Week (19 - 26 May), Leicester's Hospitals launched the Dementia Champion Network, a new initiative to support our patients with dementia and their carers when admitted to hospital.

More than 100 staff, volunteers and members attended the launch in ward 36 meaningful activities day room to find out more about becoming a Dementia Champion and to support a change in cultural attitudes and practices across our hospitals.



### **Making the right decision**

A new guide to tackle the difficult subject of care and treatment towards the end of life was launched during Dying Matters Awareness Week (13 - 19 May) across Leicester, Leicestershire and Rutland. The Deciding Right guide was created by the three local clinical commissioning groups together with Leicester's Hospitals, LOROS, GPs and community health services.

Deciding Right aims to help patients think about what care they may want to receive in the future should they become seriously ill, disabled or unable to make decisions for themselves.

### **Top healthcare award**

Two of our dedicated staff were short listed for a BMJ Group Improving Health Award 2013. The awards showcase the best of UK healthcare.

The 'Low risk chest pain management pathway' was shortlisted in the Emergency Medicine Team of the Year category.

Also in the running for an award this year is our 'Education to Improve Outcomes in Acute Kidney Injury' programme short-listed for an Excellence in Healthcare Education award.

### **Lord Mayor of Leicester opens new stroke rehabilitation unit**

The Lord Mayor of Leicester, Councillor Abdul Osman, will be officially opening the newly refurbished stroke rehabilitation unit at Leicester General Hospital.

The Lord Mayor's Appeal has successfully raised more than £70,000 to support the work of Leicester's Hospitals' Stroke service, a multi-disciplinary team supporting stroke patients from admission through to their discharge back into the community. All of the funds raised have been earmarked for specialist equipment, training and items to improve the patient experience.

### **Top of the POPS**

An innovative University of Leicester research project that enables health professionals to assess, prioritise and treat acutely ill children has been shortlisted for a Patient Safety Award.

The Paediatric Observation Priority Score (POPS) has been shortlisted in the in the Patient Safety in Paediatrics category. The Patient Safety Awards 2013 will recognise and reward work which has significantly improved the safety of patients.

Dr Damian Roland, who works in our emergency department (ED), from the University of Leicester's Department of Cardiovascular Sciences is leading the research on POPS – a checklist which saves time by immediately scoring (between 0-16) mildly ill children on a mixture of physiological, behavioural and risk identifiers, has already been awarded a Da Vinci Health Technology Award.

Using the POPS checklist helps to identify children's illnesses and treatment options as quickly as possible, also resulting in fewer hospital treatment referrals and overall reducing unnecessary diagnoses.

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## **June 2013**

### **Parents' comfort**

New-look accommodation for parents of children being cared for in intensive care at the Royal Infirmary was officially opened.

The £34,000 project funded by Heart Link Children's Charity has created three multi-function rooms that will serve as bedrooms for parents needing to stay overnight near their poorly children and living areas for those parents needing a quiet space during the day. Each room features a sofa bed, television, desk and bold landscape wall art.

### **Research is on the rise**

Clinical research is on the rise in the NHS, and we are helping to spearhead the trend – according to a new league table published in June.

More than half of the 390 NHS trusts across the country increased the number of clinical research studies done in their hospital last year, contributing to the drive for better treatments for all NHS patients. Leicester's Hospitals increased their number of studies from 246 in 2011/12 to 283 in 2012/13.

The new league table, published by the National Institute for Health Research (NIHR) Clinical Research Network, shows the number of studies done by each NHS Trust in 2012 to 2013, and the number of patients who volunteered to take part in clinical research.

Clinical research is a vital part of the work of the NHS, and provides evidence about 'what works' so that treatments for patients can be improved. Research has also show that patients do better in hospitals and surgeries that do research – even if they don't actually take part in a study themselves.

### **Scientists find potential genetic drivers behind male heart disease risk**

University of Leicester scientists working in our hospitals made a further important step forward in their research into the association between the Y chromosome and risk of coronary artery disease.

The team, from the university's Department of Cardiovascular Sciences and Department of Health Sciences, had already identified the risk of coronary artery disease in men who carry a particular type of the Y chromosome (haplogroup I) is 50 per cent greater.

Coronary artery disease is the name given to the narrowing of blood vessels delivering blood to the heart, meaning that not enough oxygen can reach it.

Their research paper, published in the journal *Arteriosclerosis, Thrombosis, and Vascular Biology* identifies the possible genes of the Y chromosome which could be responsible for its association with coronary artery disease.

This can lead to angina symptoms, such as constriction of the chest, and heart attacks.

Coronary artery disease, also known as coronary heart disease, is responsible for almost 80,000 deaths each year – more than 200 people every single day – according to figures from the British Heart Foundation, who funded the study.

### **Decision made to suspend heart review**

The Secretary of State rejected the proposal to reconfigure children's heart services, which would have moved our specialist children's heart services away from Glenfield.

MP Jeremy Hunt also suspended the review, which was designed to create a national network of surgical centres which were safe and sustainable. Now our East Midlands Congenital Heart Centre – along with our colleagues in the other trusts and NHS England – will work together to make that a reality using the right evidence, common sense and always with what's best for patients at the forefront of our minds.

Many thousands of people supported our centre, including members of Heart Link, Keep the Beat, local MPs and councillors, the LINks and local media.

### **Talented surgeon saves children's lives in India**

One of our surgeons teamed up with the charity Healing Little Hearts to perform free paediatric cardiac surgery on six children in Pune, India.

Glenfield Hospital's Dr Simone Speggorin worked with the charity to provide heart check-ups to more than 600 children in June to detect heart murmurs, severe chest pains, fever and abnormal heart rhythm. Around 60 of the children were diagnosed with a malformation of the heart.

Requiring immediate attention, they were treated at the Aditya Birla Memorial Hospital, based in Pune, India by Dr Speggorin, a congenital cardiothoracic surgeon from Leicester's Hospitals.

The project is set to continue with regular visits to the hospital.

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## **July 2013**

### **Give the gift of life**

Leicester's Hospitals organ donation team took part in the national annual campaign to encourage people to give the gift of life.

There are currently 281 people in Leicester and Leicestershire waiting for an organ.

The generosity of donors and their families enables more than 3,000 people in the UK every year to take on a new lease of life.

Our team provide a 24/7 on call provision for the whole of the Midlands.

This means that as and when a potential donor is identified they attend the hospital, liaise with the critical care or A&E staff and, when appropriate, speak to families about organ donation.

### **Live on air**

In anticipation of the birth of the Royal Baby, we welcomed BBC Radio 5 Live and their presenter Richard Bacon for the finale of their Bump Club series – following families through their experience of pregnancy and birth.

The Show started at 6.30am and continued through until 11.30pm to showcase a whole day and night at the Royal's maternity unit. Richard and the crew visited the delivery suite, wards, ante-natal clinic and neonates, interviewed expectant mums and dads as well as our midwives as they started and ended their shifts.

### **Our special GEMS help chemo patients**

Our chemotherapy patients received a comfort boost thanks to a local charity, which raised amazing £13,700 for three electronically controlled therapy chairs for patients on chemotherapy.

GEMS created by kind-hearted Sally and Peter Anderson of Kibworth in 2012, was created using the initials of four very special friends of the couple who all had cancer at a similar time; two of the four have sadly since passed away.

Due to the advancement of treatments, many patients need to be seated for even longer periods and the chairs can be fully controlled by the user for optimum comfort as well as reducing the risk of bedsores. They are also fully height adjustable so staff will have less risk of injury.

Sally and Peter, who decided to raise funds to make the chemotherapy suite at the Leicester Royal Infirmary more comfortable for users, have already provided new window blinds to improve the environment.

### **Emotional return to neonatal unit for brothers after 28 years**

Two brothers, born prematurely who spent the first months of their lives in our neonatal unit at the Royal Infirmary's Kensington Building returned in July in memory of their late mother.

Amar Sall, 28 and younger brother Shaam, 24 were fulfilling their mother's final wish that any money that was left in her bank account would be donated to the unit to help other premature babies to get the best start in life.

Their mother, Manjit had a serious heart condition and had been advised that giving birth could be fatal. Amar was born 13 weeks premature, spending the first six to nine months of his life in hospital due to loss of blood, weakness and breathing problems. As he grew up he continued to suffer with minor health complications as well as having learning difficulties.

Shaam was born 10 weeks early and in 2011 was diagnosed with a rare heart condition, which needed an operation called an ablation.

The brothers were given a tour of the recently renovated £9 million state-of-the art unit, recently relocated the second floor of the Kensington Building, as well as the original space on the fifth floor of the same building where they both spent time as tiny babies more than 25 years ago.

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## **August 2013**

### **Starlight brings sunshine to children's wards**

In August we welcomed the Starlight Children's Foundation who staged an interactive performance of Sleeping Beauty in the children's ward at the Royal Infirmary.

Every year, Starlight provides entertainment and distraction to more than half a million poorly children and the Starlight summer panto gives thousands of poorly children the chance to shout 'He's behind you!' from the safety of the hospital ward.

The pantomime offers a pleasant distraction for the children and their families staying in hospital, and is something for our long-term patients to really look forward to. Our team organises various charity events in the hospital, and Starlight are one of the charities that have visited the children.

### **Leicester eye specialist wins national award**

An eye specialist based at the Leicester Royal scooped a national award after receiving outstanding praise from his patients.

Dr Theo Empeslidis, consultant ophthalmologist, was selected as the winner of the 'Clinical Service of the Year' award over dozens of eye specialists nominated from across the country for the Macular Society's Awards for Excellence.

The judges recognised Dr Empeslidis for his exemplary patient care and leadership of his team. They also noted his interest in research and commitment to visiting local Macular Society support groups. The 'Clinical Service of the Year' is an award for medical staff, teams or services which provide diagnosis or treatment for macular disease, demonstrating exceptionally good practice in the care of people with central vision loss.

Age-related macular degeneration (AMD) affects the central vision and is the most common cause of sight loss in the UK. Of the 500,000 people with the condition in the country, 6,730 are estimated to live in Leicestershire.

There are two main types of age-related macular degeneration described as 'wet' and 'dry'. The current treatment for 'wet' macular degeneration involves an injection into the eye to stop the development of abnormal blood vessels and stabilise vision.

He was presented with his award at the Macular Society's Annual London Conference on 28 September.

### **£1 million makeover for our restaurants**

We unveiled our new-look restaurants following a £1 million refurbishment at the Leicester Royal, Leicester General and Glenfield hospitals.

Interserve, who run the three restaurants, completely revamped the facilities to provide a wider range of quality food choices and to help improve the visitor and patient experience within our hospitals.

The refurbishment took eight weeks. Each restaurant now offers a new food facility called LEat Street, offering a choice of food styles, including traditional British food, noodles and Asian-inspired dishes, American and Tex-Mex and Chipiri – offering Halal piri piri chicken and healthy options including soups and salads. There is also a choice of high-street coffee brands.

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## **September 2013**

### **Caring at its best**

A glitzy awards ceremony celebrated Leicester's Hospitals inspirational staff.

Five hundred staff, volunteers and supporters attended our Caring at its best Awards 2013 at The Athena in Leicester.

The coveted awards, launched in 2011 and supported by Age UK, recognise staff and volunteers from Leicester's Hospitals for their fantastic commitment to providing 'Caring at its best'.

### **New chief nurse**

We welcomed new chief nurse Rachel Overfield to our organisation in September.

Rachel was previously chief nurse at Sandwell and West Birmingham Hospitals NHS Trust, where she was instrumental in achieving a 70 per cent reduction in hospital acquired pressure damage and 60 per cent reduction in hospital falls, as well as improving end of life care and patient satisfaction scores.

Rachel also spent 12 years at Worcestershire Acute Hospitals NHS Trust where she was promoted through the ranks to director of nursing.

### **Leicester's Clinical Trials Unit**

Our research units dedicated to high quality clinical trials has been awarded the 'gold standard' set by UK's Clinical Research Collaboration.

Leicester's Clinical Trials Unit, a partnership between Leicester's Hospitals and the University of Leicester, was awarded the UK's Clinical Research Collaboration (UKCRC) Full Registration in October. Running high quality trials which meet regulatory and governance requirements is a complex process and depends on expert design, conduct and analysis. CTUs are specialist units set up with a specific remit to bring together the expertise needed to undertake a clinical trial, including clinicians, statisticians, IT programmers and trial managers.

### **Leicester leads two ground-breaking trials into treatments for asbestos-related cancer**

One of our lung cancer specialists is leading national and international studies into potential treatments for mesothelioma; a form of lung cancer strongly linked with exposure to asbestos.

Mesothelioma most commonly starts in the inner lining of the chest wall causing it to thicken and reduce lung capacity, which in turn puts a strain on other organs including the heart.

Since the 1960s, it has been known that the disease can be triggered by the inhalation of asbestos fibres.

Despite the UK's ban on asbestos issued in 1985, the number of deaths caused by the disease has grown each year from 153 in 1968 to 2,321 in 2009 – the highest incidence in the world.

This number is set to continue to rise sharply over the next 20 years, with a peak coming in 2020.

Dean Fennell, Professor of Thoracic Medical Oncology at Leicester's Hospitals and University of Leicester is leading two studies which aim to test new potential treatments which could improve survival and quality of life for mesothelioma patients.

The first will look at a drug called ganetespib which may shrink tumours. The second global trial could potentially reduce the need for repeated chemotherapy treatment by killing cancer stem cells remaining following front-line therapy.

### **Leicester's Hospitals appointed as local branch of the NIHR Clinical Research Network**

In September, we were named the local branch for The NIHR Clinical Research Network – the clinical research delivery arm of the NHS. It provides funding to hospitals and surgeries to pay for research nurses, scans, x-rays and other costs associated with carrying out clinical research in the NHS.

The network helps to increase the opportunities for patients from the East Midlands to take part in clinical research, ensures that studies are carried out efficiently, and supports the Government's Strategy for UK Life Sciences by helping companies to carry out vital clinical research into potential life-saving new treatments and improved ways to diagnose illnesses in the NHS.

The appointment follows a rigorous selection process to identify the NHS Trusts/Foundation Trusts to run its 15 local branches across England. The process was open to all NHS Trusts and Foundation Trusts in the region.

As the chosen trust for the East Midlands, we will be awarded a five-year contract from the Department of Health through the NIHR and we will take responsibility for distributing £23 million of funding of funding per year to support clinical research across the whole area.

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## **October 2013**

### **Online cardiac rehab**

Leicester's Hospitals' Cardiac Rehabilitation team was shortlisted in the Cardiovascular Service category of the Nursing Times Awards 2013.

Activate Your Heart is a self-management tool for cardiac patients and is the first online cardiac rehabilitation programme in the UK.

Cardiac rehabilitation is recognised as one of the most effective interventions to help individuals with coronary heart disease achieve a full and active life. Activate Your Heart offers an effective and alternative approach to cardiac rehabilitation. It allows patients to keep a record of their exercises, monitor their weight, stress and create their own goals.

Built into the web-based programme are a range of educational resources such as videos, diagrams, audio tracks and quizzes. These provide advice on making lifestyle changes and reducing risk factors for coronary heart disease.

### **Physiotherapist leads the way with new technique to ease chronic back pain**

One of our physiotherapists was shortlisted for a top innovation award for his pioneering strategy to manage chronic back pain.

Chris Newton based at the Royal Infirmary, was chosen as a finalist in the 'Innovator of the Year' in the East Midlands Leadership Academy Recognition Awards 2013 for his leadership in the implementation of a new strategy to manage patients suffering from persistent or chronic lower back pain disorders.

Chris championed the use of 'Classification Based - Cognitive Functional Therapy' (CB-CFT) in Leicester after he was trained in this technique in 2010, an approach developed and taught by Professor Peter

O'Sullivan at Curtin University in Australia. Since being trained, Chris has also started to disseminate this work with physiotherapy colleagues at Leicester's Hospitals.

Lower back pain is now ranked the number one cause of disability across in the UK, and globally according to the recent Global Burden of Disease study (The Lancet, 2012).

Chris's nomination was one of 119 that have been considered by a panel of judges for the awards.

The NHS Leadership Recognition Awards celebrate leaders at all levels and across all professions who have ultimately improved people's health, the public's experience of the NHS and those leaders others are truly proud to work alongside.

### **Leicester event helps locals worried about cancer in the family**

People concerned about a family history of cancer met with experts to advise on preventing or delaying the disease, at an event organised by the University of Leicester's Genetics Education Networking for Innovation and Excellence (GENIE) held its fourth Lifestyle and Cancer Awareness Workshop on Saturday, October 12.

The event, organised by GENIE's Supporting Families with Cancer team focuses on preventing cancer through diet and drugs and lifestyle advice and support.

Sessions were led by clinical specialists and researchers from our hospitals where people were given the opportunities to ask questions, share views and find out more about preventing or delaying the onset of inherited cancer.

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## **November 2013**

### **National award win**

Leicester's Hospitals '5 Critical Safety Actions' handover team scooped a top award at the Health Service Journal (HSJ) Awards 2013.

Nominated in the 'Enhancing Care by Sharing Data and Information' category, Leicester's Hospitals has been working in partnership with Nervecentre Software to develop mobile phone technology to give clinical staff 24/7 access to real-time status updates on patients.

The competition was extremely high with more than 1,000 entries and 139 unique organisations making the shortlist.

### **Pioneering heart operation performed for the first time in Leicester**

In a UK first, experts from Glenfield Hospital repaired a dysfunctional heart valve by inserting a tiny implant measuring just 23mm in size.

The pioneering system gives surgeons improved control of the valve throughout the keyhole procedure, enabling increased precision and the ability to reposition or retrieve the valve, even after insertion if necessary.

The Lotus™ Valve System was used in a TAVI (Trans catheter aortic valve implants) procedure to treat aortic stenosis in November 2013. It is less invasive than open-heart surgery and does not require general anaesthetic, meaning the patient is fully conscious throughout.

Aortic stenosis is a life-threatening condition where thickening and stiffening in the heart valve prevents it from opening and closing as it should. It affects approximately three percent of the population over the age of 65 and five percent of people older than 75.

Multiple specialities, including our cardiology team, cardiac surgeons, radiology, nurses and anaesthetic support, worked closely together to successfully carry out this procedure.

### **Olympic hero opened new £2 million diabetes centre in Leicester**

Five-time Olympic gold medallist – and diabetes sufferer – Sir Steve Redgrave officially opened the new Leicester Diabetes Centre.

The Leicester Diabetes Centre is an alliance between Leicester's Hospitals, the University of Leicester, the local community and primary care and is located at the General.

The multi-million pound facility is one of the largest diabetes centres in Europe and is set to improve the lives of people with diabetes, their families and their carers. It brings together our existing expertise in clinical research together with the world-class academic expertise of the University to tackle diabetes.

Diabetes is an increasing problem in society, necessitating investment into diabetes research to ensure that patients receive the best possible treatment. The new centre will provide a designated clinical research space to make this possible.

The focus is to improve outcomes and the health of people with diabetes and to stop those at high risk of type 2 diabetes developing it.

Over the last five years, the existing centre has published more than 300 original research publications and attracted more than £30 million of new funding for research to Leicester.

A bespoke exercise laboratory, designed to determine which physical activities are best suited for patients with diabetes, will be available. The Centre is also committed to training healthcare professionals to provide greater support to patients at risk and with diabetes.

One of the most significant investments on the site is the National Institute for Health Research (NIHR) Leicester-Loughborough Diet, Lifestyle and Physical Activity Biomedical Research Unit, which will look into how people with diabetes can manage their lifestyle and a clinical trials unit to continue to explore innovative treatments.

### **Clinical director appointed**

Professor David Rowbotham was appointed clinical director of NIHR CRN: East Midlands. The NIHR Clinical Research Network is the clinical research delivery arm of the NHS, and last year was responsible for helping more than 630,000 patients to take part in research studies that contribute towards improving treatments for the future.

As Clinical Director, Professor Rowbotham will be responsible for boosting the level of clinical engagement in research across the patch, ensuring that studies are carried out efficiently, maximizing the opportunities for patients to participate in a study that could benefit them and distributing the £23m of funding that the East Midlands will receive each year during the five year contract we've been awarded from the Department of Health through the NIHR.

### **New cutting edge scanners**

We began an extensive programme to replace diagnostic imaging technology across Leicester's Hospital's three sites. Eleven new CT (Computerised Tomography) and MRI (Magnetic Resonance Imaging) scanners are being replaced in total, making it the largest single installation programme for a trust in the UK.

CT and MRI scanners both play a crucial role in diagnosing and monitoring various medical conditions. The CT scanners use x-rays to produce images to show structures inside the body including the internal organs, blood vessels, bones and tumours. An MRI scan, which uses powerful magnets and radio waves to produce images, can be used to examine almost any part of the body, including the brain and spinal cord, bones and joints, breasts, heart and blood vessels and internal organs, such as the liver, womb or prostate gland.

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## **December 2013**

### **Baby Loss appeal**

We launched the Leicester Baby Loss Appeal – a sensitive fundraising campaign to raise £100,000 for a new bereavement delivery suite for parents to deliver their stillborn baby.

The suite will include vital gases, en suite wet room, nursery and courtyard away from the hustle and bustle of the main delivery area at the General's existing Sahara Room originally funded by Local MP Keith Vaz and his wife Maria in 1994 in memory of their daughter Sahara, discovered stillborn following a routine scan.

### **Christmas cheer**

Nurses at Leicester's Hospitals organised a magical Christmas party for children with cancer, who are faced with spending Christmas day in hospital this year.

For the past few years, three nurses from the Children and Young People's unit (ward 27) at the Royal have organised a Christmas party for the current and past children who have spent time on the unit, to meet up and celebrate the festive season – and this year was no different.

The get together saw more than 50 children and their families celebrate Christmas, giving them the chance to forget about their discomfort or pain for an afternoon.

### **'Gaming' training tools**

Two doctors have received more than £20,000 to develop a new 'video game' training technique to improve the decision making skills in foundation doctors.

The funding has been awarded by the Health Education England (HEE) Inspire Improvement Project, part of the HEE Better Training Better Care (BTBC) programme.

Consultant colorectal surgeon, John Jameson and specialist registrar, Muhammad Imran Aslam and their team have been selected from more than 200 applicants to join eight other trainee-led teams from across the UK to develop new training techniques, ranging from smartphone 'apps' to virtual training. 'Serious Gaming' will provide a virtual environment for junior doctors to practice decision-making in different clinical situations.

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## **January 2014**

### **Inspectors welcomed**

We welcomed the Care Quality Commission for their inspection 13 – 16 January. More than 40 inspectors visited every area of our hospitals. The inspections look at whether our services are safe, effective, caring, and responsive to people's needs.

### **Leukaemia breakthrough**

University of Leicester researchers deploy 'precision medicine' to successfully target advanced form of leukaemia with skin cancer drug.

A team of scientists from the University of Leicester has demonstrated a novel treatment for Hairy Cell Leukaemia (HCL), a rare type of blood cancer, using a drug administered to combat skin cancer. The study shows the treatment, which can be taken orally, cleared the malignant cells from the patient's blood and led to a complete clinical recovery in a number of days.

The study was led by the University of Leicester and involved treatment of a patient at the Royal Infirmary.

### **Specialist clinical pharmacist recognised for innovation**

Anusha Patel was awarded second prize in the Best Service Improvement Project category of a leadership awards for her pioneering medication review system which aims to reduce falls among elderly patients.

The East Midlands Leadership Academy's Emerging Leaders Awards prize was given for her 'ReMedi' project which aims to provide a holistic patient-centred medication review for patients over the age of 60 years who are on long-term medications.

ReMedi has so far shown great benefits such as a reduction in the risk of falls, assurance that individual needs are fully considered, ensuring medication prescribed is fit for purpose and increased patient and community involvement in their care.

### **Rising star**

An innovative paediatric doctor from Leicester has been named on the top 25 list of Health Service Journal (HSJ) Rising Stars list.

The accolade was awarded to Dr Damian Roland, previously a NIHR research fellow and now a senior registrar in paediatric emergency medicine at Leicester's Hospitals and University of Leicester, who was also named as one of 50 leading medics, policy makers and healthcare managers on the [HSJ Top Innovators](#) list in November 2013.

HSJ Rising Stars aims to celebrate the healthcare leaders of tomorrow and influencers of today.

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## February 2014

### **Bereavement room**

A new bereavement room was officially opened on level 1, Kensington for women who receive sad news during their pregnancy.

Stillbirth and neonatal death charity, Leicester & Leicestershire SANDS kindly sponsored the new bereavement room.

### **Japanese ECMO visit Glenfield Hospital**

We welcomed members of the Japanese Society of Respiratory Care Medicine (JSRCM), the Japanese Society of Intensive Care Medicine (JSICM) and government officials to see how Extra Corporeal Membrane Oxygenation (ECMO) is provided at Glenfield.

Glenfield houses one of the most experienced ECMO centres in Europe and its director Giles Peek is one of three global specialist advisers working with JSRCM and JSICM, which was founded in 1974, to help improve practice and expertise in Japan.

ECMO uses a machine to oxygenate the blood outside the body providing support for the lungs in the intensive care unit. This treatment reduces the toxic effects of ventilation, giving the lungs a chance to rest and recover.

Glenfield's ECMO experts have treated over 160 patients in the last year, making it their busiest year ever. This exceeded their previous record of 110 ECMO patients seen in 2008.

### **Leicester cardiologist selected for prestigious trip to South Africa**

Professor Anthony Gershlick, consultant cardiologist and Professor of interventional cardiology has been invited by the South African Interventional Cardiac Society to spend a two-month teaching sabbatical based in Groote Schuur Hospital in Cape Town, South Africa.

Based at Glenfield, Professor Gershlick is the fourth International cardiologist to be selected by the South African Cardiac Society to spend two months touring South Africa, teaching and lecturing junior doctors in the field of cardiology. Professor Gershlick will also be passing on tips and tricks to improve outcomes in patients undergoing coronary artery stenting through case demonstration and hands on procedures.

Many junior doctors and consultants in South Africa do not get the opportunity to attend overseas training due to logistic and financial restrictions.

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## March 2014

### **Make a change**

Our staff joined thousands of NHS staff across the country to pledge to improve patient experience, care standards and clinical outcomes to bring about a cultural change in our hospitals.

In only its second year, Change Day has already captured the attention of not only staff at Leicester's Hospitals, but the whole NHS workforce to become a 'social movement'.

Our Change Day roads how toured Leicester's hospitals and more than 250 staff, visitors and patients visited the road shows and we received 72 fantastic new pledges as a result!

### **Quality report**

The Care Quality Commission (CQC) released their Quality Report following their inspection of Leicester's Hospitals in January 2014.

The Chief Inspector of Hospitals for the CQC, Professor Sir Mike Richards, said: "We found that the University Hospitals of Leicester NHS Trust was providing services that were safe, effective, responsive, caring and well-led. Staff we spoke to were positive, and patients we spoke to were positive about the care that they had received at the trust."

The inspection regime is based around five key questions; Are services safe, effective, caring, responsive and well led?

We were rated as 'good' in three out of five questions and 'requires improvement' in two, equating to an overall rating of 'requires improvement'.

### **Leicester mums to benefit from maternity funding**

We received £161,547 to improve the environment and equipment in its maternity units. This is part of a £10million government drive to improve maternity care for women and babies in the UK.

Allocated to 63 Trusts across the country, the money will help to improve places where women are cared for before, during and after birth. The funding will also provide women with more choice over where they give birth.

We decided to use our funding to create a new bereavement room and refurbish two existing bereavement rooms at the General Hospital and Royal Infirmary. Bereavement rooms are important in caring for women who are told they have lost their babies during their pregnancy.

Elaine Broughton, acting head of midwifery for Leicester's Hospitals, said: "It is really important that we have peaceful and homely rooms for women and their families who go through the terrible experience of losing their baby. This funding will help us provide private, comfortable rooms at both the Royal and the General."

## Our priorities in 2013/14

We identified a range of priorities for 2013/14 which were designed to take forward the key elements of the Strategic Direction that was developed in autumn 2012. These are:

1. Delivering our **Quality Commitment** = save more lives, reduce avoidable harm, improve patient experience
2. Improving the **emergency process**
3. Improving **theatre productivity** = fewer cancellations, fewer delays.
4. Improving **outpatients** = fewer cancellations, fewer patients who do not attend, (DNAs)
5. Improving the **estate** = a series of schemes to bring immediate benefits as well as well as to take forward medium term reconfiguration
6. Improving **IM&T** = priority schemes to support clinical service delivery
7. Developing **Listening into Action** = better engagement with staff, leading to better support for colleagues and clear leadership standards.
8. Developing our **specialised services** = for example, vascular, adult cardiac, children's cardiac, renal.
9. Developing **medical education** = CEC improvements at the Royal Infirmary, better engagement with trainees, considering the shape of future medical workforce
10. Developing **research** = strengthening Biomedical research Units, playing a leading role in the creation of the Academic Health Sciences Network, and securing funding from the National Institute for Health Research. (NIHR).

Most of the major things that what we focussed on to improve how we deliver our services came under the banner of the **Improvement and Innovation Framework**, which replaced our Transformation Plan.

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## Our plans to become an NHS Foundation Trust

We remain committed to becoming a safe, sustainable, productive, high performing NHS Foundation Trust.

In order to proceed with our foundation trust application we will need to secure a "Good" or "Outstanding" rating from the Chief Inspector of Hospitals. We were one of the first trust's to be inspected under radical changes introduced by the Care Quality Commission, which are designed to provide a much more detailed picture of care in hospitals than ever before.

Whilst the Care Quality Commission concluded that we provide services that are safe, effective, responsive, caring and well-led, we know that there are some areas for improvement.

Our two year plan for 2014 - 2016 sets out how we intend to make these improvements and become a safe, productive, high performing and financially sustainable organisation.

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## Quality and performance – how did we do?

We are monitored by the NHS Trust Development Authority against a range of targets and thresholds. For 2013/14 these were set out in 'Delivering High Quality Care for Patients': the accountability Framework for NHS Trust Boards.

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.leicestershospitals.nhs.uk](http://www.leicestershospitals.nhs.uk)

Performance Against 2013/14 National Targets							
Performance Indicator		Target 2013/14	YTD 2013/14	2012/13	2011/12	2010/11	
Access to A&E	A&E	Total time in A&E	95%	88.4%	91.9%	93.9%	96.1%
	MRSA		0	1	2	8	12
Infection Control	Clostridium Difficile		67	66	94	108	200
	RTT waiting times	Admitted	90%	76.7%	91.3%	84.0%	92.3%
Access 18 week wait	RTT waiting times	Non-admitted	95%	93.9%	97%	96.0%	97.2%
	RTT incomplete	92% in 18 weeks	92%	92.1%	92.6%	Not applicable	Not applicable
	RTT delivery	In all specialities	0	14	2	Not applicable	Not applicable
	Diagnostic Test	Waiting times	<1%	1.9%	0.5%	Not applicable	Not applicable
	Cancer:	2 week wait from referral to date first seen - all cancers	93%	94.7% (Apr 13- Feb 14)	93.4%	94.0%	93.4%
Cancer:	2 week wait from referral to date first seen - symptomatic breast patients	93%	94.0% (Apr 13- Feb 14)	94.5%	95.9%	95.9%	
Access Cancer	All cancers:	31 day wait from diagnosis to first treatment	96%	98.1% (Apr 13- Feb 14)	97.4%	97.4%	97.0%
	All cancers:	31 day wait for second or subsequent treatment - surgery	94%	95.8% (Apr 13- Feb 14)	95.8%	94.5%	95.2%
	All cancers:	31 day wait for second or subsequent treatment - anti cancer drug treatments	98%	100% (Apr 13- Feb 14)	100%	99.9%	100%
	All cancers:	31 day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	98.1% (Apr 13- Feb 14)	98.5%	99%	99.5%
	All cancers:	62 day wait for first treatment from urgent GP referral	85%	86.2% (Apr 13- Feb 14)	83.5%	83.8%	96.4%
	All cancers:	62 day wait for first treatment from consultant screening service referral	90%	96.1% (Apr 13- Feb 14)	94.5%	93.8%	91.6%

## 4-hour performance

In 2013/14 we set a target to treat at least 95% of patients in our Emergency Department (ED) within four hours by implementing a number of jointly agreed actions with our local commissioners. Our actual performance was 88.4%.

Performance against the 4hr wait is subject to regular detailed reporting at our Trust Board. It is well recognised that the current size of our Emergency Department is too small for the number of patients who attend and as a result a significant scheme for expanding the Emergency Department has been developed. In addition, we are reviewing the number of beds required for emergency admissions with an aim to increase in 2014/15.

Working with our healthcare partners, a 'single front door' process was introduced in July 2013 to guide patients to the most appropriate care from the moment they arrive in the Emergency Department or Urgent Care Centre at the Royal Infirmary.

Executives across the healthcare community meet on a weekly basis to work on sustainable solutions to will improve performance, patient experience and staff satisfaction.

Additional resources have been allocated across the emergency pathway to ensure any delays are addressed. Measures have been put in place to ensure patients who unfortunately remain in our ED for longer than four hours receive appropriate care including prevention of pressure ulcers through the use of aides. There is a suite of ED quality metrics monitored weekly.

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## Healthcare-associated infections

We have again reduced our cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia and clostridium difficile infection (CDIFF), and this year we achieved our lowest rates ever with only one avoidable MRSA bloodstream isolate; this contrasts with 161 cases in 2001 and 66 cases of CDiff, one case lower than our trajectory of 67 (hospitals are given a target figure beyond which they are not expected to exceed. For MRSA bacteraemia this was 0 cases and for CDIFF this was 67 cases).

We also now screen all of our both our elective and non-elective patients for MRSA, achieving our 100 per cent target.

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## Referral to treatment (RTT) – 18 weeks

NHS Trusts are required to ensure:

- 90 per cent of admitted patients are treated within 18 weeks. Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment;
- 95 per cent of non-admitted patients start consultant-led treatment within 18 weeks of referral. Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required;
- 92 per cent incomplete within 18 weeks: this is proportion of all patients waiting for treatment at any time.

During the year we have been unable to consistently deliver performance against the admitted and non-admitted targets. In autumn 2013 we invited the NHS Intensive Support Team to provide advice on our plans to recover the standard. Our plans have now been agreed with local CCGs (Clinical Commissioning Groups), which include performing additional outpatient and elective work during 2014/15 to reduce waiting times in the four specialities who are the most challenged; ophthalmology, ENT, orthopaedics and general surgery. We will regain compliance against the three performance indicators in 2014 -15.

## **Cancer waits**

During the year we achieved all eight of the national waiting time targets for our cancer patients.

The plans implemented during 2013/14 to improve cancer performance, in particular the delivery of the 62-day referral-to-treatment standard for patients on a cancer pathway, have been delivered. This means that patients are being diagnosed and treated more quickly.

The trust level 62-day performance (target 85%) from referral to first treatment remains above national average. The transformation has been achieved against a national trend of increasing difficulty with the target. We continue to work internally and with the CCGs to improve the care of our cancer patients. These include:

- improving the booking process for first appointments and reducing the waiting times;
- reducing waiting times for diagnostics and follow up appointments.

We have appointed a lead cancer clinician and senior manager to lead on the performance of the 62-day wait target for cancer treatment. A weekly cancer action board has been in operation since June 2013, which focuses its attention on reducing delays, removing blockages and holding tumour site leads to account for delivery. Performance is above the agreed trajectory, and represents a significant achievement. It shows the benefit of strong clinical leadership and a clear accountability framework.

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## **Cancelled operations**

We have been unable to reduce the number of operations cancelled on the day during the year. This is a poor experience for patients and is not a good use of our resources. The primary reason for the cancellations is lack of beds on the day of admission, which is a result of the increased emergency admissions reflected in the emergency department (ED) performance. During 2014/15 we aim to significantly reduce the level of cancellations by protecting elective beds from emergency admissions, increasing the bed base and improving the scheduling of operations.

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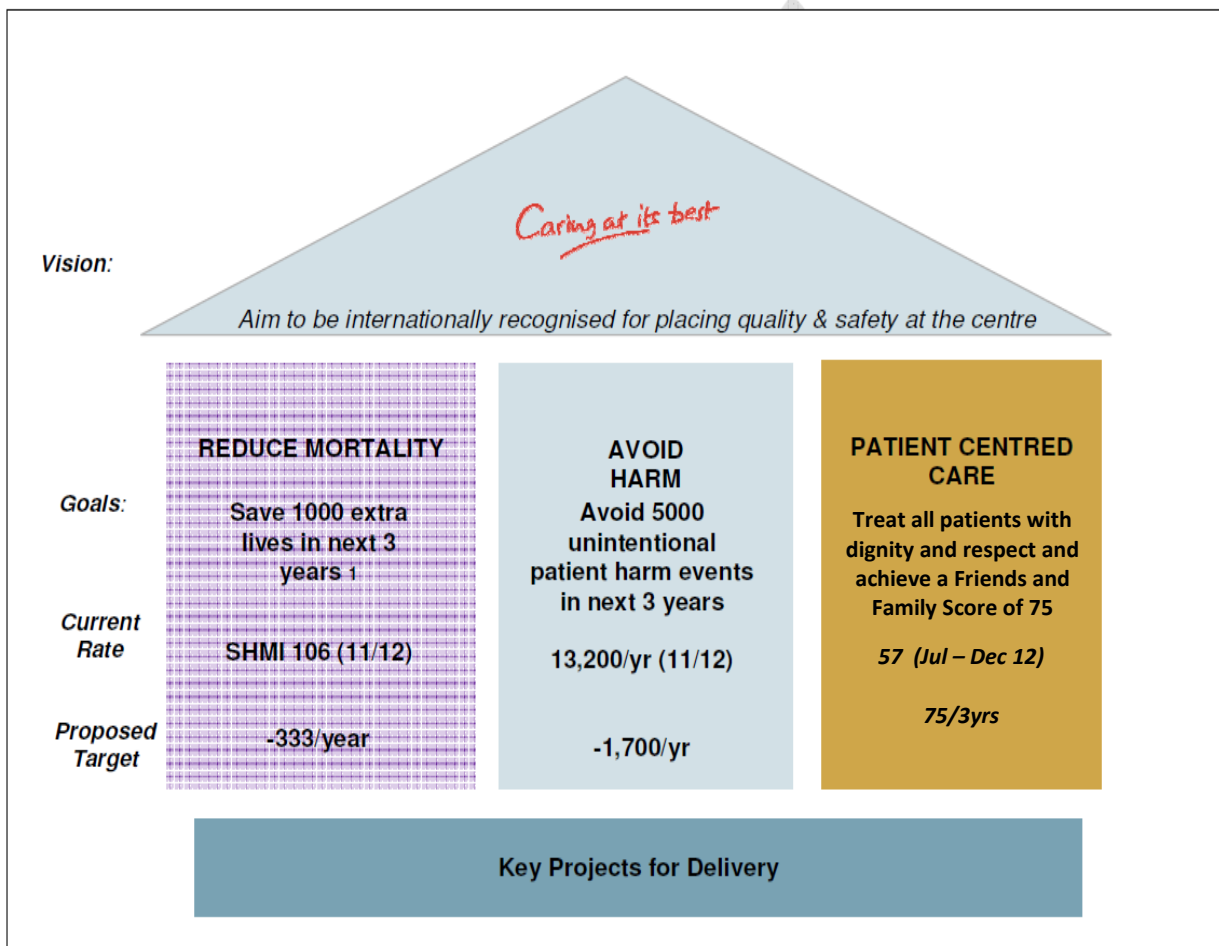
# Delivering our Quality Commitment

Save more lives

Reduce avoidable harm

Improve patient experience

Our Quality Commitment is a three-year programme approved by our Trust Board in December 2012. Three overarching goals were identified – to reduce mortality, avoid harm and patient-centred care as depicted below.



This chart shows the work streams and targets agreed as priorities for 2013

	SAVING LIVES	REDUCE HARM	PATIENT CENTRED CARE
<b>2013 priorities</b>	Out of hours (weekends and nights) Respiratory pathway	Falls Ward round review	Elderly and dementia care  Discharge processes and communication
<b>HOW MEASURED</b>	SHMI	Safety Thermometer Datix Incidents Ward Rounds	Friends and Family Test  Patient Survey (using NPS questions)

We have made good progress with at least one of the work streams in each of the goals and there have also been some early positive results in respect of the respiratory pathway and falls reduction work streams.

Due to timescales involved in setting up processes and identifying staff, it is likely that most of the work streams will need to be continued into 2014/15.

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## Reducing avoidable harm

The **Critical Safety Actions** programme embeds safety processes across all our clinical business units to ensure systematic, consistent and high quality care.

The primary objective for the programme is to see a reduction in avoidable mortality and morbidity across the organisation and an improvement in organisational safety culture.

The safety actions for 2014/15

1. Improving clinical handover
2. Relentless attention to Early Warning Score (EWS). Early warning scores rate individual patients' risk of serious deterioration. The system is derived from four psychological readings and observing patients' levels of consciousness.
3. Acting on results
4. Senior review, wards rounds and notation.

During this year it was agreed that sepsis should be included as another critical safety action to improve the care and outcome of all patients with sepsis within our hospitals. This will be achieved by improving recognition and immediate management of septic patients.

The target is to see a reduction in serious untoward incidents (SUIs) attributable to these key areas as part of the local CQUIN (Commissioning for Quality and Innovation) programme for the trust.

This year we have seen a 25 per cent reduction in SUIs against 2012/13, and a 50 per cent reduction in the two years of the Critical Safety Actions programme.

## Improved outcomes during the year

- All of our doctors and nurses have started using a new electronic handover system that interfaces with the H@N task allocation system for handing over of outstanding work. This work won the HSJ 2013 award in the category '*Enhancing Care by the Sharing of Information and Data*';
- In adherence with Royal College guidance we have introduced a ward round safety checklist and new continuation paper to improve and standardise ward documentation across the trust;
- There is now a daily follow-up radiology review (DFR) process in place in the Emergency Department (ED). This ensures that all radiology reports are followed up and reviewed for those patients that have been discharged home from the ED;
- Each speciality has an agreed documented process for managing diagnostic testing procedures to improve the consistency of action on results across specialties;
- We are now using an early warning scoring system in our neonatal service, for use in delivery suites, post natal wards and special care beds. This ensures that we identify any new babies that become unwell and manage their treatment them earlier.



For the forthcoming year, sepsis has been agreed as a CQUIN indicator for the trust with the other four priorities being added to the Quality Commitment for the work to continue.

### **Lower mortality and managing risk**

Risk management within our hospitals has continued to evolve with increased emphasis on providing effective processes that meet national standards. During the year we moved from a 'divisional structure' to clinical management groups (CMGs). As a result risks are now managed more effectively at a local level and risk management is embedded within the day-to-day work.

A risk management policy has been developed to provide the framework for risk management processes with responsibility for the management of local risks delegated to clinical/corporate directors and CMG general managers/corporate directorate managers. Risks are recorded on our risk register allowing risks to be captured at every level of the organisation and subsequently providing a dynamic risk profile to aid decision-making. A strengthened risk reporting process has been established to provide greater accountability for risk within the trust and to ensure a better line of sight for risks from 'ward to board'. All high and extreme risks are reported to the executive team on a monthly basis and to the trust board on a quarterly basis to identify common risk themes that may have strategic significance in relation to the achievement of trust objectives. The executive team hold the CMG and corporate teams to account for the effective management of their local risks.

Increased emphasis has been placed on ensuring that risk treatments are regularly monitored and reviewed to ensure actions are completed within specified deadlines. Reviews are performed by local boards and also by the executive team. 'Closing the loop' on these actions has seen a reduction in the number of long-term risks recorded on our risk register.

To ensure the continued development of our managers in relation to risk management, risk awareness training events continue to be scheduled on a monthly basis. Bespoke risk training is also held in relation to general risk assessment, risk register management and risk register administration.

Key strategic risks for 2013/14 built on those already in place for 2012/13.

### **Prevalent strategic risk themes during 2013/14**

- Failure to achieve financial sustainability;
- Failure to transform the emergency care system;
- Inability to recruit, retain, develop and motivate staff;
- Ineffective organisational transformation;
- Ineffective strategic planning and response to external influences;
- Failure to maintain productive and effective relationships;
- Failure to achieve and sustain quality standards;
- Failure to achieve and sustain high standards of operational performance;
- Inadequate reconfiguration of buildings and services;
- Loss of business continuity;
- Failure to exploit the potential of IM&T;
- Failure to enhance education and training culture.

A challenging cost improvement programme (CIP) during the year was underpinned by risk analysis to ensure that patient safety and quality of care were not adversely affected by savings. CIP risks were identified and analysed at local level with confirm or challenge from the

corporate teams. Key performance indicators were developed to enable potential adverse effects on patient safety and quality of patient care to be regularly measured, monitored and reported.

### Internal audit review

There are currently two outstanding actions yet to be completed from previous internal audit reviews and these will be addressed as part of an action plan scheduled for the second quarter of 2014.

### Compliance with National Health Service Litigation Authority (NHSLA) Risk Management Standards (ARMS) and Clinical Negligence Scheme for Trusts (CNST) Maternity Standards

We are a member of the NHSLA risk-pooling scheme and to ensure continued membership we have previously undertaken regular assessments to comply with ARMS and CNST maternity standards. In March 2014 the Women's and Children's CMG successfully achieved compliance at level 3 of the CNST maternity standards – making us one of only 20 hospitals achieving the highest level of compliance for maternity services.

The NHSLA has recently carried out a review of the standards and assessments process and as a result from April 2014 onwards there will not be any further assessments against ARMS or CNST standards and consequently no levels 1, 2 or 3 awarded. Instead there will be increased emphasis on a 'Safety Learning Service' to include a range of resources to support scheme members in learning from claims and making changes in practice to reduce litigation and the harm associated with those claims.

### Central Alerting System (CAS)

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other critical safety information and guidance to the NHS and other healthcare providers. The aim of the CAS process is to improve patient safety by recommending actions in response to national incident trends.

We have made excellent progress in improving the rates of compliance for completing recommended actions within specified deadlines for CAS alerts. From 1 January 2013 to 31 December 2013 we achieved 99 per cent compliance with deadlines: our highest rate yet. Further details of compliance in comparison to 2012 can be found in the tables below.

<b>Safety Alert Statistics   January 2013 - 31 December 2013</b>					
<b>Issuer</b>	<b>No of alerts issued</b>	<b>Alerts distributed within UHL</b>	<b>No with completion deadline within reporting period</b>	<b>Actions completed in deadline</b>	<b>% Completion Rate</b>
<b>MHRA</b>	89	45 (51%)	99	99	100%
<b>NPSA</b>	2	1 (50%)	1	0	0%
<b>DHEF</b>	67	67 (100%)	55	54	98%
<b>Total</b>	<b>158</b>	<b>67 (42%)</b>	<b>155</b>	<b>153</b>	<b>99%</b>

## Safety Alert Statistics | January 2012 - 31 December 2012

Issuer	No of alerts issued	Alerts distributed within UHL	No with completion deadline within reporting period	Actions completed in deadline	% Completion Rate
<b>MHRA</b>	84	47 (56%)	86	84	98%
<b>NPSA</b>	1	1	3	2	67%
<b>DHEF</b>	2	2	8	8	100%
<b>Total</b>	<b>87</b>	<b>50 (57%)</b>	<b>97</b>	<b>94</b>	<b>97%</b>

From 1 April 2014 our risk management team is implementing an electronic process to streamline the way in which alerts are handled to reduce the associated administrative burden.

### Looking ahead...priorities for 2014/15

- Continue to develop risk management processes within the hospitals to ensure that that all types of risk are identified and effectively managed;
- Continue to develop our internal web (intranet) risk management web page to provide a risk management resource for all our staff;
- Perform a training needs analysis to identify staff groups requiring specific levels of risk management training;
- Development of e-learning risk management training packages making it easier for staff to access the required training;
- Implement the electronic CAS process and monitor effectiveness through audit/review of CAS processes at a local level to provide assurance of effective management of alerts.

## Safeguarding adults and children

Safeguarding people from harm and abuse is integral to the care people receive within our hospitals. We recognise that people who use hospital services can be vulnerable and some may have experienced harm. We continue to work to raise awareness and put in place safety measures to protect people.

The safeguarding service continues to support our frontline staff, and following a restructure we introduced a Safeguarding Assurance Committee, to oversee and seek assurance that our services meet and exceed the minimum standards for good safeguarding practice. During the year we expanded the remit of our safeguarding team, so that the service has oversight of mental health care and domestic abuse services. Through this work we have been able to raise awareness about new services to support people vulnerable to radicalisation, domestic abuse and mental health illness.

In the past year we have seen an increase in the number of adult safeguarding cases reported to the service and we have been involved in a continued high-level of complex child protection cases. Some of these cases have been considered through serious case and domestic homicide reviews, which offer opportunity for very detailed inter-agency scrutiny. Whilst these reviews have not highlighted any significant deficits in our practice, it has given us the opportunity to reflect and further improve aspects of our services.

Scrutiny of the services we offer to safeguard people is carried out by external agencies through inspection by the Care Quality Commission and Clinical Commissioning Groups. Both agencies have confirmed that we are compliant with all key safety indicators.

For 2014/15, the safeguarding service has developed a work plan to determine the key pieces of development. This will include further work to raise awareness of domestic abuse, supporting the NHS strategic priority to raise awareness of radicalisation and increasing team capacity to provide increased frontline support to staff on safeguarding issues.

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## **Heart failure specialist service**

The heart failure specialist service was developed to enable timely access to specialist care for this group of patients. National and local data has shown that heart failure patients experience improved outcomes if cared for by a specialist during their stay. Hospital readmissions are reduced; there is improved continuity with community services and an enhanced understanding of managing their condition – which all leads to an improvement in care.

Rapid access heart failure clinics have been set up to provide urgent patient assessments. This service provides an alternative to emergency admission. Patients and referrers have been very positive about the experience of using this service. The heart failure rehabilitation service has seen a significant increase in referrals during the year and it continues to provide patients with the knowledge and tools to promote health and wellbeing for the longer term.

Advance care planning has improved for this patient group. We have seen specialist input from the palliative care team on the wards and in the newly established advanced illness clinic, as well as during weekly multi-disciplinary team meetings. This is a prime example of services working together to improve the quality of care received by patients and their families.

Through education, the specialist team has endeavoured to share knowledge and best practice across a wide forum of health care professionals involved in the care of heart failure patients.

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## **Infectious diseases and HIV services**

Professor Karl Nicholson retired in 2013 after 25 years with the speciality and Dr Wiselka has been appointed chairman of the Infectious Disease and Tropical Medicine SAC. The inpatient Infectious Diseases unit continues in its role as a regional referral centre for HIV, multi-drug resistant tuberculosis and patients with other infectious conditions and acts a base for expertise across the trust.

An OPAT (outpatient antimicrobial therapy) service is being developed following a successful pilot programme allowing patients to be treated at home, demonstrating a saving of more than 2,000 bed days. Professor Nicholson's replacement will be a full-time NHS post to support OPAT and Infectious Disease services.

Adult HIV services are now provided by specialist commissioning and the trust has successfully reconfigured adult HIV care into one service managed by infectious diseases within the Emergency and Specialty Medicine Clinical Management Group. This is now one of the largest adult HIV centres in the country with more than 1,200 patients on treatment achieving viral load suppression rates more than 95 per cent. This has provided some challenges and exciting opportunities for our Infectious Disease services as our outpatient clinics are developed.

As hepatitis C moves into a new era of highly effective treatments, the Infectious Disease specialist nurse-led hepatitis treatment liver clinics have seen increases the number of patients successfully treated.

## **Making Every Contact Count (MECC)**

Making Every Contact Count (MECC) provides a framework for our staff to deliver health promotion messages to patients, regardless of their reason for a visit to our hospitals. It encourages staff to 'ask, advise and act' on health issues such as smoking, alcohol use, exercise and healthy eating.

Both the STOP Smoking Service and Alcohol Liaison team have delivered training in making every contact count to staff, making them aware of the services available to patients in making fundamental lifestyle changes which impact on health.

### **STOP Smoking Service**

Giving up smoking is one of the fundamental health improvement activities run by our specialist STOP Smoking Service. The team has brought the service to staff through many promotional events, including stands within our hospitals for the annual 'Stoptober' national event, as well as No Smoking Day. We also took part in the Leicester Hospitals NHS Change Day Pledge roads how and the annual staff benefits fairs, which were particularly successful, with staff signing up to clinics and taking away lots of information.

The team began recording patients who smoke onto the Patient Centre database, which is now taking place in various wards at Glenfield. Patients who smoke are also identified on wards 8 and 16 at the Royal Infirmary. Once this information is collected it is inputted onto the database by the Stop Smoking Service team. Recording of this information has helped tremendously with the implementation of the bedside service at Glenfield.

During the year, the team delivered MECC training to around 2,000 front line staff.

### **Alcohol Liaison team**

Our Alcohol Liaison team now has four nurses and continues to cover all three of our hospitals. During the year, the team set a number of priorities:

- *Improve the team profile:* the team increased the number of posters in departments and wards around our hospitals and made use of the information boxes available on the internal intranet, INsite;
- *Increase referrals* – using MECC, the team worked with the STOP Smoking Service to target specific wards and educate staff on how to 'ask, advise and act' on any lifestyle issues that may be of concern to specific patients. This proved successful, but remains an on-going piece of work;
- *Increase training* – The team was involved in the mandatory training programme for the Emergency Medicine CBU/ as well as a range of formal training sessions, including healthcare assistant study days;
- *Improve accessibility to the service* – the team's working day has been extended, with staff now available from 8am until 6.30pm Monday to Friday and 8am – 4pm at weekends. This was made possible through funding provided via the MECC CQUIN. The team has also developed a database to allow staff to input information more quickly and analyse data more efficiently.

### **Healthy eating**

We have been working with our colleagues at Leicestershire Partnership NHS Trust to deliver the healthy eating and physical element of MECC. Our staff now ensure that each patient has an opportunity talk about their individual needs and to find out what is available locally for them.

Patients are receiving information to enable them to make healthier lifestyle choices leading to the kinds of long-term change which mean better health and wellbeing.

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## **Hospital 24/7**

Hospital 24/7 is an integrated approach to out of hours care at all three of our hospitals through a phased approach on acute medical, surgical and cancer wards. This new way of working has been supported by the implementation of an IT solution for workload delegation called NerveCentre. We started the project in August 2012 and implemented at the Glenfield in Feb 2013, the General Hospital in April 2013 and the Royal Infirmary over a phased period between August and December 2013.

Since beginning the project we have seen a number of benefits realised for patients, staff and our processes. We have enhanced patient safety by introducing a system that allows staff to prioritise care for acutely sick patients through improved clinical handover and the implementation of a traffic light system, which ensures the patient is seen according to their condition. This new process avoids delays in care as the right skilled person for the appropriate care can be immediately contacted and attend to the patient according to priority of need.

We have seen a reduction in the numbers of clinical incidences with an improved communication system which lets senior doctors know exactly what is happening and the priority of each patient.

The system allows staff to see a complete record of tasks that have been completed, when and by whom. This significantly reduces clinical risk by eradicating any possibility of tasks being missed by supporting timely and appropriate care.

Doctors training records are now electronic which gives them the ability to see a summary of the work they have performed. This means that the hospital will be able demonstrate the level of training opportunities and show that the junior doctor has achieved a full range of competencies.

Key performance indicators have shown

- Doctors have been notified of patients with a EWS (Early Warning Score) of 4 or above immediately, and have responded within 30 minutes for 95 per cent of the time. This means that patients who are deteriorating are being seen and treated quicker;
- A minimum of 22 per cent of out of hours tasks are completed by non-medical staff out of hours, which means that the medical staff are concentrating on tasks appropriate for their skill level, and non-medical tasks are being completed quicker by the most appropriate member of staff;
- A reduction in clinical incidents in the out of hour's period improving patient safety.

The new way of working advocates a multidisciplinary approach to handover night and day. This will be enhanced by an electronic handover being implemented using the same software (NerveCentre), which is important to support continuously improving handing patients over from shift to shift.

The process and system are now fully operational and managed by the Out Reach Lead. In the coming year continuous improvements will be made to enhance and develop the work. This will include the integration with electronic handover, review of the work allocation out of hours, development on requesting results, adding apps to the iPhones for educational purposes, and exploring additional safety initiatives.

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## Improving the emergency process

This year our Emergency Department (ED) has seen more patients than ever. It was designed for about 115,000 patients a year and in 2013/14 we saw over 150,000. So, not only have we started to develop a scheme to tackle this by investing in a new ED, which is likely to cost about £40m, but we have also changed the way we do things during the year to cope with the larger numbers of more complex patients we are seeing.

In July, and working jointly with the local Clinical Commissioning Groups (CCGs) and the Urgent Care Centre (next door to the current ED entrance), we created a one entrance for patients using both Adults' ED and the Urgent Care Centre. Aimed at reducing waiting times, adult patients who arrive on foot are now triaged by a nurse to make sure they receive their treatment in the most appropriate place for their condition. This could be in ED, with their GP, a local pharmacist or at the Urgent Care Centre, which operates 24 hours a day, 7 days a week. If the patient's condition is deemed appropriate to be seen by their GP, they will have an appointment made for them at their own practice within 24 hours. If they are not registered with a GP, they will be registered with a practice close to where they live.

We know that there has never been more choice for patients and this can be confusing. Instead of expecting patients to decide what is 'urgent' and what is an 'emergency', we have made it easier by directing all walk-in patients through one new single front door located in the Urgent Care Centre.

By creating a 'single front door', something that already works well in other NHS trusts, it has allowed us to guide patients through to the most appropriate care, which has released pressure in ED allowing our staff to deal with medical emergencies. This change has also seen an improvement in patient experience.

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## Developing integrated, quality services for frail older people

Building on the success of the emergency frailty unit (for frail older patients staying for under 24 hours), we developed the acute frailty unit (for stays of up to 48 hours). Working with the LPT (Leicestershire Partnership Trust) we are in the process of appointing new staff to deliver a comprehensive geriatric assessment in all of the community hospitals of Leicester, Leicestershire and Rutland. This consolidates the existing vertically integrated care pathway for frail older people with urgent care needs and fits well with our plans for the urgent care floor and our commissioners' plans to further develop community geriatric services in the future.

Over the next few years, geriatric medicine will enhance horizontally integrated services within our hospitals through development in the FOPAL service, reaching into novel areas such as surgery, oncology and psychiatry. Geriatric medicine will expand its academic base to deliver education training and innovation that will support the health economy in the management of frail older people in the years ahead.

## Avoiding 5000 harm events by 2016 – Falls

By adopting initiatives such as cohorting patients in dedicated fall-risk bays, the older people's team has achieved an impressive drop in the number of falls observed in Datix reports and in the Safety Thermometer audit.

## **Emergency Department improvements**

We have continued to improve our emergency department and respond to comments from patients and visitors to the department. In particular, we have worked on plans to create an emergency floor concept at the Royal Infirmary site which will address the future demands and challenges faced by the service.

The overwhelming themes that come through are about the efficient service and the friendly staff. Of the 137 patients that made comments about friendly staff, 102 were extremely likely to recommend our service to their friends and family.

Work carried out during the year includes:

- Increased the number of consultants;
- Increased the number of nurses;
- Extensive building works to increase resus bays to eight beds from five;
- Design and development of emergency floor undertaken;
- Development and training of international recruits;
- Good feedback from the GMC (General Medical Council) and deanery;
- Funding secured for development of the model to roll out to nursing staff.
- Our patient survey reports 618 positive responses and 46 negative responses. Only 13 patients commented about long waits (these are our discharged-home patients).

### **Assessment Units**

Our assessment units have undergone a review and have had their bed base (number of beds) increased. A new process has been piloted over the year where acute medical consultants discuss GP referrals to ED. Other improvements include:

- improvement in coding and data quality of patient information;
- a dedicated seminar room;
- a dedicated geriatric lead on the Acute Frailty Unit.

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## **Integrated stroke services and delivering care closer to home**

Our stroke department now provides a service caring for people with a stroke from the time they enter our Emergency Department, through their hospital stay to providing care and therapy for them at home.

The stroke team will assess patients in the Emergency Department on a 24/7 basis, arrange initial investigations, take them to the acute stroke unit and then onto further rehabilitation either in the stroke rehabilitation units or in their own home. The Early Supported Discharge Service is now being rolled out to all stroke patients across Leicester and Leicestershire. This allows many patients to leave hospital earlier than usual to continue therapy in their own home.

If a patient is seen in the Emergency Department and has recovered from their stroke, instead of being admitted to the hospital for investigations they are given an appointment to be seen the next day or within a few days in the TIA clinic. This one-stop clinic operates 365 days a year and enables patients to have all their investigations undertaken and results reviewed all on the same day. Essential treatment required to help prevent further strokes is then provided for patients in the clinic.



## **Safety/joined up emergency care**

During the past year our biochemistry and critical care outreach services have developed a trust-wide acute kidney injury (AKI) alert system.

Studies suggest that as many as one in five people admitted to hospital as an emergency suffer from AKI and it has a significant impact on patient outcomes and NHS resources.

The 2009 *Adding Insult to Injury* report from the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) found that only around 50 per cent of AKI patients received good care and identified significant delays in the recognition of AKI.

Nephrologists have worked closely with the biochemistry service to develop electronic flagging of patients with confirmed AKI wherever they are admitted within our hospitals so that they can be managed optimally with the advice of a nephrology consultant if necessary.

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## **New fracture liaison service**

A new Fracture Liaison Service devised to speed up the diagnosis of osteoporosis opened at the rheumatology department at the Royal Infirmary.

The referral service, set up by Dr Peter Sheldon, consultant rheumatologist and his team at Leicester's hospitals, works with the Royal's Fracture Clinic and local GPs to ensure that patients are offered a specialist scan to measure bone density. A total of 880 patients have been seen within the pilot service and we will be reviewing this in 2014 to potentially expand it into a permanent service.

Infliximab in the community has proved to be a successful pilot that has released full day-case slots and there are plans to expand the number of places to 30 in 2014 as patients are keen to enrol on the programme.

A DAWN system of monitoring DMARD and biological therapy drugs has been introduced to improve safety and quality of care. Once fully established this should improve patient centred healthcare.

The young adult service for rheumatology is now set up and has just started offering joint rheumatology/renal clinic appointments.

In 2014/15 we aim to recruit a consultant post to join the rheumatology department, particularly to work on establishing an early inflammatory arthritis pathway which meets recognised best practice.

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## Improving theatre productivity

### **Fewer cancellations, fewer delays**

We have been unable to reduce the number of operations cancelled on the day during the year. This is a poor experience for patients and is not a good use of our resources.

The primary reason for the cancellations is lack of beds on the day of admission, which is a result of the increased emergency admissions reflected in the emergency department (ED) performance.

During 2014/15 we aim to significantly reduce the level of cancellations by protecting elective beds from emergency admissions, increasing the bed base and improving the scheduling of operations.

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## Improving outpatients

### Fewer cancellations, fewer patients who do not attend (DNAs)

Patients, who do not attend (DNA) their booked appointments without informing the hospital, mean that the hospital has wasted an appointment slot and the appointment could have been used to see other patients earlier. To tackle this, we have implemented texting patients to remind them to attend their appointments and this has had a positive effect. In 2012 the DNA rate was 7.4 per cent but for the same period in 2013 this reduced to 6.6 per cent, equating to approximately 500 less DNAs per month. This is better for patients and is a real efficiency for our hospitals.

At the moment approximately 85 per cent of our clinics are covered by the texting service, with more than 50 per cent of patients receiving text reminders for their appointments, the plan is to increase this further, but it is dependent on patients providing their mobile phone numbers whenever they attend the hospital.

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### Care closer to home for haemodialysis patients

The number of home haemodialysis patients has increased throughout the year so that we now have 80 patients able to dialyse at a time and frequency of their choice. We are planning to build on this progress in 2014/15 by adding at least a further 20 patients to the home dialysis programme.

We are redeveloping and increasing our dialysis capacity starting with the units in Northamptonshire. During 2013/14 we have identified a commercial partner to develop two new dialysis units in Northamptonshire to provide up-to-date modern facilities for patients. The new units are planned to open towards the end of 2014/15.

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### Developing services for neurology patients closer to home

We have recently started a nurse-led community service and we are now able to offer patients appointments in a clinic setting closer to home, which includes community clinics, GP practices, community hospitals and home visits where necessary. Our service offers appointments to all patients living with Parkinson's disease (with or without dementia) Progressive Supranuclear Palsy and Multiple System Atrophy. The clinics offer practical advice on drug and disease management, education for patient's families and the wider community and support for the patient and their family.

We have also managed to secure funding for a fifth and sixth consultant to help ensure we meet demand on the service, and we have recruited a neurophysiologist to help deliver a comprehensive neurophysiology department.

Over the next two years we will develop an epilepsy nurse-led community service which will also include community and GP clinics. We are also working towards a seven-day ambulatory 'first fit' service.

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### Dermatology care closer to home

We have started working on a bid for the Alliance contract that will see our dermatology department managing all dermatology care throughout Leicestershire. The vision is to offer all

Leicester, Leicestershire and Rutland patients a choice which includes integrated care pathways for routine elective care. Ultimately we hope to provide more care for patients closer to their home, with specialist nurses providing more post-diagnosis care.

The skin cancer service recently passed an external peer review, which highlighted three serious concerns which are/ have been addressed. The review has given us the opportunity to review the skin cancer service and increase the CNS team and going forward into next year, we aim to create one-stop sessions to speed up diagnosis and subsequently treatment for patients with suspected skin cancer. As part of our trust-wide initiative, skin cancer will be one of the first tumour sites to move to directly booked urgent (two-week wait) referrals. We aim to deliver these urgent appointments within seven days.

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## **Improving care for children**

Over the past year we have been in negotiation with our colleagues at Peterborough regarding the provision of Paediatric Surgery for their children. We have had a long established working relationship with them with one of our surgeons providing outpatient services over there, which then evolved to include some day case operating sessions in Peterborough.

As a result one of the Peterborough surgeons retiring we have worked with them to have a joint Consultant Appointment, which will see a Consultant working there 50 per cent of the time, and 50 per cent here in Leicester. This is an additional appointment and will run alongside the existing agreement. Essentially all Paediatric General Surgery for patients under the care of Peterborough Hospital will be cared for by one of our consultants.

This is a model we would like to roll out further and we have already established links with Lincoln Hospital, Kettering, Nuneaton, and Warwick and we are looking to expand these links at those sites in the future and to extend to other sites if possible. This maintains the ethos of treatment locally using the expertise of Tertiary Centres.

On the medical front, we have successfully expanded our Consultant paediatrician numbers covering the Children's Assessment Unit and now offer a much broader range of options for General Practitioners, including telephone advice and rapid access appointments as an alternative to hospital admission. This is continually being developed and will move towards a 16 hour a day service at some point.

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## Improving the estate

### Immediate benefits and medium term reconfiguration

A *Strategic Plan for Leicester, Leicestershire and Rutland Health and Care* sets out the direction for the models of health, care and support services that will need to be in place in five year's time across Leicester, Leicestershire and Rutland.

The sustainable future strategy is underpinned by robust contract and financial models which will support the delivery of the right care in the right place; focusing on the best outcomes for our patients.

As part of this work, we have updated our clinical strategy to complement that of our LLR partners and address the diverse needs of the populations we serve.

The strategy focuses on:

- quality care for all – patient safety, improve outcomes and patient experience
- our Quality Commitment to *Save Lives, Reduce Harm, Patient-centred care*
- seven-day a week consultant delivered services
- optimising clinical service adjacencies to reduce avoidable deaths in our hospitals
- reducing the amount of time patients avoidably spend in hospital
- care closer to home through better and more integration with community services
- providing high quality services in a financially affordable and sustainable way.

Over the last twelve months, the capital planning and delivery team is working on the outline business case for the emergency department (ED) to create an emergency floor concept on the Royal Infirmary that will address the future demands and challenges faced by the service to provide:

- increased capacity for emergency services
- a centre of excellence
- an improved environment and experience for users.

Other areas of improvement

- An outline business case is also being developed for the proposed move of vascular services to Glenfield; bringing it together with cardiology/cardiothoracic surgical services and support vascular services as a centre of excellence.
- A surgical triage facility at the Royal Infirmary that enables a streamlined patient assessment process by introducing senior clinical decision-makers at the beginning of the patient journey.
- Reconfiguration of endoscopy facilities at the Royal Infirmary providing enhanced patient privacy and dignity and improved infection prevention.
- Improved ventilation for patients in the Osborne building, at the Royal Infirmary.

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### Making improvements to our delivery suites

This year we have invested £2.9m to make improvements to our maternity units to improve the experience of women and their partners, as well as the working environment for our staff.

By the end of the project we will have created four extra delivery rooms to improve capacity (two on each site), three additional high dependency care spaces; 13 additional ward beds; four-bedded birth centre at the General and relocation of the birth centre at the Royal Infirmary, co-located to delivery suite; created a maternity assessment centre situated away from labour wards on both sites; refurbished ward 1 at the Royal Infirmary to facilitate efficiencies in Gynaecology Assessment Unit; created additional bathroom facilities for the majority of delivery rooms at the Royal Infirmary and refurbished and upgraded the maternity theatres at both sites. The birth centre at the General, “the meadow birth centre”, has two new birthing pools and active birth rooms, which were finished in March 2014 and are already being very well used by the women.

Although the scheme is not complete (it will be finished by Summer 2014), we have already received very positive feedback from women, their partners and staff on the new areas.

We also received £246,000 of funding from the government as part of their fund to improve choice for women and improve their experience of maternity care. The new areas will have reclining armchairs for our delivery rooms as well as a selection for our maternity wards at both the Royal and the General. These will allow partners the opportunity to stay and be comfortable. The rest of the funding will improve our two current pool rooms and add two new birthing pools allowing more women to use water during their labour.

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## Improving IM&T

### Priority schemes to support clinical service delivery

It has been an exciting year for the Information and Management Technology team (IM&T), which has completed the first full year in partnership with IBM. This includes introducing several key systems to support patient care through the trust without any hitches. We have also strengthened our commitment to effective communication with our primary care partners.

We made significant investment, with the support of external funding from NHS England, in improving our mobile computing infrastructure. This has included significant improvements in the security and performance of our equipment as well as investing in mobile solutions, such as the mobile clinical handover tool, to enable clinical staff to have information when and where they need it. This is the start of an exciting revolution with mobile computing to be placed at the heart of the technical innovation strategy. This is just the start and we expect to be doing much more in 2014/15 to build on this.

As part of the transition to becoming a digital, paper-free hospital we have begun several key projects. This includes the electronic patient record and electronic document and records management. These will change how we record new information about our patient's care, how we access the information held within our existing 495 million sheets of paper and how patients will be able to view and interact with their information. These are significant projects and will be completed in 2016.

We have had a successful year in terms of external appraisal of our products and plans. We are one of the very few NHS organisations to have achieved the international ISO 27001 accreditation for the security of our services and information within our hospitals. We also received the Heath Services Journal award for '*Enhancing Care by Sharing Data and Information*' and we received additional inward investment from NHS England of £4m to accelerate our mobile clinical IT programme.

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## Developing Listening into Action

### Better engagement with staff, leading to better support for colleagues and clear leadership standards

Introducing 'Listening into Action' (LiA) has been an exciting journey to mobilise and engage staff for better patient care. We launched LiA in March 2013 to give our staff the power to transform our hospitals to deliver 'Caring at its best'.



LiA creates a culture for frontline staff to lead and develop services, whilst ensuring that services are patient-centred, safe and efficient. It builds strong foundations through:

- senior leaders connecting the right people around all our major challenges;
- providing service teams with the opportunity to collaborate and share ideas;
- listening to frontline staff so that they get on and deliver actions which will benefit patients and staff;
- fostering a sense of collective ownership by the teams to deliver results.

Frontline staff and those who help them are supported to work differently, in a way that links to outcomes they care about, makes them feel valued, and gives them 'permission to act'. To date 23 pioneering teams have adopted LiA at a local level within wards and departments and 11 trust-wide schemes have used LiA to make significant changes.

- **Seamless Out of Hours services:** TTO (medicines to take home) turnaround has improved to less than 60 minutes on all our sites (50 per cent within 30 minutes) avoiding discharge delays;
- **Equipment fit for the job:** 46 per cent improvement in the use of infusion pumps and 20 per cent reduction in equipment being hoarded by ward / department staff;
- **Reducing paperwork and processes:** reduced day case documents from 14 to one;
- **Car parking and travelling:** by March 2014 75 per cent of bike shed locks were replaced at the Royal Infirmary. We also introduced an 80 per cent reduction in prices for patient/visitors using Welford Road NCP car park;
- **IM&T:** 30 per cent drop in complaints related to IM&T;
- **Right staffing:** more than 200 overseas nurses recruited for 2014 and counting...

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### Listening to our staff

A healthy organisation starts with a Pulse Check...Pulse Check surveys are a way of finding out how staff feel about working for us and asking their views on the services we provide.

At the start of our LiA journey back in March 2013 we conducted an organisation-wide Pulse Check, which was then repeated in January 2014. The results showed an upward trend in positive responses, and a positive position when compared to other LiA organisations nationally.

Following the Listening Events, Pioneering Teams and Enabling Our People Schemes were chosen. Pioneering teams are clinically-led teams, departments, pathways, wards or functions who want to pioneer adoption of Listening into Action (LiA) to engage and mobilise all the right people - across the usual boundaries - around their own specific challenges, and drive forward those changes together. The Enabling Our People (EoP) Schemes are teams, departments, pathways or corporate functions who have been nominated to help address specific issues raised by staff.



Pioneering teams have also completed a team-based Pulse Check during the 'listening' phase of their change initiative and repeated this at the end of their 'action' phase. Like the organisational responses, we found that the teams responded much more positively following the action phase.

### Sustaining the spread of LiA

Although there are many examples of the positive impact of LiA, we recognise that there is still a lot of work to do in 2014/ 15.

Listening into Action repeat Pulse Check		March 2013	January 2014	Comparison
Q1	I feel happy and supported working in my team/department/service	50.05%	49.82%	-0.23%
Q2	Our organisational culture encourages me to contribute to changes that affect my team/department/service	28.46%	42.61%	+14.15%
Q3	Managers and leaders seek my views about how we can improve our services	27.07%	40.08%	+13.0%
Q4	Day-to-day issues and frustrations that get in our way are quickly identified and resolved	12.44%	25.59%	+13.15%
Q5	I feel that our organisation communicates clearly with staff about its priorities and goals	28.25%	46.42%	+18.17%
Q6	I believe we are providing high quality services to our patients/service users	30.09%	53.73%	+23.64%
Q7	I feel valued for the contribution I make and the work I do	17.3%	43.1%	+25.8%
*Q8	I would recommend our Trust to my family and friends	-	46.19%	-
Q9	I understand how my role contributes to the wider organisational vision	41.28%	72.36%	+31.08%
Q10	Communication between senior management and staff is effective	16.64%	36.24%	+19.6%
Q11	I feel that the quality and safety of patient care is our organisation's top priority	-	52.85%	-
Q12	I feel able to prioritise patient care over other work	-	48.71%	-
Q13	Our organisational structures and processes support and enable me to do my job well	-	33.92%	-
Q14	Our work environment, facilities and systems enable me to do my job well	-	32.39%	-
Q15	This organisation supports me to develop and grow in my role	-	36.77%	-

\*Please note that Q8 was changed in the repeat survey and therefore cannot be compared with survey one. In addition, questions 11-15 were new additions to the survey.

## Developing our specialised services

**Our specialised services are expanding to meet the growing needs of our patients and the wider area**

### **East Midlands Congenital Heart (EMCHC) Service**

During 2013/14 the East Midlands Congenital Heart (EMCHC) service has worked hard to ensure that the service specification standards of the new Congenital Heart Disease review will be met. A revised business plan is currently being finalised redefining the estates, facilities and staffing requirements to deliver a future proof congenital cardiac service for the population of the East Midlands.

The surgical service continues to build on its success in carrying out the full range of congenital cardiac procedures and this year has successfully provided surgery for congenitally corrected transposition of the great arteries for the first time. We have introduced state of the art head light and video camera technology in our operating theatre and used both for internal training and sharing of practice via The Cardiothoracic Surgery Network (CTS NET). **Watch one of the videos [here](#).**

Individual successes within the surgical team include Mr Giles Peek featuring in the Sunday Times “Top 100 Doctors” list and Mr Attilio Lotto being appointed as the Regional Training Programme Director for Cardio-Thoracic Surgery. In November 2013 the service was delighted to appoint Mr Simone Speggorin as its newest substantive consultant surgeon.

We are extremely proud that the service has continued innovation in interventional catheter treatments. The Team, led by Drs Abdul Duke and Demetris Taliotis are now doing Percutaneous Pulmonary Valve Implantation (PPVI) independently and are in the process of introducing the new generation (Sapien ST) valve. Over the last 12 months the Team have successfully introduced procedures for stenting patent ductus arteriosus and ventricular outflow tracts. These innovations have been supported by internationally renowned experts including Dr Mike Mullen (The Heart Hospital, London), Dr Jo de Giovanni (Birmingham Children’s Hospital) and Dr Shakeel Qureshi (Evelina Children’s Hospital).

The Adult Congenital Cardiac Team has continued to expand its presence in hospitals within the East Midlands, now providing out-patient clinics that patients can access locally, in Kettering, Derby, Nottingham, Mansfield and Lincoln. Dr Simon MacDonald has recently been appointed as the second substantive ACHD consultant and brings expertise from several major centres in the UK. Simon has a particular interest in Research.

The EMCHC nursing team continues to grow in strength and expertise. Two senior nurses, Jo Wright and Claire Bostock, have recently completed the first stage of their advanced practice training and were successfully appointed to substantive Advanced Nurse Practitioner posts in Paediatric Intensive Care (PICU) in April 2014. Their input has noticeably improved the continuity and quality of care on PICU. The quality of nursing care in all areas is reflected in consistently high results in nursing metrics and success in projects carried out through the Releasing Time to Care initiative. Nurse recruitment remains an on-going challenge, but new initiatives this year have included international recruitment, presence at national recruitment events and approaches to universities in the region offering opportunities for specialised training/education and placements.

The EMCHC team were delighted to have been awarded an overall “Good” for its services and “Outstanding” in the category of “Caring” by the Care Quality Commission Inspection Team.

The comments in the report reflect the philosophy of the service; inclusion of families in all aspects of care, and providing a professional but friendly service.

Members of the EMCHC team continue to raise the profile of the unit through representation on national forums and working groups including

- Congenital Heart Services - Clinical Reference Group (CRG) Mr Giles Peek
- National Standards Group - Dr Frances Bu'Lock
- British Congenital Cardiac Association Council – Elizabeth Aryeetey
- Paediatric Intensive Care Society Managers – Carmel Hunt

The EMCHC network events continue on a quarterly basis and the educational aspect of these has been very well received and evaluated by referring centres, hosting the events. The forthcoming May meeting is being held for the first time by the services in Lincoln.

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## **ECMO**

The Extra Corporeal Membrane Oxygenation (ECMO) service for neonates and infants up to the age of six months is a now well-established service and has just completed its fifteenth successful year. This advanced treatment has included lung protective ventilation, HFOV, partial liquid ventilation, inhaled nitric oxide, prone positioning and ECMO.

The Heart Link ECMO Centre at Glenfield Hospital has been providing advanced respiratory support to patients of all ages since 1989, and we have treated over 1,900 patients in that time, and we have developed a national network of referring hospitals. The Leicester ECMO programme was established in 1989 and has grown over the past 25 years to become the busiest ECMO programme in the UK to date.

CESAR was a collaboration between 109 UK Intensive Care Units. Of the 180 patients randomised during the CESAR trial, one fifth of those randomised to receive ECMO were treated with advanced respiratory management in our unit. The excellent survival of these patients (83 per cent) has been used as the central argument in the establishment of advanced respiratory care units / designated ECMO centres. Our experience and the CESAR trial network, on which this is based, is therefore the benchmark for advanced respiratory care/ designation of adult ECMO centres in the UK. Co-operation and collaboration has continued between the neonatal and paediatric units at The Freeman Hospital in Newcastle and Great Ormond Street Hospital in London. In addition to this, we have established close relationships with Birmingham Children's Hospital and Alder Hey Children's Hospital in Liverpool; who are now surge centres.

Due to the increase in demand for respiratory ECMO, we have seen the successful designation and integration of four additional adult ECMO respiratory centres in the UK. The UK national adult ECMO network comprises of our own Glenfield Hospital, the Royal Brompton Hospital and Guys & St Thomas' Hospital in London, Papworth Hospital in Cambridge and Wythenshawe Hospital in Manchester. The designation process for Scotland will occur at a later date. In the meantime, all Scottish patients will continue to be referred to the Glenfield. We also continue to work in close collaboration with the Sick Children's Hospital in Yorkhill, Glasgow and the Karolinska Hospital in Sweden.

We have continued to provide a conventional transport retrieval service for our national network and we have established a mobile ECMO retrieval service. The team reviews the patient in the referring hospital, performs the cannulation and then establishes the patient safely on ECMO before transferring the stabilised patient back to our unit at the Glenfield.

### **Activity during 2013/14:**

<b>Group</b>	<b>Respiratory</b>	<b>Cardiac</b>
Neonatal	50	13
Paediatric	17	15
Adult	71	2

We also transferred six neonatal/ paediatric patients to other designated ECMO centres during this financial year for on-going care and management.

The ECMO service creates an environment for staff to grasp opportunities to advance their skills, knowledge and expertise in leadership, research, specialist and advanced nurse practice. All staff participate in clinical supervision and reflective practice, engage in different resources to keep abreast of nursing / medical professional issues.

The ECMO Specialist Training Course is held three times a year and the permanent ECMO team train and support staff from all over the UK and around the world. All team members mentor, educate and support ECMO students throughout their period of preceptorship.

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### **Reducing delays for cancer patients**

We have appointed a lead cancer clinician and senior manager to lead on the performance of the 62-day wait target for cancer treatment. A weekly cancer action board began meeting in June 2013 to focus on reducing delays, removing any blockages in the patient's care journey and holding tumour site leads to account for achieving the target.

Our results are now above the agreed improvement– this illustrates the benefit of strong clinical leadership and a clear accountability framework.

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### **Older people and dementia care**

We appointed meaningful activities facilitators in September 2013 to provide additional support for people with dementia within our hospitals. These activities are designed to support physical, sensory and psychological wellbeing and help to gain deeper understanding of the person behind the dementia.

Working with the Alzheimer's Society, we implemented three carer's support programmes for new carers of people with dementia. We have secured further funding for four more programmes in 2014/15.

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### **Elective Care Bundle**

We have been working on a new health ALLiAe, formed to provide Community Elective Care services in Leicester, Leicestershire and Rutland (LLR). The Alliance has been formed by us, Leicestershire Partnership NHS Trust, LLR Provider Company Limited, East Leicestershire and Rutland Clinical Commissioning Group (CCG) and West Leicestershire CCG who took over from Derbyshire Community Health Services NHS Trust (DCHS) which has provided the Elective Care services in LLR for the last three years. We were appointed the contract which officially started on 1 April 2014.

The Alliance now provides services including outpatient appointments, outpatient treatment, day case surgery, radiology and community paediatric services across Leicester, Leicestershire and Rutland community hospitals. The partnership will make best use of clinical resources and offer flexible, elective and diagnostic services ensuring wider patient choice.

There will be a six month 'stabilisation period' to ensure the service is running efficiently, followed by a period of 'transformational' change from January 2015 onwards, where the Alliance will look at ways to improve the service for the public. LLR NHS Partners will work with a Clinical Reference Group and a Patient & Public Partnership Group to design and deliver new care pathways, focussing on integration, and encouraging better ways of working between organisations.

Just over three hundred members of staff have TUPE'd (Transfer of Undertakings [Protection of Employment]) to the Alliance, and will initially be employed by us and will continue to provide these services across the nine community hospital sites.

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### **Increasing our transplant service**

To further improve our specialist services, we have expanded the transplant programme with two additional consultant surgeons. This has led to an increase of around 25 per cent in the number of transplants carried out in 2013/14. This means that more patients are able to benefit from a transplant in their local centre and receive all the benefits of ceasing long-term dialysis. We plan to further increase the number of transplants carried out in 2014/15.

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## Developing medical education

### **Improvements to our Clinical Education Centre at the Royal Infirmary, better engagement with trainees and considering the shape of our future medical workforce**

Development is underway to convert the old Odames Ward at Royal Infirmary into a new, state of the art, library and learning space. All of our staff will have access to the latest information supported by a team of library professionals. Staff will be able to enhance their learning experience while working in our hospitals.

We have established an organisation-wide committee to improve engagement and improve the working lives of our junior doctors. Our Doctors In Training committee represents all specialties and all grades of junior doctors. The committee meets every other month and is currently working on improving communication and patient safety within our hospitals. A Listening in Action (LiA) event took place in December 2013 specifically for junior doctors and a number of areas for improvement were identified.

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### **Developing the medical workforce**

Medical trainers are supported to encourage excellence in our training. We work with the Leicester Education and Training Council (LETC) over the number and types of training posts we have and help us to explore and support the development of innovative workforce solutions to support patient care through education and training.

Enhance non-training medical posts to improve support and education and training quality, which will ultimately enhance the recruitment and retention of our medical staff. We have now set up an '*Education to improve patient safety group*', supporting innovative education and patient safety projects with the University of Leicester; we also ran a successful '*education to improve patient safety*' symposium.

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## Developing research

### **Strengthening Biomedical Research Units, playing a leading role in the creation of the Academic Health Sciences Network and securing funding from the National Institute for Health Research (NIHR)**

Our prestigious Biomedical Research Units (BRUs) continued to perform well as shown in the annual report submissions feedback from the NIHR. The Respiratory BRU was formally opened in September of 2013. The other new unit, Lifestyle, Diet and Nutrition BRU, is part of the internationally-renowned Leicester Diabetes Centre and was formally opened in November 2013.

It was announced in November 2013 that Leicester will also house a prestigious Cancer Research UK Centre as part of a national £100 million investment by Cancer Research UK (CRUK) to help train a new generation of cancer researchers and get new treatments and diagnostics to cancer patients sooner. The Leicester Centre is a partnership with the University of Leicester, the local Hope Against Cancer charity and the Medical Research Council Toxicology Unit at the university. The centre is based across the university and the Royal Infirmary and funding will be provided from April 2014.

We reached our annual target for recruitment of patients to national studies by the end of January 2014. The target is set by NIHR (National Institute of Health Research) and underlines our commitment to the NHS research agenda, particularly in view of the reduction in Comprehensive Local Research Network funding for the year.

We are one of 15 NHS trusts chosen to host the new NIHR Clinical Research Networks (CRN). This follows on from hosting the previous Leicestershire, Northamptonshire and Rutland Comprehensive Local Research Network. The new CRN will cover the whole of the East Midlands region and will be responsible for a budget in excess of £20m. The East Midlands Local Clinical Research Network covers the same geographical area as the East Midlands Academic Health Sciences Network in which we continue to play an important role.

We are set to play a leading role in the East Midlands Collaborations for Leadership in Applied Health Research and Care (CLAHRC) which came into being at the start of 2014. The East Midlands CLAHRC is the next phase in the CLAHRC programme developing on the previous successful first phase Leicestershire, Northamptonshire and Rutland and Trent CLAHRCs. The East Midlands CLAHRC will be hosted by Nottinghamshire Healthcare NHS Trust, but many of the themes and management will be Leicester-based.

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### **NIHR Biomedical Research Unit: Diabetes Centre of Excellence**

The team at the Leicester Diabetes Centre has been busy in the last 12 months, along with the official launch of the new centre in November 2013 by Sir Steve Redgrave who praised the work being carried out at the centre.

He said he was 'blown away' by the quality of what he had seen, adding that placing academic research alongside the work of clinicians would bring real benefits to patients.

Speaking of the time he was diagnosed with Type 2 diabetes 16 years ago, he said he felt devastated that he might not be able to achieve his ambitions. But the education he received about the condition helped him to adjust his lifestyle and achieve another record fifth gold medal.

“Having researchers and forward-thinking specialists in one area- that is why this centre is so important.”

The Leicester diabetes centre team have been producing high quality, high impact publications; notably a Lancet paper by Dr Tom Yates: *An increase of just 2,000 steps a day cuts cardiovascular disease risk by 8 per cent in those with a high risk of type 2 diabetes.*

A large international study of people with impaired glucose tolerance (IGT; a precursor to diabetes) has found that every additional 2,000 steps taken a day over one year roughly equivalent to 20 minutes a day of moderately-paced walking reduces the risk of cardiovascular events such as heart attack and stroke by 8 per cent.

“People with IGT have a greatly increased risk of cardiovascular disease”, explains study leader Dr Thomas Yates from the University of Leicester in the UK in *The Lancet*. “While several studies have suggested that physical activity is beneficially linked to health in those with IGT, this is the first study to specifically quantify the extent to which change in walking behaviour can modify the risk of heart disease, stroke, and cardiovascular-related deaths.”\*

IGT affects about 7.9 per cent of the adult population (344 million people worldwide), and this number is projected to increase to 472 million (8.4 per cent) by 2030.

Another of our researchers, Dr João Viana, working in chronic kidney disease also had a strong publication that was well received internationally. Walking exercise is safe from an immunological perspective and has anti-inflammatory effects in patients with pre-dialysis chronic kidney disease (CKD), according to new data from João Viana and colleagues. They suggest that these patients should be encouraged to take part in regular exercise as this will promote a healthy, more-active lifestyle that might have cardiovascular benefits.

The Leicester Diabetes Centre team was also shortlisted in the HSJ 2013 awards for clinical research. On being shortlisted, Tim Skelton, manager of the Leicester Diabetes Centre, said: “This nomination highlights our unique way of doing things, a way that provides close integration of research, innovation, postgraduate education, service transformation and delivery. Our diabetic patients receive the very best treatment and can be confident that their care is based on the most up to date knowledge.”

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## **NIHR Leicester Cardiovascular Biomedical Research Unit**

The Leicester Cardiovascular Biomedical Research Unit (LCBRU) aims to improve the diagnosis, prognosis and treatment of cardiovascular diseases. The unit’s research is focused around two themes: genetics and biomarkers and novel cardiovascular interventions. During 2013/14, LCBRU has been involved in more than 80 studies contributing to the body of evidence regarding new drugs and devices for use in cardiovascular medicine, and has published almost 90 peer reviewed journal articles, including publications in the *Lancet*, *Nature* and *New England Journal of Medicine*.

The diastolic heart failure study (DHF) continues to make good progress, having recruited 138/200 patients, while the RESCAN study demonstrated that surveillance scanning for small abdominal aortic aneurysms (AAA) at up to five years maintains a low rate of AAA rupture and was published in *JAMA (The Journal of the American Medical Association)*. This study will enable screening programmes to operate more cost efficiently and is likely to change clinical practice.

The genetics and vascular health check study (GENVASC), which is being run in GP practices across Leicester City and West Leicester, capitalises on the unique opportunity provided by the health check programme and has recruited more than 5,000 patients in an extremely time and



cost effective manner. This longitudinal study aims to determine whether the addition of genetic data improves risk outcome in patients.

The novel interventions theme continues to run a portfolio of studies, including a multi-national observational study of stent thrombosis (PRESTIGE), in which the UK is the leading recruitment centre. The INTERACT2 trial has provided evidence that intensive blood pressure-lowering within six hours of the onset of acute intra-cerebral haemorrhage is safe and is associated with significantly better functional outcome at three months. The current revision to US stroke guidelines was delayed pending the publication of this study in the prestigious *New England Journal of Medicine*, further demonstrating our commitment to providing world-leading, practice-changing research.

We are heavily committed to involving the public in our research and we are particularly proud of the patient-led research into spontaneous coronary artery dissection (SCAD) that recently received funding from the British Heart Foundation.

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## **National Centre for Sports and Exercise Medicine**

The National Sports and Exercise Medicine Centre in the East Midlands (SEMC-EM) is on track to open in early 2015. It is planned as an Olympic legacy project and will combine facilities for performance medicine, sports injuries as well as a focus on exercise as treatment in long term conditions.

There will be clinical research and teaching facilities alongside the clinical facilities. The building at Loughborough University campus has already been completed and is being kitted out with the help of a large catalyst grant from the Higher Education Funding Council awarded to Loughborough University. Leicester's Hospitals is one of the six NHS and University stakeholders, and we have taken responsibility for several areas including the clinical governance and radiology. Most of this year has been taken up by developing the governance arrangements of this shared venture, but hopefully these are now nearing completion and we can look forward to the opening of this unique facility next year.

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## **Hope Against Cancer**

During 2013/14, The Hope Clinical Trials Unit continued to build on its opening year's success. We have seen an increase in capacity to conduct research as the unit's reputation has increased. Predominantly the work has been NIHR portfolio studies and global commercial trial activity relating to different stages of drug development: usually Phase I, Phase II or Phase III.

As well as attracting patients from the immediate vicinity, we have drawn patients from various areas of the country. To date 1,947 patients have attended the unit for either treatment or review. While the majority of patients attend on a daycase basis, this has now extended to overnight stays for some when there is a requirement for more intense monitoring.

Dedicated clinics run for two specific genetics trials, and we have recently introduced a third for a haematology study. Since February, we have diverted 85 patients from a haematology outpatient clinic to attend a combined standard and research appointment in the unit. This has improved capacity in outpatients as well as providing improved consulting time for clinicians.

Recruitment into cancer trials at our hospitals has increased for its sixth successive year (now 7 per cent). The maximum number of trials open throughout the course of the year was 103. While some trials have remained difficult to recruit to, others have over-recruited. This includes a trial that has been reported in the press as '*wiping out cancer symptoms overnight*'.

Two doctors have conducted their own research projects over recent months on the unit which has provided a more efficient way of seeing and treating their patients as well as them being able to process samples in the immediate vicinity. Two nurses have been asked to sit on nurse advisory boards for the research studies that they are conducting – a tremendous accolade.

Our educational programme continues to develop: we have both medical and nursing student placements on the unit and promote a teaching programme that is open to all working within the Cancer Centre.

We receive very positive feedback from all our patients (and visitors) and we are about to complete a survey to ensure that we are meeting the needs of both patients and carers alike.

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## Valuing people – valuing our staff

### Our staff

	2013/14	2012/13	2011/12	2010/11	2009/10
Medical and Dental	1,570	1,551	1,496	1,477	1,496
Administration and Estates	1,982	1,924	1,953	2,054	2,104
Healthcare Assistants and other support staff	2,016	1,832	2,033	2,117	2,284
Registered Nursing and Midwifery	3,499	3,375	3,338	3,301	3,261
Scientific, Therapeutic and Technical	1,099	1,179	1,208	1,222	1,278

Please note that some staff (approx. 60) were reclassified from healthcare scientists (STT) to support staff. This was part of the Modernising Scientific Careers recoding exercise.

### Recruiting more nursing staff

Last year we made a commitment to get more frontline ward staff into our hospitals and onto our wards. Following a review we identified that we had over 400 nursing vacancies. Our Chief Nurse, Rachel Overfield, made it one of her top priorities when she joined us and since then, we have been actively recruiting trained nurses who want to work in theatre, emergency medicine, our intensive care units, cardiac and respiratory, trauma and orthopaedics, surgery, as well as those who want to care for children, cancer patients and those with renal disease.

We are not the only hospital trust in the country trying to recruit nurses; there is a lot of competition out there to get the best nurses. We already have close a relationship with DeMontfort University and it is important for us that the nurses who train with us choose to stay with us. But we have also needed to look further afield, and like many other Trust's, we have been trying to tempt nurses from other areas of the country and overseas from places like Ireland, Italy, Greece, Portugal and Madrid for nurses interested in working in with us.

So far we have recruited 200 nurses from overseas, and during 2014/15 we will continue with our recruitment campaign, ensuring that we have enough of the right staff to care for our patients.

When they join us they begin an induction programme that lasts for a minimum of four weeks, but could stretch to three months. The induction programme consists of our classroom based learning to understand the NHS, our organisation and our policies and procedures as well as adapting to cultural differences. Then they move onto the wards and carry out specially designed training to get them used to NHS practices and protocols. Initially they are not expected to take care of patients on their own, and work with the full supervision of qualified nurses.

### NHS staff survey

We collect staff views and experiences of working for us through the annual National Staff Survey and LiA Pulse Check to help improve the working lives of staff and the quality of care we provide. This analysis of results helps to identify if we are making sustainable change and to

identify areas for improvement. We have recently reviewed our results in the 2013 National NHS Staff Survey and the recent LiA Pulse Check results.

This year all staff were given the opportunity to complete the National Staff Survey and local questions were introduced for the first time. The results described below are based on the CQC sample (379 responses from 850 sampled). After seeing some large improvements last year, the CQC reported only one statistically significant change in 2013 – the completion of equality and diversity training.

One of the key measures is overall staff engagement and our results slightly increased from 3.66 in 2012 to 3.68 in 2013. It is disappointing that we slipped from average to below average when compared to other similar trusts.

In general we received positive results in relation to staff appraisal and education, training and learning and less positive results in relation to the observation of and reporting of incidents and accidents. There were also less positive results in relation to job satisfaction and motivation.

In contrast the results from local questions and the LiA Pulse Check portrayed a more positive picture. More staff now receive information from chief executive cascades and almost 70 per cent of staff believe colleagues and managers exemplify our values. There have been significant improvements in LiA Pulse Check results since the first survey in 2013 particularly in relation to improvements in the provision of high quality services, recognition of staff contribution and role clarity.

Actions to address concerns will continue to be driven through our Organisational Development Plan which is currently being refreshed. We have set out key actions to continue to build on staff and team experiences including team building development sessions for newly formed leadership teams and piloting new multi-professional development programmes such as 'Leading Across Boundaries'.

During 2014/15 we will be running 'listening events' in every ward and clinical department and will focus on improving mechanisms for raising staff concerns/incidents placing emphasis on building resilience into the organisation.

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## **Reducing staff absence**

Our staff are our most valuable resource. Our approach to reduce sickness absence in the last year goes hand in hand with promoting staff wellbeing. We have seen a small reduction in the annual cumulative sickness absence from 3.4 per cent in January 2013 to 3.3 per cent in January 2014. We were awarded a gold accreditation by the Department of Health in their Sports and Physical Activity Challenge in recognition of the comprehensive wellbeing programme offered to our staff.

We have improved our reporting of sickness absence and reasons through the use of an in-hours sickness monitoring and reporting system (SMART) to monitor the completion of 'return to work' discussions and ensure compliance with our sickness absence policy.

In February 2013, we looked at our promoting wellbeing and management of sickness absence policy and procedure, and it now further clarifies our approach to managing sickness absence, employee and management responsibilities and provides further guidance in supporting staff with long-term or chronic underlying health conditions.

We have spent time looking at ways to keep our staff well, and a number of projects have helped us to reduce sickness due to work-related stress. This work includes developing emotional resilience and self-care at work. Clinical management group management teams and

our human resources department (HR) have also continued to work closely with line managers to ensure appropriate support for staff and good management of their sickness absence.

Our Health and Wellbeing Steering Group was formed in the latter half of 2013 to ensure a strategic focus based on the five High Impact Changes that apply to every NHS organisation. Our key priorities over the next year are stress management and training which will be underpinned by our commitment to the Public Health Responsibility Deal (PHRD). To date, we have signed up to three PHRD pledges: *Chronic Conditions Guide*, *Occupational Health Standards* and *Physical Activity in the Workplace*.

And the staff tell us we are doing well: in the National Staff Attitude and Opinion Survey we rated above average for health, wellbeing and safety at work. We will continue to monitor the National Staff Survey and local staff polling results to identify any issues, either at a local level or across the organisation.

During 2014/15 we plan to make a further PHRD pledge by reporting on the *Health and Wellbeing of Employees* in annual reports and / or on our website, and will publish our sickness absence rates and organisational approach to its management.

We launched emotional resilience workshops in 2013, which have proved popular and beneficial – the format of the workshops will now be reviewed to meet demand.

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## Learning and development

Meeting the needs of our patients, through delivering safe, high quality care is dependent on having the right workforce capacity and capability, in the right place, with the right education, skills and behaviours.

To guide the development of our staff, we use a range of tools including the NHS Knowledge and Skills Framework (KSF) and National Occupational Standards and Competencies. These are designed to ensure that all staff have clear expectations of the skills, knowledge and behaviours they need to demonstrate in their role and have development plans to support them in acquiring these.

We are committed to providing learning and development opportunities for all staff. Our internal education teams coordinate a wide range of courses working together with Health Education East Midlands, East Midlands Leadership Academy, further education colleges, higher education institutions and private training providers.

Our 2013 national staff survey results show that one of our top ranking findings – in the best 20 per cent of acute trusts – relates to *'staff receiving relevant training, learning or development in the last 12 months'*.

We assess the quality of internal/external learning, education and development offered through a number of different ways for example understanding the impact on the individual's own development. We also capture and promote (both internally and externally) powerful personal stories where learning, education and development interventions have been especially effective in demonstrating the 'so what' difference from exposure to development.

Throughout the year we hosted a number of events to celebrate achievements and learning and to showcase projects and service developments implemented by learners who have attended development programmes in order to inspire others to make positive changes and encourage the transfer the learning.

## Core training

We have focused on statutory and mandatory training during 2013/14 as this is critical to ensuring that staff are safe at work and are providing safe, high quality patient-centred care. We have identified training that is absolutely essential and reflects the national Core Skills Training Framework (Skills for Health 2013). We re-designed statutory and mandatory training programmes in an e-learning format (where appropriate) to improve access and ensure the training we provide is high quality and educationally relevant. We have also increased capacity to deliver classroom-based training in core clinical areas including basic life support.

We set – and achieved – a minimum target of 75 per cent staff to complete statutory and mandatory training across all core programme areas by 31 March 2014.

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## Organisational Development (including medical engagement)

Quality is not just about numbers; it is important that we embed a common culture of openness, transparency, candour and compassionate care which puts the patient at the heart of everything we do. Culture can be defined as *'the values, beliefs and attitudes an organisation and its employees share about the way we do things around here'*.

We have embedded a set of core values and behaviours to enable us to place quality and safety at the heart of our hospitals and fulfil our purpose to provide 'Caring at its best'.



## Leadership qualities and behaviours

Leadership qualities and behaviours that support our vision will enable us to consistently demonstrate leadership excellence and deliver safe high quality patient-centred health care. Leadership qualities and behaviours are aligned to our values and have been developed following extensive consultation with staff and leaders from across our organisation.

## Leadership Qualities and Behaviours

*Leadership excellence in delivering safe high quality patient-centred health care*

<p><b>We treat people how we would like to be treated</b></p> 	<p><b>Live our Values in our actions every day</b></p> <ul style="list-style-type: none"> <li>Set clear expectations</li> <li>Show empathy and respect</li> <li>Trust and empower</li> </ul>
<p><b>We do what we say we are going to do</b></p> 	<ul style="list-style-type: none"> <li>Be responsive and accountable</li> <li>Communicate and feed back</li> <li>Be transparent and honest</li> <li>Support and develop</li> </ul>
<p><b>We focus on what matters most</b></p> 	<ul style="list-style-type: none"> <li>Be patient centred</li> <li>Plan effectively for the short and longer term</li> <li>Use resources effectively and efficiently</li> </ul>
<p><b>We are one team and we are best when we work together</b></p> 	<ul style="list-style-type: none"> <li>Be visible, available and accessible</li> <li>Listen to and act on the voice of the front line</li> <li>Build and maintain relationships and working partnerships</li> </ul>
<p><b>We are passionate and creative in our work</b></p> 	<ul style="list-style-type: none"> <li>Support innovation and creativity</li> <li>Recognise and celebrate success</li> </ul>

### One team shared values

*Approved by John Adler, Chief Executive, 1/8/2013*

To facilitate the required level of organisational change from the 2012 national staff survey, we set out an ambitious organisational development (OD) plan comprising of six work streams with clear alignment to our strategic direction:

- live our values
- improve two-way engagement
- strengthen leadership

- enhance workplace learning
- improve external relationships and workplace partnerships
- encourage creativity and innovation.

The plan has been reviewed by our external auditors and findings confirm strong implementation with actions evolving to ensure the direction and emphasis of the OD plan is meeting the needs of the organisation.

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## Medical engagement

Since November 2012, we have provided a three-day leadership programme for heads of service and consultants aspiring to leadership positions. Workshops are framed within the concept of task-orientated thinking. To date 67 senior medical colleagues have accessed the programme and – as a direct result of the feedback from medical colleagues – an additional follow-up day has been commissioned. The aim of day will be to review successes and obstacles and deepen understanding of the theory and application of Task Orientated® thinking. Further negotiation and managing performance skills will be practiced using real-life situations.

In partnership with Health Education East Midlands (HEEM), during December 2013, we piloted a successful one-day programme for mentors trained to use the 'Egan skilled Helper' model, to refresh their skills and for those new to/or interested in mentoring and buddying to gain insight into the Egan Model for mentoring. Fourteen consultants attended the workshop and further buddying and an additional mentoring programme are currently being developed with HEEM.

Practical half-day financial workshops were held in 2013 targeting consultants and doctors in training to provide hands-on assistance to examine their own patient-level information and costing systems (PLICS) data. The workshop also covered an overview of NHS finance, coding, business cases and general budgeting. Approximately 200 consultants have attended the workshops to date and an additional workshop was held for doctors in training in July 2013, with 54 participants (including those training outside of our hospitals). Further workshops are planned for 2014 targeting medical staff.

We have established a 'UHL Clinical Senate' to provide a sense check for current proposals and help develop strategy. The senate has been elected from across the consultant body and is specifically targeted at consultants who are not currently in trust management positions.

'LiA Code Breakers' are looking at ways to improve the accuracy and depth of recording and coding of co-morbidities and a full-day course 'preparing for your first consultant job' was held in February for senior registrars to prepare for consultant interviews.

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## Occupational health support

Our Occupational Health Service recognises the importance of ensuring staff health and wellbeing because this underpins improvements in staff engagement which in turn secure better care for patients (*Boorman Review 2009*).

We aim to help staff improve their general health, ensure that they are able to attend work, avoid work-related ill health and assist in managing stress and developing emotional resilience.

The service achieved SEQOHS (Safe Effective Quality Occupational Health Service) accreditation in 2012 – the national quality benchmark for OH. Accreditation demonstrates that our staff are receiving occupational health care of the highest quality meeting recognised



national standards, including Department of Health, Faculty of Occupational Medicine and the Royal College of Physicians.

We have demonstrated our role in assisting in rehabilitation and return to work in staff with chronic health conditions. A paper demonstrating our work with healthcare workers following a diagnosis of breast cancer is to be published shortly.

Dr Anne de Bono, Head of Service for Occupational Health, was elected chairman of the national Health and Work Network in April 2013. This two-year post promotes and represents NHS occupational health services across England, assisting in the development of best common practice and working towards greater collaboration between occupational health services, including the potential to deliver national contracts.

We aim to foster regional collaboration in 2014/15 and to ensure that we meet NHS Employers' profile of the ideal occupational health service in the NHS (*Your Occupational Health Service. NHS Employers December 2013*).

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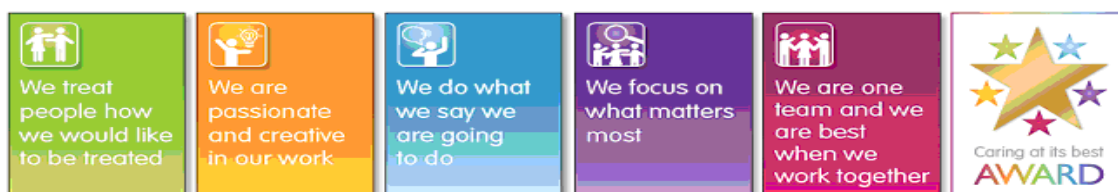
## Valuing our staff – reward and recognition

We recognise that our staff are the most valuable resource we have 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.

This year we used two 'Listening Events' to shape and develop a reward and recognition strategy designed to support the motivation, recruitment and retention of a high quality workforce. This is built around six key themes: pay and reward, benefits, learning and development, health and wellbeing. Together these form our 'employer brand' which is underpinned by our values. A cornerstone of this strategy is the formal celebration of staff achievements.

Our 'Caring at its Best' Awards Ceremony recognises individual staff and teams who epitomise our values and directly or indirectly enhance quality of patient care. Colleagues, patients and visitors make nominations and all those who have been winners and highly commended throughout the year are invited to the ceremony when overall winners are announced together with a winner for the category 'volunteer of the year'.



Our learning and development awards recognise staff who have invested time and energy in their personal development to enhance the experience of patients and carers. At our 2014 annual event more than 140 learners were presented with certificates for successfully completing vocational, skills for life or leadership / management qualifications. A number of special achievement awards were also presented by members of the trust board.

## **Attracting and retaining staff – our staff benefits scheme**

We introduced more highly popular 'salary maxing' salary exchange schemes to further aid employee retention. These included a salary maxing car scheme providing a brand new car, with around 200 people signing up in the first year alone. The Take IT Home provided the latest computing technology to our staff. The salary maxing benefits portal allows staff to consolidate all their benefits and savings in an easy to use way.

The first ever staff benefits fair was held during March at each of the main sites attracting around 1,100 employees. The fair offered employees the opportunity to visit a wide variety of stalls including 'the full range of salary maxing' offerings, staff accommodation, payroll, pensions, training and development, travel, wellbeing at work, AMICA staff counselling, occupational health, STOP smoking service and the staff Lotto.

We also launched our salary maxing benefits pages on our internet pages attracting enquiries from prospective employees about the benefits of working with us.

Our 'salary maxing car scheme' was Highly Commended in the prestigious 'Pay and Benefits Awards 2014' in the best Salary Sacrifice category.

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## **Health and safety**

We have now integrated health and safety, local security management and manual handling under one management umbrella. Health and Safety Services gives us a platform for delivering key elements of the patient and staff safety agenda under a much more robust system.

Key achievements so far include:

- integration of the three services
- cost efficient management of the patient surfaces management contract
- completion of the innovative manual handling work on the care of the bariatric deceased
- a reduction in RIDDOR reportable workplace injuries compared to last year
- conflict resolution training (CRT) for staff – there was a 500per cent increase in staff completing the various courses compared to 2012/13
- manual handling training compliance rose to 74per cent– an increase of 15per cent on last year
- introducing the health and safety e-learning course from 1April 2014.

During 2014/15 our Health and Safety Service will carry out an organisation-wide training risk analysis to ensure that all CRT training programmes target the right staff at the right time with bespoke programmes specific to job roles. We also be recruiting a qualified conflict resolution trainer to deliver our CRT training plan and introduce our new induction programme featuring revised manual handling training courses.

Other plans for 2014/15 include:

- complete the integration of the health and safety role with that of local security management to give greater resilience to both areas
- two members to complete the local security management specialist training from NHS Protect to support the HS/LSMS role
- a trust-wide security audit

- to develop and add roles to the current service
- better service for bariatric patients.

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## **Equality and diversity**

We continue to declare legal compliance with the Public Sector Equality Duty supported by a range of activities and processes. In 2013/14 we hosted a conference for staff on health issues for people who are gay, lesbian, bisexual and transgender.

We have seen an increase in use of the interpreting service, improved access for patients with a learning disability to our specialist nursing service and developed an e-learning hate crime training package for staff working in emergency areas and services. In addition we are meeting all of our external requirements via the Quality Schedule and the Learning Disability Self-Assessment Framework.

Mainstreaming equality has been the main focus for this year: our equality manager conducted a review of how equality is managed within our clinical areas. The review found that across all areas there is genuine commitment to the principles of fairness, equality of access for patients, carers and visitors as well as equal of opportunity for staff. There is also a good understanding of how to access the various services that are in place to make sure those patients with additional needs are well cared for and not disadvantaged. These include meeting the religious, spiritual, dietary and communication needs of patients.

### **Key findings from our Workforce Report 2012/2013**

Our workforce data was published in January. Broadly ethnic, disability, gender, sexual orientation and age representation has remained the same and is representative of our local population. We have seen a small increase in the number of female medical consultants, and an improvement in the numbers of staff declaring their sexual orientation and disability status. Further work needs to be undertaken in 2014/15 – but the results provide assurance that our human resources (HR) processes do not appear to discriminate against our staff from protected groups.

Our priorities for 2014/15

- Look at career progression for our black and minority ethnic (BME) staff at band 7
- Adopt best practice data collection and reporting for patients and staff
- Conduct a review of our grievances and disciplinary data
- Pilot a women's network
- Monitor patient access to the most commonly used care pathways and experience by protected characteristic
- Ensure equality due regard is built in to all service development and improvement

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## **Building on our relationships with GPs**

This year we have continued to build on improving our relationships with GPs and the clinical commissioning groups (CCGs) and to strengthen our communication links. We provide a monthly GP newsletter to update primary care on developments within our hospitals, offer educational sessions to GP staff using through their protected learning times (PLT), practical

sessions and clinical guidance. We maintain a website for healthcare professionals to access key information and provide a GP referrer's guide to explain the services available in our hospitals.

The GP hotline is very popular and we have introduced advice and guidance through choose and book (CAB) to further support GPs. The service has been well received and we hope to attract funding to continue to expand the services we offer to GPs.

Our inaugural GP and consultant conference focused on leading change. In addition we have run regular meetings for CCG lay-members to discuss health issues with directors including the chief executive.

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# Valuing people – valuing our patients

## Patient experience

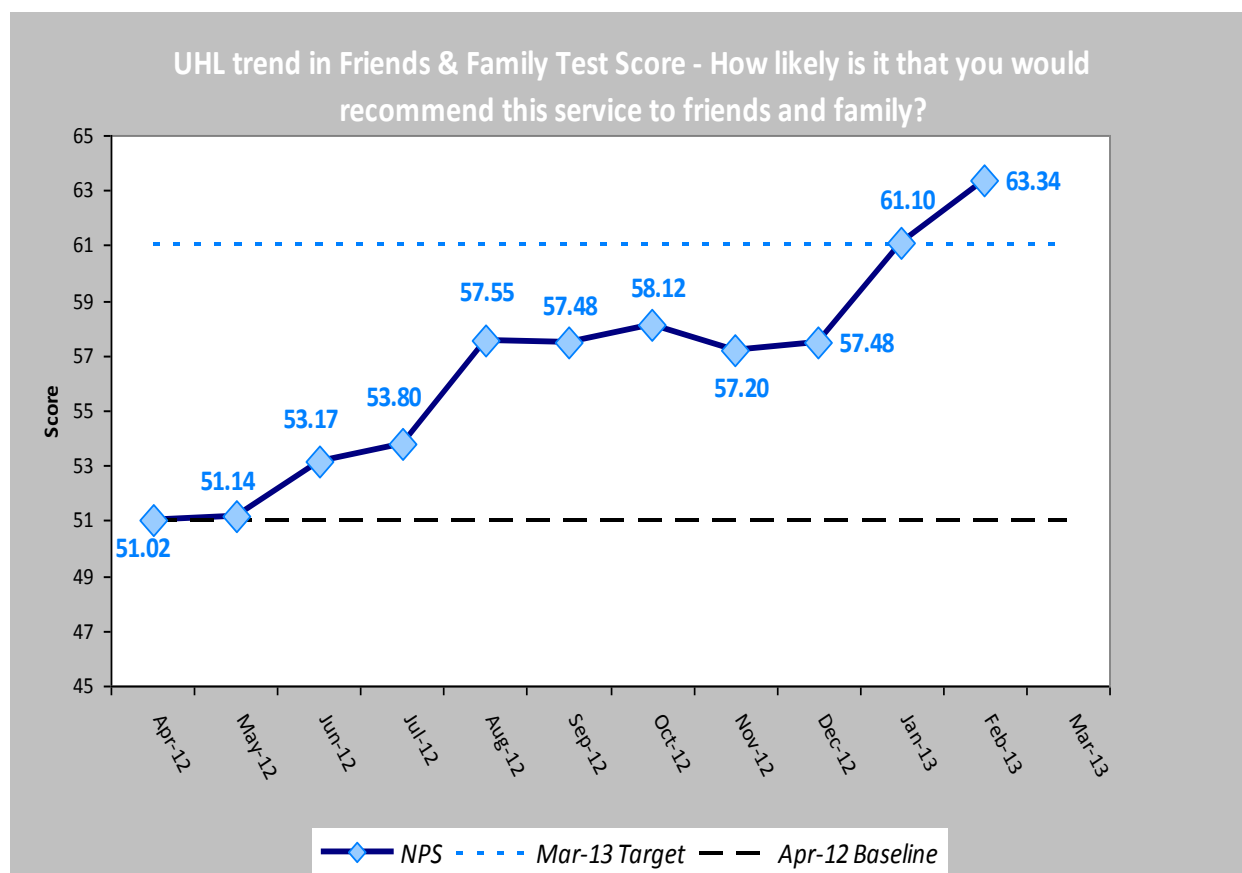
We continue to offer patient experience surveys to all patients, families and carers, so they can provide feedback on the care they have received across all services. The survey continues to ask the nationally set friends and family test question: ‘how likely are you to recommend our ward/unit to friend and family if they needed similar care or treatment?’ Extremely likely, likely, neither likely not unlikely, unlikely, extremely unlikely and don’t know.

The friends and family test results are available for each ward and department and feedback is reviewed by the clinical teams, and acted upon appropriately. The friends and family test can be collected using various methods including paper surveys, touch screens, hand held devices, QR scanning, texting, emails and through our website.

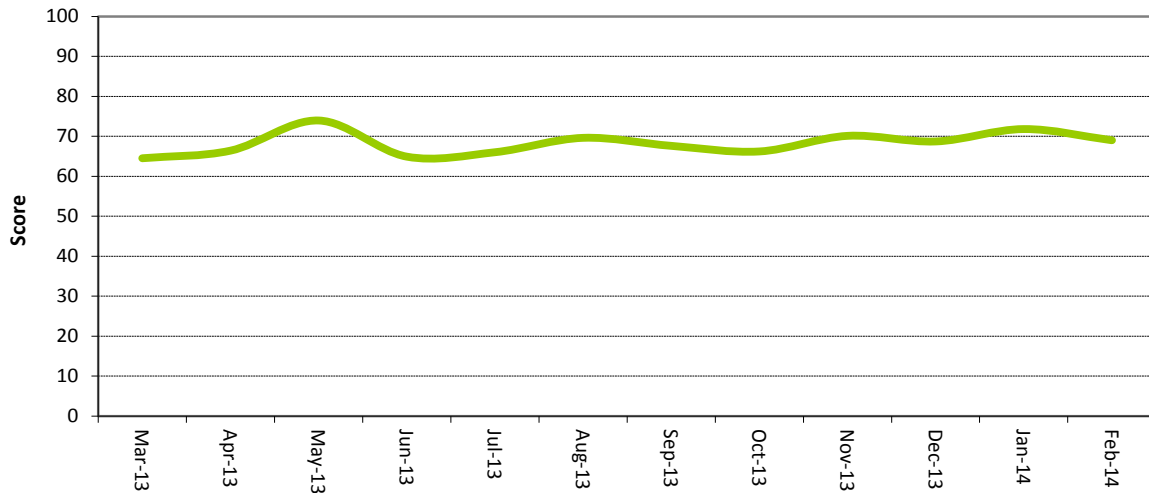
We began a 12-month trial, texting patients who have attended the endoscopy unit at Glenfield and the fracture clinic at the Royal Infirmary. Patients are asked if they would like to take part in the trial and provide their mobile number to a member of staff, who sends the friends and family test to their mobile phone, where they have the option to send free text comments. So far there has been an overall 54per cent success rate.

We have been offering the test in Gujarati, Punjabi and Polish as part of a trial on three wards. The results and comments are then translated into English and used to develop the service.

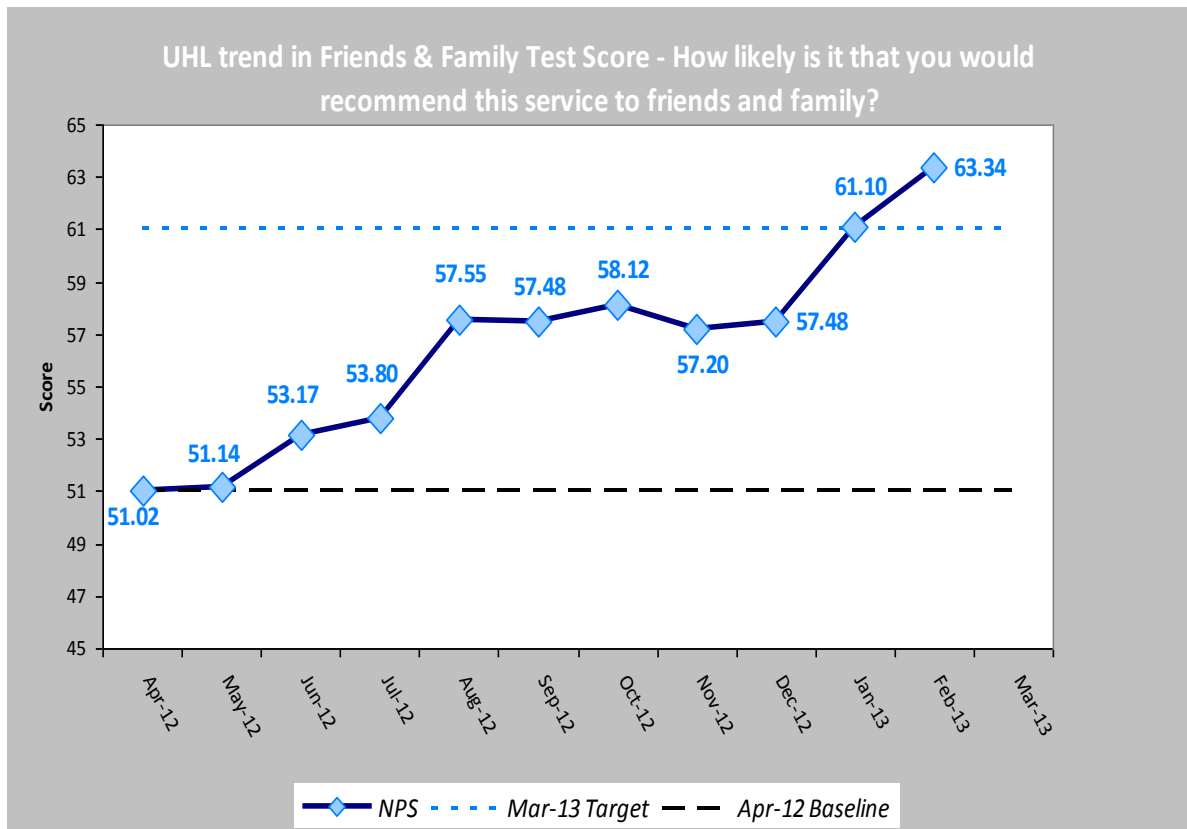
There has been year-on-year improvement in our test scores as detailed in the charts below.



### Inpatient - Friends and Family Test Score



### UHL trend in Friends & Family Test Score - How likely is it that you would recommend this service to friends and family?



### Message to Matron

Message to Matron cards are available at the entrance to most clinical areas and give patients, relatives, carers and visitors the opportunity to ‘tell us what they think’. The cards include space for comments to be given about any aspect of the service and allow the public to leave their name and number so the matron can contact them to provide further information. Matrons are able to act immediately on any issues and concerns.

Similar schemes such as 'Postcard to Leicester' in outpatients and 'you help us learn' in maternity continues to be used.

## **Volunteer surveys**

Throughout the year our volunteers carry out surveys within the trust. Volunteers make the patients feel at ease and give the volunteers very useful feedback. This year they have completed surveys on:

- call bells and the length of time it takes for them to be answered and patients being informed about them
- involved in care to discover if our patients feel they are involved in the care and decisions made about them and an
- older people's survey, to discover what matters most to older people when they come into hospital.

## **Trust board stories**

Monthly trust board meetings are open to the public in the afternoon, where the patient experience team present a monthly patient story. This can be about a good experience or an experience where improvements could be made. The stories can be presented by a patient in person or through video and audio recordings, and give us valuable feedback which can help to develop services.

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## **Privacy and dignity**

The patient experience team conduct a three-monthly privacy and dignity walk round, along with a manager linked to Interserve (our provider of estates services) and a senior nurse from the areas visited. The team ensure that the clinical areas allow patients to maintain their privacy and dignity while in hospital by checking wards to ensure that patients from both sexes have access to the appropriate bathroom facilities and that there is appropriate signage in the clinical areas. Any areas that are not compliant are addressed and appropriate changes are made.

## **Carer's post**

Following discussion with carers at a forum, we introduced a new role in February 2014. The carers' advice/support and liaison worker works on eleven wards at the Royal Infirmary, identifying and supporting carers while the person they care for is in hospital ensuring that they are given the right information and involvement in the care planning and discharge planning of the person they care for.

She has been able to support a number of carers and signpost them to appropriate services to support them when the person they care for is discharged home.

## **Improving experience for patients and staff**

We held three training days for medical and nursing staff in October 2013 focusing on ways to improve communication and the experience patients get while in our hospitals. It gave a greater understanding of different communication types and how we can adapt our communication methods. The training days were well received by staff, who went away armed with new ideas to develop the services that are offered.

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## **Discharge experience**

Multidisciplinary board rounds have been introduced daily in all medical wards at the Royal Infirmary and Ward 2 at the General monitored through daily conference calls which includes members of integrated discharge team, social care and pharmacy.



To improve communication with patients we now provide leaflets called 'Leaving hospital' and 'Now you are getting better' to help them plan.

To ensure privacy and dignity standards are met for all patients, outdoor clothes are now available for patients to go to a discharge lounge (if they do not have their own in hospital).

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## **Involving our members and the wider public**

This year we have been improving and refining the ways in which we talk and work with our members, patients and the wider public. We have recruited several new patient advisors – we now have 16 – who provide a lay perspective across the organisation on many boards, committees and projects. When we reorganised our management structure to create seven clinical management groups (CMGs), we allocated at least two patient advisors to each CMG. All CMGs have a named lead responsible for coordinating patient and public involvement (PPI) activity in their area.

Our public membership has now grown to more than 14,500 people. Members are invited to a range of engagement opportunities, as well as our monthly medical talks (now '*Leicester's Marvellous Medicine*'). Over the year the number of our younger members has also increased, with many joining as a first step to volunteering with our hospitals.

In November 2013 the popular Prospective Governors group was consulted on the general direction of meetings over the coming years. The focus of the meetings will be on engagement between our public members and the trust board, with the agenda being set by our members and us.

The involvement of patients has become fundamental to the management of our new Listening in to Action (LiA) projects and each of the 12 new 'pioneering teams' includes a patient representative who participates in the running and development of the project. The patient representatives on these project groups have been drawn from our patient advisors, members of Healthwatch and also members of our Prospective Governors group.

In December 2013 our chief nurse held a successful listening event in which patients were invited to share their experience of care at our hospitals. More than 50 people took part in this event and despite the fact that some experiences were not positive, the event was well evaluated by both participants and our staff. The format will be used again for an event later in 2014.

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## **Older People's Champions network**

We have an active Older People's Champions network made up of staff from a range of backgrounds and specialties who have volunteered to support older people within the clinical setting to promote excellence in practice and a responsive individualised service.

Champions can be identified by patients, their family and carers by their Older People's Champion badge. To date, more than 1,700 members of staff have been trained to become an Older People's Champions.

To support September's Older People's Month, an Older People's Champions celebration event took place entitled 'Listening to Older People' and focused on patient experience feedback from older people and their carers.

More than 100 staff and volunteers attended the event to learn more about what matters most to older people in hospital as well as sharing ideas in how we can make a difference in practice.

External agencies including Age UK, Alzheimer's Society and Older Peoples Engagement Network supported the day.

There were key speakers from consultants, volunteer services, education and practice development, patient experience and health care assistants. A carer also shared her story of how the Carers Support and Information Programme (CrISP) which we support, in partnership with the Alzheimer's Society, has helped her in caring for her mother.

Three workshops were run throughout the day to promote dementia champions, the patient profile and Parkinson's disease.

At the end staff were asked what they would do in their areas to improve the experience for older people in our hospitals, the main theme was to listen more to older people.

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## **Meaningful activities**

Meaningful Activities Facilitators were appointed in September 2013 to provide additional support for people with dementia. Activities supporting physical, sensory and psychological wellbeing help to gain deeper understanding of the person behind the dementia.

With the Alzheimer's Society, we have implemented three 'Carers Support Programmes' for new carers of people with dementia. Further funding has now been secured for four more programmes to continue in 2014/15.

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## **Providing spiritual and religious care**

Our chaplaincy aims to provide high quality, safe and compassionate spiritual and religious care in a cost effective way. We provide patient-centred care to enhance the experience of patients and bereaved families.

Over the year our chaplains and chaplaincy volunteers made more than 14,000 visits to patients. This is an invaluable part of our commitment to deliver 'caring at its best' to patients and their relatives' right up to the end of life. Chaplains support those who face emotional distress arising from questions concerning life, death, meaning and purpose – questions that can be acutely highlighted by illness and suffering. We ensure that a chaplain is available day and night for when patients or families ask to see a chaplain urgently (especially around the time of death).

We provide multi-faith chapels and prayer facilities on each site, for the use of patients, visitors and staff. The chaplains, who are from various faiths, also help patients continue to perform their religious rituals while they are in hospital.

The chaplaincy is not only for 'religious' people. On many occasions people with no faith find comfort and strength from talking to someone who is a part of the healthcare team, but not involved in their immediate care on the ward. Often patients want to talk about how their illness is affecting them and their family.

## **Volunteering**

We have been running our volunteer service for 12 years and have around 800 active volunteers at any time. Some are involved in volunteering as a route to a future career or further education, some to 'give back' and others because of where they are in their life: so we have a constant throughput of people and we are always recruiting to our volunteering team. There are more than 100 different volunteering opportunities across our hospitals. Our

volunteers are as diverse as the community we serve and each require individual support and management.

The profile of volunteers is much higher than in previous years and the range of activities that they are involved in is increasing. Volunteer roles are carefully selected and monitored to make sure that they fit within the acceptable standards for volunteer involvement.

This year we have been working towards the Quality Mark Investing in Volunteers to reinforce and recognise our commitment to volunteers. The assessment process requires standards to be met in nine different areas: these range from a promise to commit adequate resources to support volunteers and to offer clear recognition for volunteer involvement to having clear recruitment and training policies and procedures to ensure the safety and wellbeing of volunteers and the patients they support.

We have already completed the first stage of the assessment – the provision of paper evidence and statistics – and the assessment stage commences in May. Stage two involves a visit by an assessor who will speak with volunteers and staff and observe volunteers ‘in action’ to establish whether or not we are following our good practice guidelines.

Achieving this Quality Mark will represent a huge leap forward for our service in recognising the contribution that volunteers make towards patient care. This not only impacts on the importance that is placed on the extra support that volunteers can give to patients and their families but also on the value of our individual volunteers. Each volunteer is unique in their motivation and involvement as a volunteer – they all bring something special to the role.



## Sustainability

We are fully committed to supporting and implementing sustainability across a wide and diverse range of services and procurement initiatives and this was reinforced by the presentation of a sustainability plan to the our trust board in May 2013. The plan outlined the main requirements to implement the plan.

We are a key member of the Leicester Leicestershire and Rutland FM Energy and Sustainability group which has been established by NHS Horizons and Interserve to provide technical and statutory compliance guidance in support our sustainability strategy. NHS Horizons and Interserve also ran a series of events promoting sustainability, leading up to the NHS Sustainability Day on the 27 March and beyond.

NHS Horizons have started the process for gathering data for the 2014 ERIC (Estates Return Information Collection) return and are on course to meet the mid-June 2014 deadline for submitting the return.

### Energy and Sustainability Projects

**Heating and Power** There are two schemes to install new and improved combined heat and power (CHP) units at the Royal Infirmary and Glenfield that will reduce carbon emissions by a total of 4,707 tonnes.

Description	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	Annual Change		Overall change 2009-2014	
	Gas usage (KWh)	93,697,272	96,694,476	85,673,210	86,601,762	83,164,032	-3,437,730	-4.14%	-10,533,240
Electricity Usage (KWh)	36,426,819	39,489,130	42,535,080	46,390,022	48,522,097	2,132,075	4.39%	12,095,278	33.20%
Totals (KWh)	130,124,091	136,183,606	28,208,289	132,991,784	131,686,129	-1,305,655	-0.10%	1,562,038	1.20%
Costs (£)	£5,136,734	£5,282,765	£6,479,603	£7,223,638	£7,995,022	771,384	9.65%	2,858,288	55.64%
CO2 Emissions (Tonnes)	36,910	39,236	38,881	41,334	40,724	-610	1.48%	3,814	10.33%
CO2 Emissions (CRC Cost)	N/A	N/A	£376,571	£404,539	£400,777	-3,762	-0.94%	N/A	N/A

**Refurbishment of our restaurants:** During refurbishments we looked for sustainable elements and introduced:

- recyclable wooden furniture and fittings
- recyclable wooden cutlery and recyclable takeaway packaging.

**Minor works / refurbishment projects:** Lighting upgrades have introduced low energy LED technology at the General and Glenfield hospitals.

At the Royal Infirmary the emergency department (ED) flooring and theatre recovery projects have both received a very good BREEM rating for sustainable building and development. BREEM sets the standard for best practice in sustainable building design, construction and operation and has become one of the most comprehensive and widely recognised measures of a building's environmental performance.

**Reduce chemical usage:** Interserve has introduced microfibre cleaning technology. This new method of cleaning all clinical and non-clinical areas has reduced chemical usage across our hospitals.

**Waste disposal and recycling:** Our waste management committee has proposed a Waste Awareness week in July 2014. Reducing waste at source, using materials from sustainable sources and recycling are key initiatives for the group.

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## Travel management

Our Travel Plan was approved by the board in December 2013 and incorporates a range of environmental initiatives.

Discussions have and continue to take place with Leicester City Council and Leicestershire County Council with regards to park and ride opportunities. We are also working with the councils to establish a travel portal. This will provide information on all modes of transport.

Alternative staff travel – including cycling and walking initiatives – is being actively promoted and the new Leicestershire car share scheme has been launched. We have always been part of the Leicestershire Car Share scheme, but this scheme has been re-launched with a new website. Our staff can choose to share with other staff alone or with people outside of Leicester's Hospitals.

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## Patient information and liaison service (PILS)

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

Activity through the PILS continues to increase, which is a reflection in part of the ease in reporting concerns, as well as the increased profile for complaints management and issues of patient safety within the media.

We have also seen a significant increase in formal complaints received and investigated in 2013/14 from the previous year.

<b>PILS Activity</b>	<b>2013/14</b>	<b>2012/13</b>	<b>2011/12</b>	<b>2010/11</b>
Verbal complaints	1390	1054	1152	1289
Formal complaints	2057	1549	1723	1531
Concerns	346	343	66	-
Request for information	203	292	434	356
<b>Total</b>	<b>3996</b>	<b>3238</b>	<b>3375</b>	<b>3176</b>

## Complaints

We endeavour to respond as quickly as possible to all issues raised, with a standard for 95 per cent compliance within the agreed 10, 25 and 45 working day performance targets. The table below identifies, by clinical management group (CMG) and speciality, how we managed during the year. Clearly we could have done better and by re-organising the team and working closer with the CMGs, we endeavour to see an improvement over the coming year.

The CMGs have been requested to scrutinise their complaints response performance and ensure that statements from clinicians and final responses letters are provided within the required timescales. Improved compliance with complaints performance will be monitored through the CMG Quality and Safety Board meetings and poor performance escalated to the Executive Quality Board.

An improvement trajectory of >90% compliance for 10, 25 and 45 day complaints was set for all CMGs to achieve by May 2014, but due to an increase of activity across the service this has not been met. Performance to date for quarter 1 2014/15 has shown an improvement.

### 10 and 25 day Performance – 1 April 2013 to 31 March 2014

	10 day				25 day			
	Number received	No. replied within 10 days	No. replied over 10 days	% replied within 10 days	Number received	No. replied within 25 days	No. replied over 25 days	% replied within 25 days
<b>Emergency Care</b>	37	34	3	92%	91	78	13	86%
<b>Specialty Medicine</b>	31	24	7	77%	112	84	28	75%
<b>Cardiac, Renal, Respiratory</b>	22	18	4	82%	50	42	8	84%
<b>Respiratory and Thoracic</b>					4	4	0	100%
<b>Imaging &amp; Medical Physics</b>	21	20	1	95%	9	9	0	100%
<b>Professional Services</b>	8	8	0	100%	11	10	1	91%
<b>Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGS)</b>	39	33	6	85%	98	84	14	86%
<b>Renal, Respiratory and Cardiac (RRC)</b>	11	9	2	82%	50	34	16	68%
<b>Emergency and Specialist Medicine</b>	37	27	10	73%	134	89	45	66%
<b>Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep (ITAPS)</b>	3	3	0	100%	10	9	1	90%
<b>Musculoskeletal and Specialist Surgery</b>	133	128	5	96%	105	92	13	88%

	10 day				25 day			
	Number received	No. replied within 10 days	No. replied over 10 days	% replied within 10 days	Number received	No. replied within 25 days	No. replied over 25 days	% replied within 25 days
<b>Clinical Support and Imaging</b>	23	22	1	96%	33	26	7	79%
<b>Women's and Children's</b>	9	8	1	89%	106	94	12	89%
<b>Corporate and Legal Affairs</b>	1	0	1	0%	0			
<b>Trust Medical Director</b>	1	0	1	0%	0			
<b>Finance and Procurement</b>	3	1	2	33%	1	0	1	0%
<b>Human Resources</b>	2	2	0	100%	0			
<b>Interserve</b>	33	26	7	79%	5	4	1	80%
<b>NHS Horizons</b>	13	11	2	85%	11	9	2	82%
<b>Nursing</b>	2	2	0	100%	8	6	2	75%
<b>Operations Directorate</b>	1	1	0	100%	4	2	2	50%
<b>Pathology</b>	3	1	2	33%	1	1	0	100%
<b>Specialist Surgery</b>	157	156	1	99%	79	75	4	95%
<b>GI Medicine, Surgery, Urology</b>	58	56	2	97%	121	102	19	84%
<b>Cancer, Haematology, Oncology</b>	10	9	1	90%	20	20	0	100%
<b>Musculoskeletal</b>	23	23	0	100%	73	69	4	95%
<b>Intensive Care/Theatres/Anaesthesia/Pain Management/Sleep</b>	3	3	0	100%	12	12	0	100%
<b>Women's</b>	22	22	0	100%	81	77	4	95%
<b>Children's</b>	0				29	25	4	86%
<b>Totals:</b>	<b>706</b>	<b>647</b>	<b>59</b>	<b>92%</b>	<b>1258</b>	<b>1057</b>	<b>201</b>	<b>84%</b>

## 45 day performance | April 2013 – 31 March 2014

	<b>Number received</b>	<b>No. replied within 45 days</b>	<b>No. replied over 45 days</b>	<b>% replied within 45 days</b>
<b>Emergency Care</b>	9	6	3	67%
<b>Specialty Medicine</b>	5	4	1	80%
<b>Cardiac, Renal, Respiratory</b>	3	3	0	100%
<b>CMG - Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS)</b>	8	4	4	50%
<b>CMG - Renal, Respiratory and Cardiac (RRC)</b>	3	1	2	33%
<b>CMG - Emergency and Specialist Medicine</b>	8	6	2	75%
<b>CMG - Clinical Support and Imaging</b>	1	1	0	100%
<b>CMG - Women's and Children's</b>	3	3	0	100%
<b>Specialist Surgery</b>	1	1	0	100%
<b>GI Medicine, Surgery, Urology</b>	8	7	1	88%
<b>Cancer, Haematology, Oncology</b>	2	2	0	100%
<b>Musculoskeletal</b>	3	3	0	100%
<b>Women's</b>	4	4	0	100%
<b>Children's</b>	3	3	0	100%
<b>Totals:</b>	<b>61</b>	<b>48</b>	<b>13</b>	<b>79%</b>



## Freedom of information

The Freedom of Information (FOI) Act was passed on 30 November 2000, and the full Act came into force on 1 January 2005. The Act applies to all public authorities including us. The purpose of the Act is to allow anyone, no matter who they are, to ask whether information on a particular subject is held by us and to ask to see that information. The Act sets out exemptions from that right, covering any information that may not have to be released.

In 2013/14, we received **500** Freedom of Information requests and/ or requests for environmental information, compared to 370 in 2012/13 (a 26% rise in requests).

We responded to 96% of these requests within the statutory 20 working-day deadline in 2013/14. Many of these requests contained multiple individual questions, with information needing to be obtained from more than one clinical or corporate area of our organisation – the table below shows the number of times that different areas had to provide information during the year to respond to all of the individual questions within those 500 FOI requests.

Some information (such as patient information leaflets and 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.

### Freedom of Information/Environmental Information Regulation requests received between 1 April 2013 and 31 March 2014, split by Clinical Management Group (CMG)\*\*/Corporate Directorate

Area	Number of times asked to provide FOI data in 2013/14	Approx. % of overall 2013/14 FOI activity
Finance and Procurement	95	19%
Human Resources	84	16.8%
Corporate Nursing	53	10.6%
Women's and Children's CMG	41	8.2%
Clinical Supporting and Imaging CMG	39	7.8%
Emergency and Specialist Medicine CMG	37	7.4%
Strategy	36	7.2%
Operations	34	6.8%
Cancer, Haematology, Urology, Gastroenterology and Surgery CMG	31	6.2%
NHS Horizons (facilities management issues)	29	5.8%
Information, Management and Technology	29	5.8%
Corporate Medical	27	5.4%
Musculoskeletal and Specialist Surgery CMG	21	4.2%
Corporate and Legal Affairs	19	3.8%

**Freedom of Information/Environmental Information Regulation requests received between 1 April 2013 and 31 March 2014, split by Clinical Management Group (CMG)\*\*/Corporate Directorate**

Area	Number of times asked to provide FOI data in 2013/14	Approx. % of overall 2013/14 FOI activity
Renal, Respiratory and Cardiac CMG	18	3.6%
Critical Care, Theatres, Anaesthesia and Pain Management CMG	11	2.2%
Marketing and Communications	4	0.8%
Research and Development	1	0.2%

*Many of the requests involve multiple clinical areas/corporate teams, so the numbers shown above are higher than the total number of 500 FOI requests received in 2013/14.*

*\*\* Clinical Management Groups were formed in November 2013, replacing our clinical divisions. In the table above, requests have been allocated to whichever CMG now covers that particular service.*

## Information governance

Protecting patient privacy continues to be one of our key objectives and has been supported by a range of new activities to ensure that risks arising from the management of personal data are managed to the highest standards.

With changes across the NHS impacting on our services there needs to be a drive to protecting patient's privacy. Sharing information remains an important part of the way in which the NHS operates as whole but we can only provide information where there is a clear legal basis. A new project to secure sharing of information has been introduced and will deliver improvements during 2014/15.

Our performance with all compliance targets continues to improve during this year. We achieved a related objective to train all staff to understand information rights. Our privacy strategy is now focused on making the most of the technologies and services that allow information to be managed to the greatest benefit of the public.

### Information Governance incidents

Category		
1	Loss of inadequately protected electronic equipment, devices or equipment from secured NHS premises	2
2	Loss of inadequately protected electronic equipment, devices or equipment from outside secured NHS premises	2
3	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	2
4	Unauthorised disclosure	4
5	Other	0

## Emergency planning

This year has seen big changes in how we as an organisation and the NHS operate. The emergency planning team has been working with our new facilities and IT providers as well as local NHS organisations to ensure continued resilience in local NHS services.

The team hosted a placement student from De Montfort University's Master's programme who worked on ensuring that we could identify the risks of failure in our supply chain, and what suppliers had in place to continue providing goods to our hospitals. As a result of their work the supplies team now has a plan for responding to supplier failures.

The rest of the team has focused on the development of the new major incident plan and local business continuity plans for all service areas. More staff have now been trained in what to do when an incident occurs and recent minor incidents have shown that staff are using their training. The team has also redeveloped the trust control room where duty managers operate. This gives the team, senior manager and director's on-call access to the latest information.

In November we took part in an NHS England regional exercise that saw Leicestershire respond to a fictitious train crash with chemicals involved. We responded well with a positive outcome from the exercise, but there are undoubtedly a few areas of improvements that we are working hard to resolve.

During 2014/15 the team working on hospital evacuation, pandemic flu, internal incidents, chemical, biological, radiological and nuclear (CBRN) incidents and developing local and trust-wide exercise of the major incident plan.

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## Procurement and supplies

The Department of Health published procurement guidance '*Better Procurement, Better Value, Better Care*' in August 2013 followed by an e-procurement strategy in February 2014. Both documents have a focus on improved data, collaboration and improving procurement skills.

Our procurement strategy encompasses the areas of priority over the next three years to meet the Department of Health requirements and ensure that we achieve sustainable efficiencies. This Strategy 2014 -2017 has been developed in line with our strategic objectives and the recent Department of Health procurement guidance.

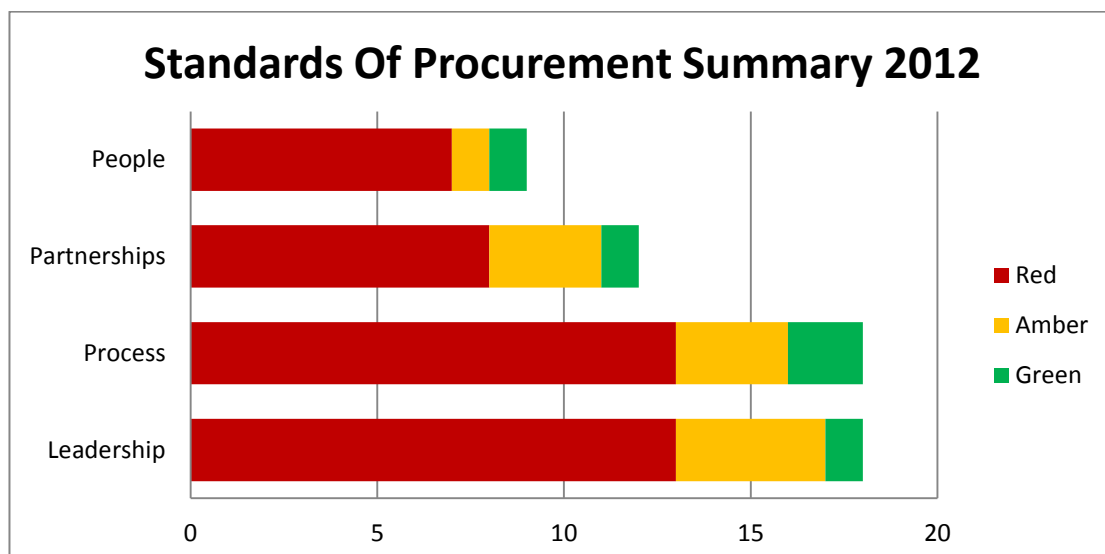
The Department of Health required a non-executive director procurement sponsor to be the point of contact with the National Procurement Development Team. Acting Chairman, Richard Kilner, volunteered to take up this role and will be involved in the procurement summit due to take place in 2014.

Our achievements during the year:

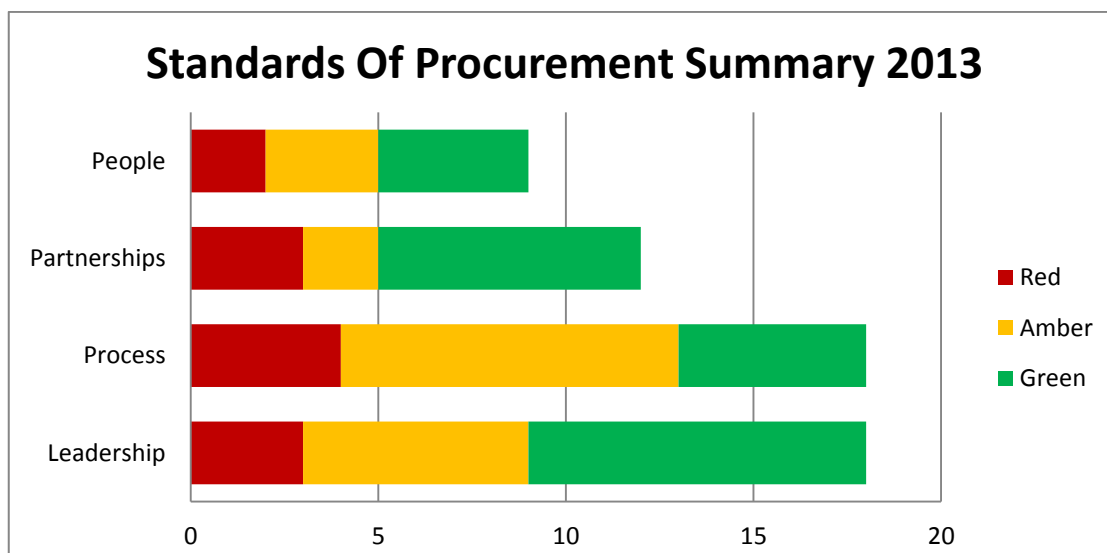
- We made £6m of procurement savings;
- The data about products and prices on the Catalogue was poor and out of date, our first step was to carry out a data cleansing exercise in order to understand the product usage and ordering patterns;
- We have increased the number of products at contracted prices available to the Trust on catalogue from 22,000 to 79,300 product lines;
- Catalogue orders have since increased from 21 per cent to 64 per cent (in January 2014);
- Richard Kilner appointed as the non-executive procurement sponsor;

- We identified who our critical suppliers are and put a business continuity plan in place;
- We have improved buying practise across the Trust by ensuring that all orders have a purchase order. This means we have moved away from processing invoices without purchase orders;
- We have ensured that all non-contracted products ordered, do have e-class codes in order to meet the NHS Standard for quality requirements;
- Staff across the Trust can buy certain approved products from the NHS Supply Chain catalogue. We have made sure that only the products that have been clinically evaluated and ensure value for money are available to Staff to order from our approved products list;
- We reviewed our stock management systems and made recommendations for a transformation of the system which moves to minimum stock holding; manages stock throughout the Trust; reduces clinical time lost in acquisition of products and supports patient level costing. A detailed business case was approved by the Trust Board in July 2013 and is now with NHS Trust Development Authority for final approval;
- We created and introduced a webpage on our intranet, INsite, for Procurement and Supplies which provides a point of communication with a range of materials about the policy, procedures and training material for procurement and stock management;
- We are member of the North of England NHS Commercial Procurement Collaborative (NoECPC) procurement hub allowing access to a greater number of collaborative procurement opportunities which means the Trust can benefit from contracts and savings already negotiated;

In November 2012 we carried out the following baseline assessment:



The assessment carried out in 2013 shows a notable improvement with the following results:



#### Our priorities for 2014/15

- Progress the procurement standards to achieve Green status in the majority of areas, whilst recognising that some standards may always remain red due to current arrangements and capacity for example having the Procurement Lead at Board level and advertising all procurement opportunities over £10k;
  - Introduce a stock management solution, including restructuring the supplies and receipts & distribution areas to transform the internal supply chain and stock management flow;
  - Achieve £5m of procurement savings;
  - Report procurement progress to the trust board on a quarterly basis;
  - Have a better understanding of all our contracts for non-pay expenditure and to ensure compliance to our Procurement Strategy by introducing a trust wide contracts database;
  - Improve data and introduce GSI level coding which is a standard bar code requirement for all products used by the NHS in the future. The GSI bar code data can automatically identify the product or service and its location at any point in the supply chain.
  - Continue to improve engagement with clinical staff in the role of procurement.
-

## Our priorities for 2014/ 15

In November 2012 we set out our plans in our Strategic Direction. Over the last few months we have been working to update our plans in line with our 2 and 5 year strategies.

Delivering Caring at its Best pulls together all the major things we are doing to take us to our vision of Caring at its Best and how these plans will take shape over the next couple of years, the specific things that we will be looking to achieve within this in 2014/15.

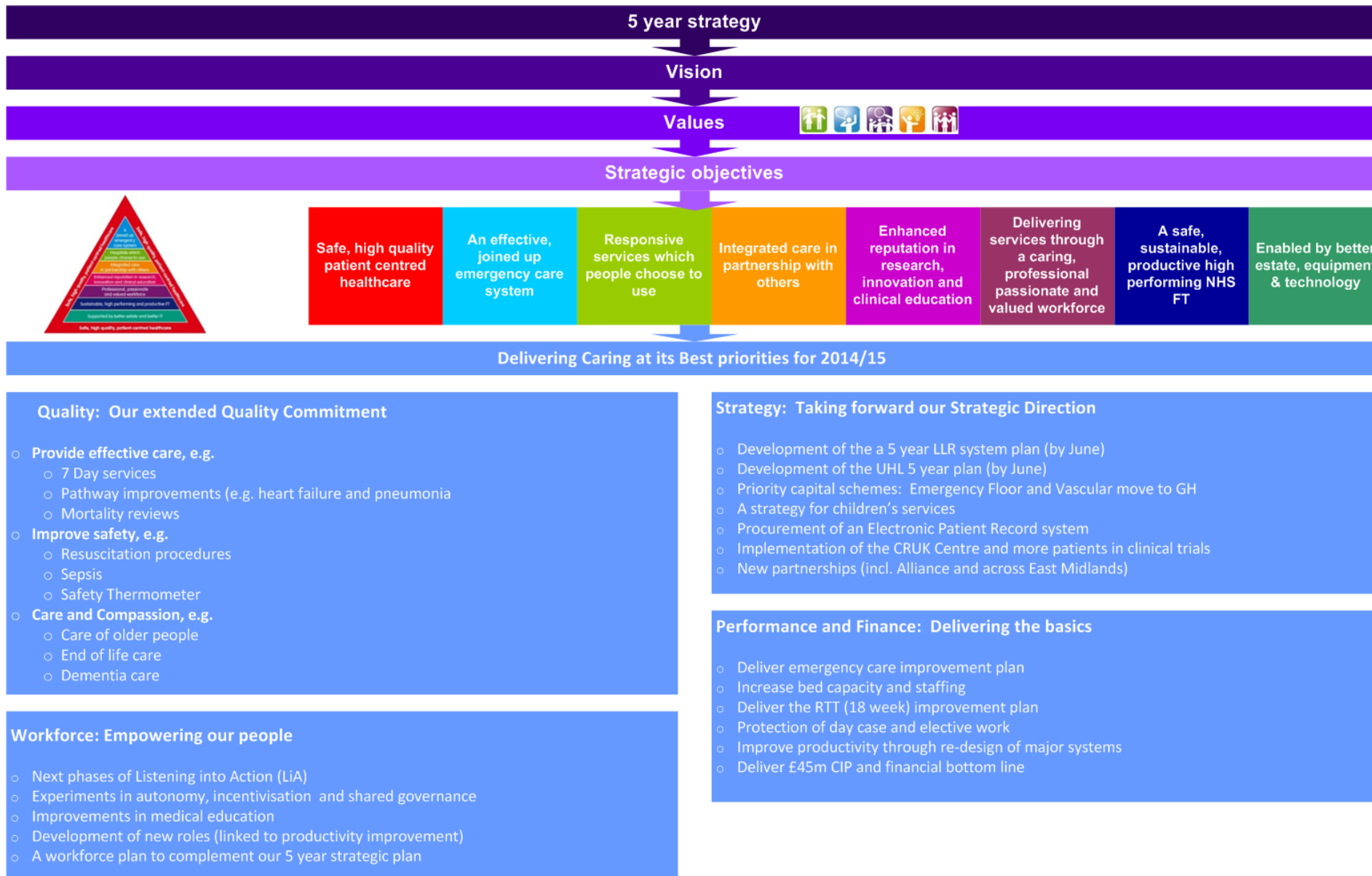
Delivering Caring at its Best (DCAB) includes a whole range of programmes, from the Quality Commitment to our reconfiguration plans, from our IM&T Strategy to Listening into Action. Because it is so complicated, it's very important to be able to see the whole picture.

You will recognise this triangle from the original Strategic Direction, which we have recently been updated, but it keeps the same goals that we set out in the Strategic Direction at the end of 2012. Encompassing our strategic objectives is our aim to deliver 'Safe, high quality, patient-centred care' which is our main purpose.

DCAB is a whole range of programmes, which we have sorted into four categories: Quality Commitment, Performance and Finance, Strategy and Workforce.



The chart over the page details our priorities for the coming year and how they will help us achieve our vision of Delivering Caring at its Best.



## Operating and financial review

2013/14 was a challenging year both operationally and financially and we reported a deficit for the first time since our organisation was formed in 2000.

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 Clinical Commissioning Groups, NHS England, 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.

### Financial review for the year ended 31 March 2014

We have not met all of our financial and performance duties for 2013/14:

- **Balancing the books** - delivery of an income and expenditure deficit of £39.7m.
- **Managing cash** - undershot the revised External Financing Limit by £1.3 million, which is permissible.
- **Investment in buildings, equipment and technology** - invested £36.6 million in capital developments.

### Performance against our Financial Plan

We delivered a £39.7m deficit for the year against a planned surplus of £3.7m. Our Annual Operating Plan (the Plan) included income of £745.3m (excluding the impact of donated assets) and expenditure of £741.6m. The principal drivers for the deficit are:

- non-receipt of £15m strategic transitional support;
- £5.3m less non-recurrent transformation funding from commissioners;
- £14.3m relating to in year operating cost pressures and a deliberate investment in nurse staffing to sustain quality of care and patient safety standards; and
- contractual penalties and deductions of £5.2m including a £3.4m increase in MRET deductions.

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

- Total income £770.4m actual; £25.1m over plan.
- Total expenditure £809.9m actual; £68.3m over plan.
- Capital expenditure £36.6m against a revised capital resource limit of £36.6m
- Closing cash balance £515k against a revised target of £500k.

### Overview of financial performance

Our challenging financial year was driven by the requirement to deliver a £40.4m (5.5per cent) CIP programme set against the backdrop of the following:

- An opening underlying deficit of £12.5m;
- The net tariff deflator of £2.9m;
- A reduction in teaching and training income of £3m;
- Inflation of just under 2per cent, totalling £13m across pay and non-pay;
- We have managed a higher than planned level of activity in 2013-14 resulting in increased costs, particularly around emergency activity;



In addition the following assumptions were made within the Plan:

- Planned income was stated net of £8m of marginal rate emergency threshold (MRET) deduction and readmission penalties;
- No allowance was made for any performance related fines or performance penalties;
- Service development costs of £10.6m were included. Key priorities included increases in nurse staffing (acuity and supervisory) and investment in services to support emergency patient flow. We did not assume any additional transformational support to fund these schemes.

At the 2013/14 planning stage there were concerns by ourselves and our commissioners regarding the monthly financial performance during the previous year, and our poor access performance, particularly against the 4-hour A&E target.

In order to address this risk and give a greater degree of certainty around delivery of the Plan, our Trust Board determined that strategic transitional support of £15m was required from commissioners to assure delivery of the Plan.

We made a request for transitional funding of £15m in May 2013 to the Local Area Team of NHS England, the NHS Trust Development Authority and CCGs. This was intended to address the risks to the delivery of the Plan and fund the start of strategic site reconfiguration projects designed to address the long-term financial and clinical sustainability of our services. In making this bid, we implicitly acknowledged that site and service reconfiguration is essential to ensure long term financial and clinical sustainability.

There was a difference of view between ourselves and our commissioners as to whether the 2013/14 contracting agreement was understood to have addressed our underlying deficit. It is our contention that this was not the case, hence the need for the bid for transitional support.

In September the issue was referred back to us and CCGs for local resolution, but by that stage the CCGs did not have unallocated resources and were unable to fund the transitional support. In December 2013 we identified a forecast I&E deficit of £39.8m and this is the deficit that has been achieved at the year end.

## **Balance Sheet**

### **Cash**

We initially planned to maintain our cash holdings at £17.3m at the end of March 2014, and this plan resulted in a negative External Financing Limit (EFL) of £1.4m which meant that we would be generating slightly more cash than was necessary to fund our spending.

Due to our deteriorating financial performance and overspending across the year we experienced significant cash flow restrictions from quarter two onwards. This led to poor performance against the Better Payment Practice Code (BPPC) as demonstrated in the summary financial statements.

We were not in a position to apply for longer term financing given the timescales and lack of certainty concerning its granting. Equally, temporary borrowing would have been repayable by the 31<sup>st</sup> March 2014 and this would not have solved the year end liquidity problem.

The Trust Board was made aware of operational difficulties with cash flow during the first half of 2013/14 and approved a number of measures for the management of cash balances to the year-end, including: the limiting of payment runs; earlier in-month receipts of SLA cash; re-profiling of non-essential capital expenditure; improved accounts receivable performance; and other working capital

adjustments. These measures provided sufficient flexibility to cover payments in the latter part of 2013/14 without prejudicing our liquidity.

The NHS Trust Development Authority (NTDA) reset our External Financing Limit (EFL) from minus £1.4m to £20.7m. This enabled us to reduce our year-end cash balance to £515k and maximise the number of creditor payments that we were able to make whilst still achieving the EFL.

### **Non-current assets**

Total non-current assets have increased by £10.5m as a result of total purchased and donated additions of £37.4m plus completion of assets under construction of £4.3m less depreciation and amortisation of £31.2m.

### **Debtors**

Our debtors have increased by £7.8m mainly due to an increase in year-end invoicing for winter pressure and performance income.

### **Creditors**

Our creditors have increased by £36.1m since the last year end mainly due to the deferral of £5.2m of income due to changes in how we are paid for maternity care; £7.5m due to an increase in capital creditors following increased expenditure late in the year; and a general increase in invoices that were not paid due to the low levels of cash at the year end.

### **Taxpayer's equity**

This represents the methods of funding the assets and liabilities of the Trust. The main balance is Public Dividend Capital and this increased by £4.8m in the year as we received additional funding for the following schemes:

- £2.4m Safer Hospitals Technology Fund
- £0.1m Improving Maternity Care Settings
- £0.6m Nursing Technology Fund
- £1.8m Energy Efficiency Schemes

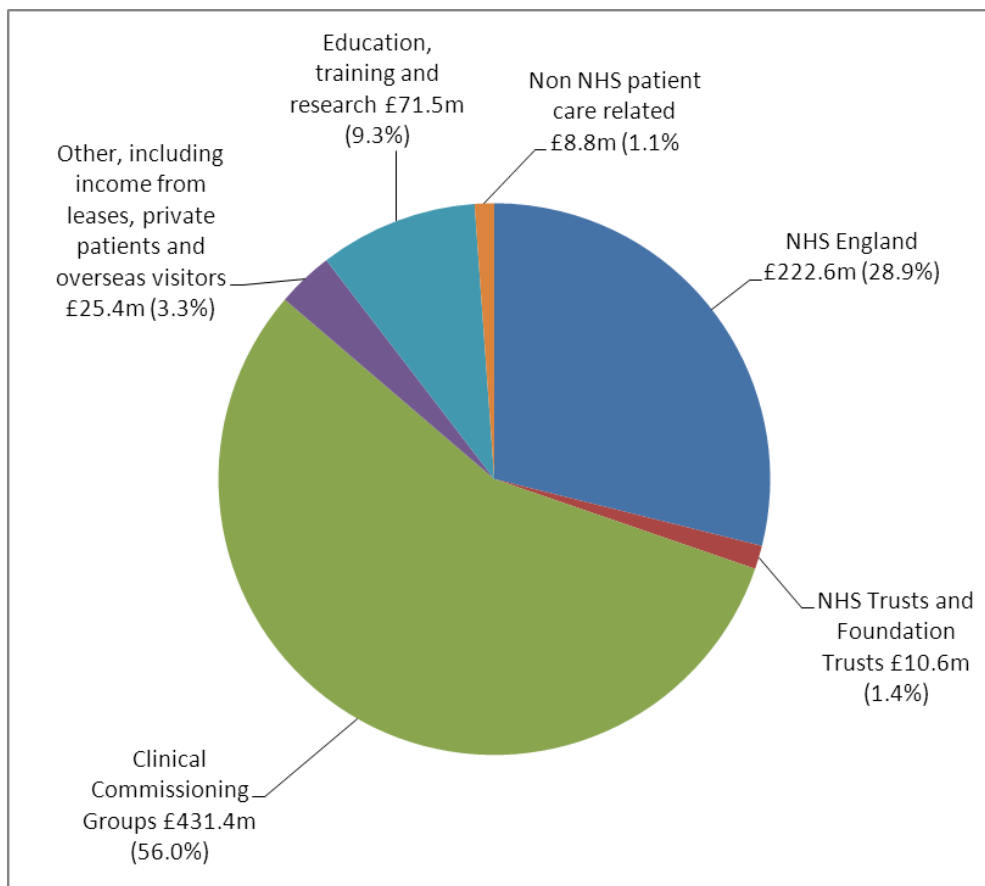
The value of our retained earnings reserve reduced by £39.5m as a result of our financial deficit of £39.7m less £141,000 relating to the value of donated asset receipts (net of donated asset depreciation). This figure is removed from the final retained deficit figure in accordance with Department of Health Accounting guidance. This removes the effect on our financial performance of no longer having a donated asset reserve and ensures that performance can be measured consistently.

## Key Financial Indicators

### Our income 2013/14

The chart below details the £770.4m of income (excluding donated assets) we received. This is a £12.7m (1.7 per cent) increase from the £757.7m we received in 2012/13.

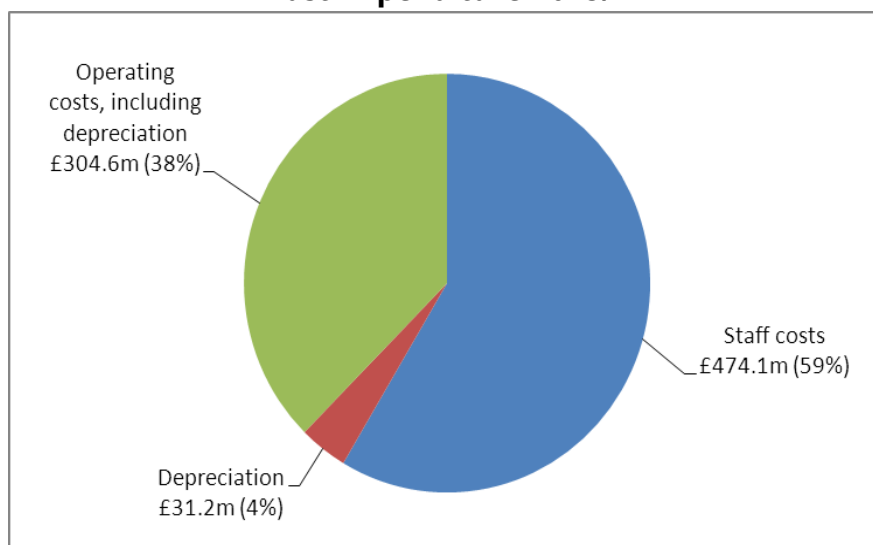
#### Trust Income 2013/14



### What we spent 2013/14

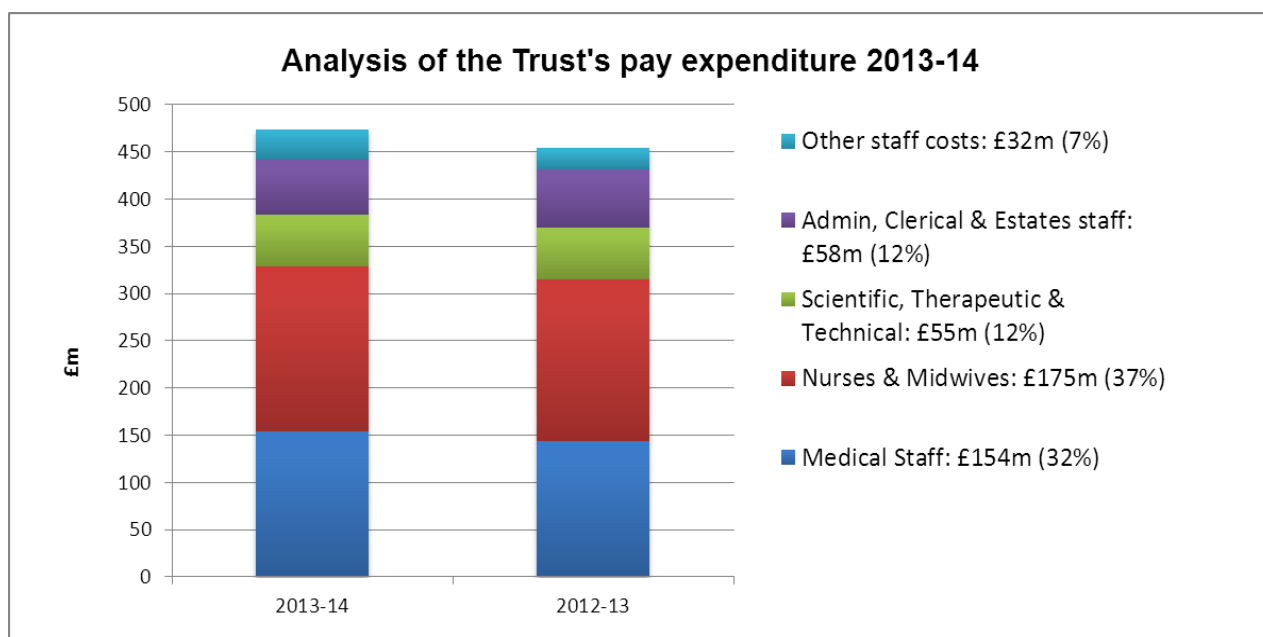
The chart below details the £809.9m total we spent during 2013/14. This is a £52.3m (6.9 per cent) increase from the £757.6m we spent in 2012/13.

#### Trust Expenditure 2013/14



### Pay expenditure by staff group 2013/14

The chart below shows we spent £474.1m on pay for 2013/14, which is a £19m (4.3 per cent) increase over the 2012/13 total of £455.1m.



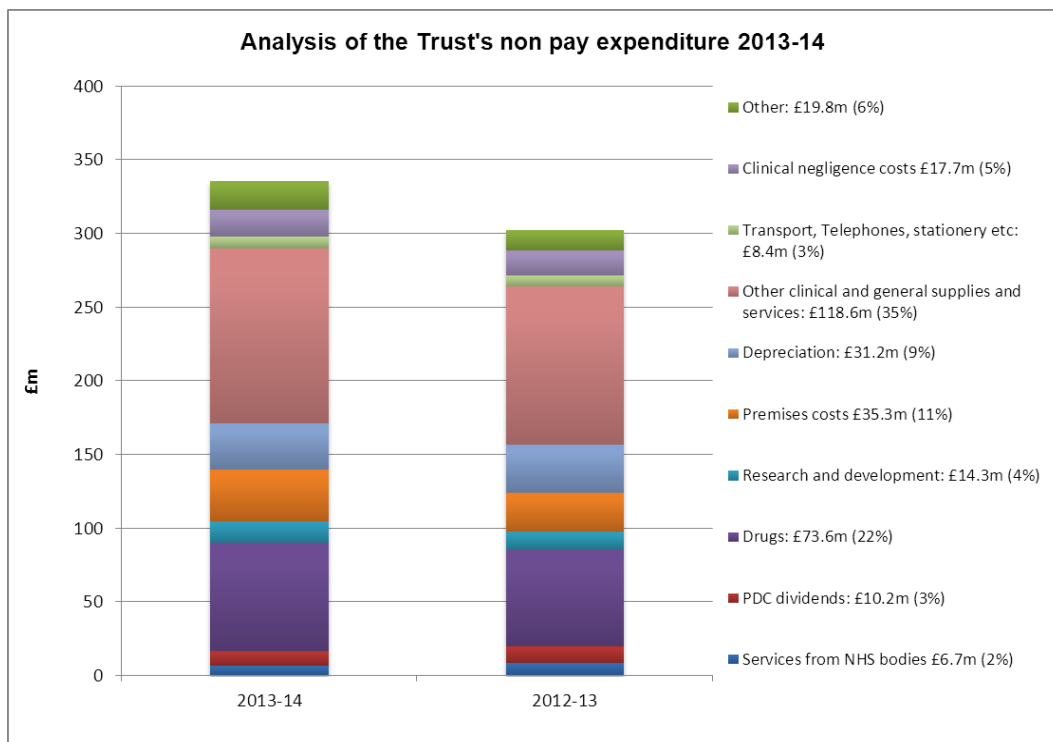
The main factors contributing to the increase in pay expenditure are:

- £4.6m due to a 1 per cent pay award for all staff on 1<sup>st</sup> April 2013;
- £2.0m incremental drift;
- £3.4m relating to the net increase in staff numbers; and
- other movements including a higher average skill mix of staff due to the movement of staff to both Interserve (Estates and Facilities services) and IBM (Information Technology services).

### Non-pay expenditure 2013/14

The chart overleaf shows our non-pay operating expenditure for 2013/14, which was £335.8m, a £33.2m (11.0 per cent) increase over the 2012/13 total of £302.6m. This increase is due to a number of factors including the following increases:

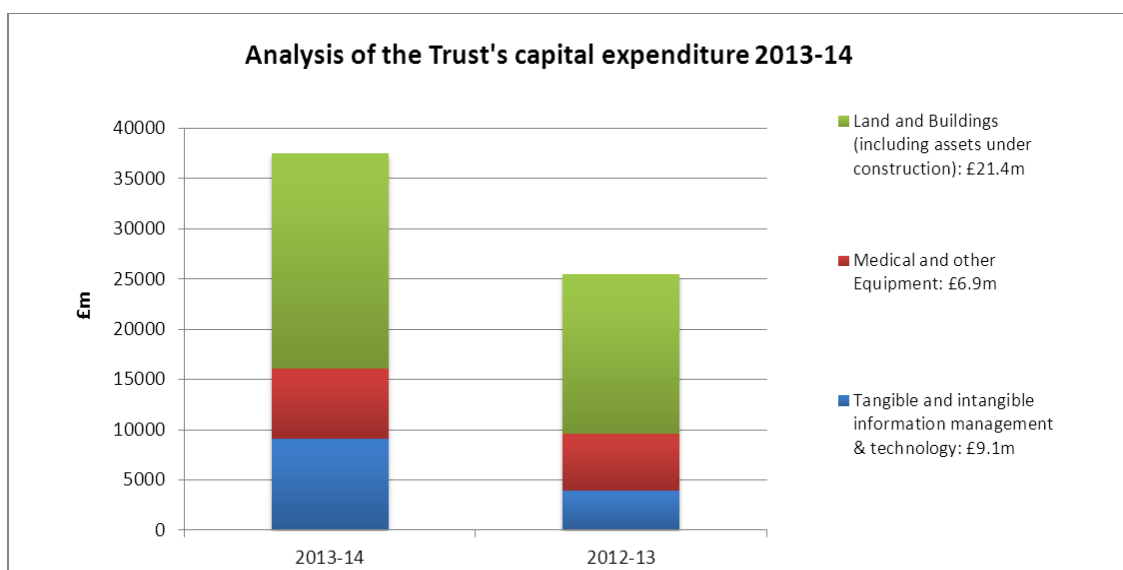
- £10.8m increase in clinical supplies and services costs due to an annual inflationary increase plus additional costs associated with increased patient care activity, with more than 4,000 additional day cases and over 2,500 additional emergency and elective inpatients;
- £8.9m increase in premises costs including the movement of £4.3m from pay to non-pay in relation to the Interserve contract; £3.5m due to the cost of the IBM outsourcing contract and £0.9m due to utility and business rate increases;
- £7.9m increase in drugs costs predominantly due to investment in NICE as well as excluded drugs and devices; and
- £6.1m increase in other expenditure.



### Capital expenditure 2013/14

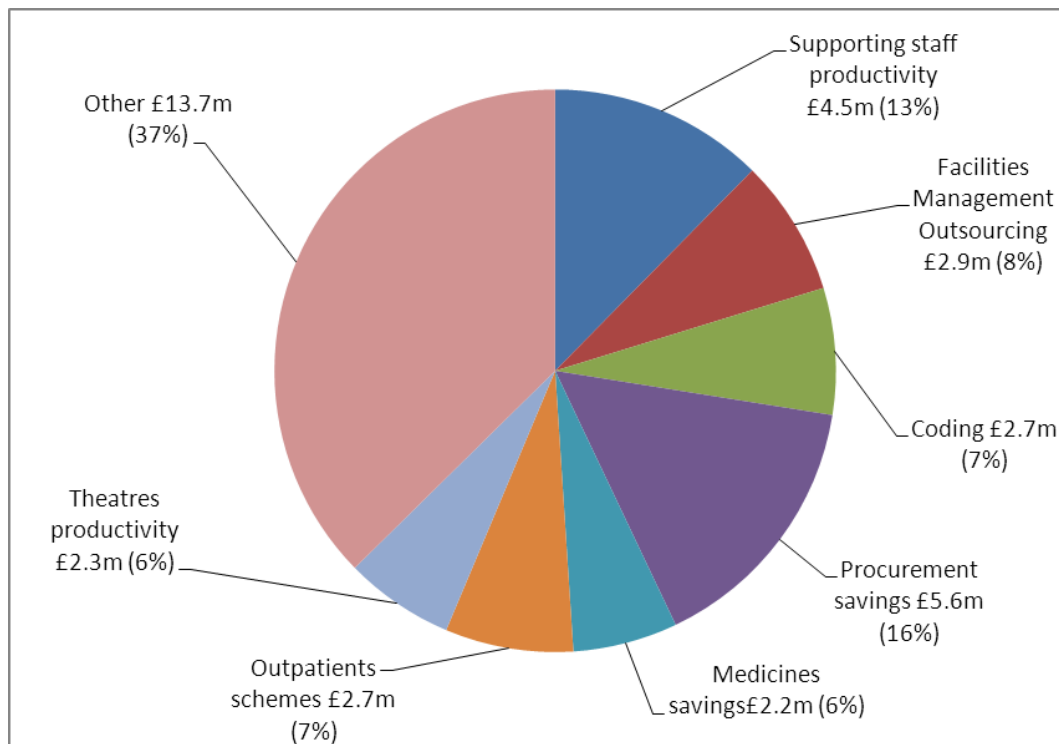
The chart below shows our capital expenditure (excluding adjustments for donated assets) for 2013/14 which was £37.4m, a £12.0m (47.6per cent) increase over the 2012/13 total of £25.4m. This increase is due to the following material items of expenditure:

- £3.15m for the initial works and planning towards the major ED development;
- £2.36m for the phased reconfiguration of maternity areas at the General and Royal Infirmary;
- £1.67m for the creation of new theatre admissions and assessment area at the Royal Infirmary;
- £0.60m for new ventilation systems for cancer wards in the Osborne building to reduce infections; and
- £1.91m for new CHP units funded by the Department of Health to generate green energy.



## Our efficiency programme 2013/14

We delivered £36.6m of our £37.7m cost improvement programme during the year. The major components of the delivery of the programme are outlined in the chart below. These 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 the Trust Board's assurance framework, which regularly reviews all key risks and action plans. These plans cover clinical as well as corporate and business risks.

As in 2012/13, 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.

The Trust Board continually reviews, and takes steps to develop, contingency plans to address emergencies should they arise. Health and social services partners in the Leicester, Leicestershire and Rutland health economy are jointly committed to the Better Care Together strategic change programme. The Better Care Together programme is designed to address the necessary changes in clinical pathways and service configuration so as to deliver a clinically and financially sustainable health and social care services for the Leicester, Leicestershire and Rutland health economy.

A major factor in our long term planning is our Integrated Business Planning (IBP) approach, which is underpinned by service specific strategies; investment/disinvestment decisions and annual phasing of delivery. The IBP process brings together a number of factors including:

- Trust objectives;
- Contractual requirements;
- Operational targets;
- Activity and capacity planning;
- Cost Improvement plans;
- Workforce planning;
- Budgets and establishments;

- Capital plans;
- Risk assessments and risk mitigation plans.

The culmination of this process will be the Strategic Outline Case (SOC) and production of a 5-year plan by June 2014 which joins up a number of key planning elements within the Trust.

## **Future Challenges**

### **Financial planning**

We have submitted the final version of our two year plan to the NTDA. The key details relating to the plan for 2014/15 are as follows:

- Planned I&E deficit of £40.7m;
- A major CIP plan of £45m;
- A capital expenditure plan of £63.3m, including the Emergency Floor development and the vascular services move;
- Permanent PDC funding of £78m to fund the deficit plan and part fund the capital programme;
- An external Financing Limit (EFL) of £28.6m including a requirement to receive temporary borrowing of £28m in the first half of the year until the permanent funding is received;
- A Financial Risk Rating (FRR) of 4 (calculated in accordance with the NTDA planning submission guidelines).

Although, as at the end of April 2014, we had not formally signed contracts with our main commissioners it is not anticipated that there will be any material changes to the level of income that is assumed within the planned deficit of £40.7m.

We have agreed with the NTDA that a financial recovery plan will be produced by the end of Quarter 1 for us to achieve a recurrent balanced financial position within three years. This will be linked to our 5-year plan and Service Strategy to be submitted to the NTDA by the end of the first quarter.

The financial recovery plan will be considered in the wider context of the Leicester, Leicestershire and Rutland health economy position. The quantum of our 2013/14 deficit and the increase in the in-year deficit has given significant cause for concern, both for ourselves and for the local health economy. 2013/14 will be the first year that the local health economy has not delivered a balanced financial position.

The overall financial plan and resulting deficit position is driven by our activity and income assumptions, workforce implications and the Cost Improvement Programme (CIP). We have a clear process for delivering against these areas, and to ensure a realistic monthly profile of income and expenditure. Income will be regularly discussed during weekly meetings with CCGs.

### **Cash management**

The financial plan for 2014/15 forecasts that we will require both temporary borrowing and permanent financing as follows:

- £28m temporary borrowing from April to clear the outstanding creditor payments and to fund the deficit plan until permanent financing is received mid-year; and
- £78m permanent revenue financing to fund the £40.7m deficit plan for the full year; cover the outstanding creditors brought forward at the start of the year; and provide funding for the capital programme and primarily the Emergency Floor project.

We will improve our performance against the Better Payment Practice Code (BPPC) in 2014/15 as a result of the financing outlined above. The financing solutions will give us sufficient cash to aim to settle invoices within the 30-day payment terms during 2014/15.

Sufficient liquidity therefore will exist, or can be made available, to support the operations of the Trust in the coming twelve months from the date of annual accounts.

### **Efficiency programme for 2014/15**

In 2014/15, we have set a challenging efficiency target of £45m. Delivery of our CIP is challenging for 2014/15 and processes have been put in place to give assurance over the schemes and their quality impact. These include weekly CIP performance Board, monthly integrated performance management meetings and the engagement of external consultancy support. Each scheme will be quality and risk assessed and there will be regular reporting to the Executive Team, Finance and Performance Committee and Trust Board.

This target reflects the minimum 4 per cent (£30m) required through the national tariff (Payment By Results) plus an additional amount to reduce our underlying financial deficit. The key themes, as in previous years, centre on:

- Procurement - buying goods and services;
- reducing agency pay costs;
- improvement in our theatre efficiency; and
- reducing outpatient cancellations and non-attenders (DNAs).

### **Capital programme**

We are continuing to invest in our buildings and equipment across the Trust. We have a major capital agenda across the medium term from 2014/15, including the Emergency Floor project and the reconfiguration scheme, both of which will start in 2014/15. The capital programme is being split between operational and strategic capital. Operational capital includes back log maintenance and equipment; Strategic capital is linked to our long term plan and the SOC.

The capital programme for 2014/15 involves up to £63m of investment. Major plans include:

- £2.8m to improve theatre facilities at the Royal Infirmary;
- £11m to start developing a new expanded Emergency Department;
- £4m to start developing vascular services at Glenfield; and
- £3.3m to implement an Electronic Document and Records Management (EDRM) system across the Trust.

In addition we are investing over £42m on replacing medical equipment, improving buildings and developing IT systems.



## **Foreword to the Summary Financial Statements**

### **University Hospitals of Leicester NHS Trust**

These accounts for the year ended 31 March 2014 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 2013-14 have been prepared under International Financial Reporting Standards (IFRS), which have been effective for the NHS from 1st April 2009.

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:

Director of Finance

Trust Headquarters

Level 3

Balmoral Building

Leicester Royal Infirmary

Infirmary Square

LE1 5WW

0116 258 8557

## Summary Financial Statements

### Statement of Comprehensive Income for year ended 31 March 2014

	2013-14	2012-13
	£000s	£000s
Gross employee benefits	(474,090)	(455,142)
Other operating costs	(325,181)	(290,721)
Revenue from patient care activities	675,045	649,145
Other Operating revenue	95,348	109,520
<b>Operating surplus/(deficit)</b>	<b>(28,878)</b>	12,802
Investment revenue	66	77
Other gains and (losses)	(51)	0
Finance costs	(263)	(612)
<b>Surplus/(deficit) for the financial year</b>	<b>(29,126)</b>	12,267
Public dividend capital dividends payable	(10,388)	(11,090)
<b>Retained surplus/(deficit) for the year</b>	<b>(39,514)</b>	1,177
<b>Total Comprehensive Income for the year</b>	<b>(39,514)</b>	1,177
<b>Financial performance for the year</b>		
Retained surplus/(deficit) for the year	(39,514)	1,177
Adjustments in respect of donated gov't grant asset reserve elimination	(141)	(1,086)
<b>Adjusted retained surplus/(deficit)</b>	<b>(39,655)</b>	91

Total Comprehensive Income of (£39,514) includes £141,000 relating to the receipt of donated assets (net of donated asset depreciation). This figure is removed from the final retained surplus/ (deficit) figure in accordance with Department of Health Accounting guidance. This removes the effect on the Trust's financial performance of no longer having a donated asset or government granted asset reserve and ensures that performance can be measured consistently.

## Statement of Financial Position as at 31 March 2014

	31 March 2014	31 March 2013
	£000s	£000s
<b>Non-current assets:</b>		
Property, plant and equipment	362,465	354,658
Intangible assets	8,019	5,308
Trade and other receivables	3,123	3,155
<b>Total non-current assets</b>	<b>373,607</b>	<b>363,121</b>
<b>Current assets:</b>		
Inventories	13,937	13,064
Trade and other receivables	49,892	45,689
Cash and cash equivalents	515	19,986
<b>Total current assets</b>	<b>64,344</b>	<b>78,739</b>
Non-current assets held for sale	0	0
<b>Total current assets</b>	<b>64,344</b>	<b>78,739</b>
<b>Total assets</b>	<b>437,492</b>	<b>441,860</b>
<b>Current liabilities</b>		
Trade and other payables	(109,135)	(76,594)
Provisions	(1,585)	(1,906)
Borrowings	(6,590)	(2,727)
<b>Total current liabilities</b>	<b>(117,310)</b>	<b>(81,227)</b>
<b>Net current liabilities</b>	<b>(52,966)</b>	<b>(2,488)</b>
<b>Total non-current assets less net current liabilities</b>	<b>320,641</b>	<b>360,633</b>
<b>Non-current liabilities</b>		
Provisions	(2,070)	(2,406)
Borrowings	(5,890)	(10,906)
<b>Total non-current liabilities</b>	<b>(7,960)</b>	<b>(13,312)</b>
<b>Total Assets Employed:</b>	<b>312,681</b>	<b>347,321</b>
<b>FINANCED BY:</b>		
<b>TAXPAYERS' EQUITY</b>		
Public Dividend Capital	282,625	277,733
Retained earnings	(34,542)	4,960
Revaluation reserve	64,598	64,628
<b>Total Taxpayers' Equity:</b>	<b>312,681</b>	<b>347,321</b>

## Statement of Cash Flows for the Year Ended 31 March 2014

	2013-14	2012-13
	£000s	£000s
<b>Cash Flows from Operating Activities</b>		
Operating Surplus/(Deficit)	(28,878)	12,802
Depreciation and Amortisation	31,245	32,097
Donated Assets received credited to revenue but non-cash	(765)	(1,617)
Interest Paid	(468)	(540)
Dividend paid	(10,232)	(10,030)
(Increase)/Decrease in Inventories	(873)	(802)
(Increase)/Decrease in Trade and Other Receivables	(4,211)	(18,283)
(Increase)/Decrease in Other Current Assets	40	0
Increase/(Decrease) in Trade and Other Payables	24,835	11,289
Provisions Utilised	(1,229)	(667)
Increase/(Decrease) in Provisions	458	2,069
<b>Net Cash Inflow/(Outflow) from Operating Activities</b>	<b>10,573</b>	<b>26,318</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Interest Received	66	77
(Payments) for Property, Plant and Equipment	(26,342)	(18,838)
(Payments) for Intangible Assets	(3,503)	(1,938)
<b>Net Cash Inflow/(Outflow) from Investing Activities</b>	<b>(29,779)</b>	<b>(20,699)</b>
<b>NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING</b>	<b>(19,206)</b>	<b>5,619</b>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>		
Public Dividend Capital Received	5,269	246
Public Dividend Capital Repaid	(377)	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(5,157)	(4,248)
<b>Net Cash Inflow/(Outflow) from Financing Activities</b>	<b>(265)</b>	<b>(4,002)</b>
<b>NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS</b>	<b>(19,471)</b>	<b>1,617</b>
<b>Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period</b>	<b>19,986</b>	<b>18,369</b>
<b>Cash and Cash Equivalents (and Bank Overdraft) at year end</b>	<b>515</b>	<b>19,986</b>

## 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:

	£000s	Number
<b>Non-NHS Payables</b>		
Total non-NHS trade invoices paid in the year	396,204	128,364
Total non-NHS trade invoices paid within target	271,621	59,150
Percentage of non-NHS trade invoices paid within target	68.56%	46.08%
<b>NHS Payables</b>		
Total NHS trade invoices paid in the year	163,108	4,654
Total NHS trade invoices paid within target	133,356	2,549
Percentage of NHS trade invoices paid within target	81.76%	54.77%

### Audit Fees

Our external auditor for statutory audit and services during 2013/14 was KPMG LLP. The Audit Commission appointed KPMG LLP as our external auditors in 2000. The total value of payments to KPMG for statutory audit services in 2013/14 was £209,000.

### Pension liabilities

University Hospitals of Leicester NHS Trust is a member of the NHS Pensions Scheme. Information regarding how the Trust accounts for its pension liabilities is reported at note 10 of the Trust's 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.

## Salary and Pension entitlements of senior managers - Salary

Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	Other remuneration (bands of £5,000) £000	TOTAL (bands of £5,000) £000
R Kilner, Chairman (from 1 Oct 2013); Non-Executive Director (until 30 Sept 2013)	10-15	3	0	0	0	0	15-20
J Adler, Chief Executive	175-180	199	0	0	22.5-25.0	0	220-225
R Mitchell, Chief Operating Officer (from 10 Jul 2013)	100-105	0	0	0	12.5-15.0	0	115-120
A Seddon, Director of Finance and Procurement	140-145	11	0	0	17.5-20.0	0	160-165
R Overfield, Chief Nurse (from 9 Sept 2013)	75-80	0	0	0	10.0-12.5	0	90-95
K Harris, Medical Director	40-45	7	0	0	0	165-170	200-205
P Hollinshead, Interim Director of Financial Strategy (from 20 Jan 2014)	60-65	0	0	0	0	0	60-65
K Shields, Director of Strategy (from 4 Nov 2013)	50-55	0	0	0	7.0-7.5	0	55-60
K Bradley, Director of Human Resources	125-130	45	0	0	17.0-17.5	0	145-150
S Ward, Director of Corporate & Legal Affairs	105-110	19	0	0	14.0-14.5	0	120-125
M Wightman, Director of Communications	100-105	23	0	0	14.0-14.5	0	120-125
N Brunskill, Director of Research and Development (from 22 Jun 2013)	10-15	0	0	0	0	65-70	75-80
D Wynford-Thomas, Non-Executive Director	5-10	2	0	0	0	0	5-10
Colonel (retired) I Crowe, Non-Executive Director (from 1 Jul 2013)	0-5	20	0	0	0	0	5-10
Dr S Dauncey, Non-Executive Director (from 1 May 2013)	0-5	0	0	0	0	0	0-5
J E Wilson, Non-Executive Director	5-10	8	0	0	0	0	5-10
P Panchal, Non-Executive Director	5-10	12	0	0	0	0	5-10
K Jenkins, Non-Executive Director	5-10	5	0	0	0	0	5-10
Mr I Sadd, Non-Executive Director (from 1 Oct 2013 until 31 Dec 2013)	0-5	0	0	0	0	0	0-5
I Reid, Non-Executive Director (until 30 Sept 2013)	0-5	1	0	0	0	0	0-5
M Hindle, Chairman (until 30 Sept 2013)	10-15	31	0	0	2.0-2.5	0	15-20
S Hinchliffe, Chief Operating Officer (until 30 Jun 2013)	20-25	7	0	0	2.5-3.0	0	25-30
Prof D Rowbotham, Director of Research & Development (until 22 Jun 2013)	5-10	0	0	0	0	170-175	175-180

## Salary and Pension entitlements of senior managers – Salary 2012/13

Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension- related benefits (bands of £2,500) £000	Other remuneration (bands of £5,000) £000	TOTAL (bands of £5,000) £000
R Kilner, Chairman (from 1 Oct 2013); Non-Executive Director (until 30 Sept 2013)	5-10	0	0	0	0	0	5-10
J Adler, Chief Executive	40-45	18	0	0	5.5-6.0	0	45-50
A Seddon, Director of Finance and Procurement	135-140	4	0	0	17.5-20.0	0	155-160
K Harris, Medical Director	40-45	0	0	0	0	165-170	210-215
K Bradley, Director of Human Resources	120-125	38	0	0	15.0-17.5	0	145-150
S Ward, Director of Corporate & Legal Affairs	100-105	41	0	0	12.5-15.0	0	120-125
M Wightman, Director of Communications	95-100	40	0	0	12.5-15.0	0	115-120
D Wynford-Thomas, Non-Executive Director	5-10	2	0	0	0	0	5-10
J E Wilson, Non-Executive Director	5-10	7	0	0	0	0	5-10
P Panchal, Non-Executive Director	5-10	11	0	0	0	0	5-10
K Jenkins, Non-Executive Director	5-10	9	0	0	0	0	5-10
I Reid, Non-Executive Director (until 30 Sept 2013)	5-10	12	0	0	0	0	5-10
M Hindle, Chairman (until 30 Sept 2013)	20-25	26	0	0	0	0	25-30
M Lowe-Lauri, Chief Executive (until 31 Aug 2012)	190-195	29	0	0	10.0-12.5	0	200-205
S Hinchliffe, Chief Operating Officer (until 30 Jun 2013)	160-165	50	0	0	20.0-22.5	0	190-195
Prof D Rowbotham, Director of Research & Development (until 22 Jun 2013)	20-25	0	0	0	0	200-205	220-225
A Tierney, Director of Strategy (until 30 Apr 2013)	105-110	4	0	0	17.5-20.0	0	125-130
D Tracy, Non-Executive Director (until 31 May 2013)	5-10	16	0	0	0	0	5-10

Dr K Harris, D Rowbotham and N Brunskill's salaries have been split according to the time allocated for managerial activities.

The remuneration for Peter Hollinshead, interim Director of Finance, was paid to the trading company Brandhill Financial Services. This is a commercial rate covering all away from home expenses, business overheads and VAT. As a result of the payments being made to a trading company the Trust did not incur any additional costs (such as tax, national insurance and pension payments). The liability for making such payments rests with the trading company, Brandhill Financial Services.

### 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 2014 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5000) £000	Cash Equiv' Transfer Value at 31 March 2014 £000	Cash Equiv' Transfer Value at 31 March 2013 £000	Real Increase in Cash Equiv' Transfer Value £000	Employers Contribution to Stakeholder Pension £000
<b>J Adler</b> , Chief Executive	2.5 - 5.0	12.5 - 15.0	55 - 60	170 - 175	1,104	972	110	0
<b>R Mitchell</b> , Chief Operating Officer (from 10 July 2013)	2.5 - 5.0	12.5 - 15.0	15 - 20	50 - 55	190	110	57	0
<b>A Seddon</b> , Director of Finance and Procurement	0.0 - 2.5	5.0 - 7.5	20 - 25	60 - 65	410	358	45	0
<b>R Overfield</b> , Chief Nurse (from 9 September 2013)	2.5 - 5.0	10.0 - 12.5	50 - 55	150 - 155	895	729	84	0
<b>S Hinchliffe</b> , Chief Operating Officer (until 30 June 2013)	(0.0 - 2.5)	(0.0 - 2.5)	60 - 65	180 - 185	1,175	1,135	4	0
<b>K Bradley</b> , Director of Human Resources	2.5 - 5.0	7.5 - 10.0	40 - 45	120 - 125	740	652	74	0
<b>S Ward</b> , Director of Corporate & Legal Affairs	0.0 - 2.5	5.0 - 7.5	40 - 45	120 - 125	779	702	62	0
<b>M Wightman</b> , Director of Communications	2.5 - 5.0	7.5 - 10.0	20 - 25	70 - 75	376	311	58	0
<b>K Shields</b> , Director of Strategy (from 4 November 2013)	0.0 - 2.5	2.5 - 5.0	35 - 40	110 - 115	607	521	30	0

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior



capacity to which the disclosure applies. The CETV figures, 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.

## Exit Packages

2013/14								
Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	Cost of Compulsory redundancies £'s	Number of other departures agreed Number	Cost of Other Departures agreed Number	Total Number of exit packages Number	Total cost of exit packages £'s	Number of Departures Where Special Payments have been made Number	Cost of Special Payment Element Included in exit packages £'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	2	44,652	0	2	2	44,652	0	0
£25,001-£50,000	1	47,087	0	1	1	47,087	0	0
£50,001-£100,000	1	90,252	0	1	1	90,252	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
<b>Totals</b>	<b>4</b>	<b>181,991</b>	<b>0</b>	<b>4</b>	<b>4</b>	<b>181,991</b>	<b>0</b>	<b>0</b>

2012-13								
Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	Cost of compulsory redundancies £'s	Number of other departures agreed Number	Cost of other departures agreed Number	Total number of exit packages Number	Total cost of exit packages £'s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	1	26,771	0	0	1	26,771	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
<b>Totals</b>	<b>1</b>	<b>26,771</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>26,771</b>	<b>0</b>	<b>0</b>

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the NHS Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension's scheme. Ill-health retirement costs are met by the NHS pension's scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

## Off payroll payments

**For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:**

	Number
Number of existing engagements as of 31 March 2014	2
<i>Of which, the number that have existed:</i>	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

All existing off-payroll engagements have been subject to a risk based assessment and assurance has been sought as to whether the individual is paying the right amount of tax.

**For all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months:**

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	2
Number of new engagements which include contractual clauses giving the University Hospitals of Leicester NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	2

<i>Of which:</i>	
assurance has been received	0
assurance has not been received	2
engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	1
Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	9

### **Pay multiples**

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director in the University Hospitals of Leicester NHS Trust in the financial year 2013/14 was £175k - £180k (2012-13: £170k - £175k). This was 6.9 times (7.2 times in 2012-13) the median remuneration of the workforce, which was in the banding £25k - £30k (2012-13: £20k - £25k).

There was a 1 per cent pay increase for all staff groups on the 1st April 2013 which added £4.6m to the overall pay costs. A further £2.0m was added due to the impact of incremental drift and a net increase in staff added an additional £3.4m.

In 2013/14, 20 employees received remuneration in excess of the highest-paid director (22 employees in 2012-13). Remuneration across the Trust ranged from £1k - £310k (2012-13 £1k - £270k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

# Annual Governance Statement

## ***Scope of Responsibility***

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports adherence to the Trust's policies and achievement of its aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

## **The Governance Framework of the Organisation**

### ***Trust Board Composition and Membership***

The Trust Board comprises 13 members: a Chairman, seven Non-Executive Directors and five Executive Directors. There have been a number of changes in the composition of the Board during 2013/14. Mr Martin Hindle stood down as Trust Chairman on 30 September 2013. One of the Trust's Non-Executive Directors, Mr Richard Kilner was appointed by the Trust Board to serve as Acting Chairman pending the appointment of a substantive Chairman by the NHS Trust Development Authority and continues to serve in this capacity. Until such time as the post is filled substantively, a post of Non-Executive Director remains open.

Col. (Retd) Ian Crowe joined the Board as a Non-Executive Director on 1 July 2013 and Dr Sarah Dauncey resumed her position as a Non-Executive Director on 27 January 2014, having earlier served in this capacity between 1 May and 17 June 2013. Messrs Ian Reid and Ian Sadd stood down as Non-Executive Directors on 30 June and 31 December 2013, respectively.

Mr Richard Mitchell joined the Trust as Chief Operating Officer on 1 July 2013 and Ms Rachel Overfield commenced her role as Chief Nurse on 9 September 2013.

The Board is supported in its work by the Director of Human Resources, Director of Marketing and Communications, Director of Corporate and Legal Affairs and Director of Strategy. Ms Kate Shields joined the Trust as Director of Strategy on 4 November 2013.

### ***Performance Management Reporting Framework***

To ensure that the Board is aware to a sufficient degree of granularity of what is happening in the hospitals, a comprehensive quality and performance report is reviewed at each monthly public Board meeting.

The monthly report:

- is structured across several domains: quality and patient safety; patient experience; operational performance; human resources; facilities management; information management and technology service delivery; and financial performance;
- includes information on the Trust's performance against the NHS Trust Development Authority outcome and quality governance measures;
- includes performance indicators rated red, amber or green;
- includes data quality indicators, measured against six key data quality components to assist the Board in gaining assurance;
- is complemented by commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

Importantly, the quality and performance report includes information on 'never events' and the Trust Board receive information on follow-up action.

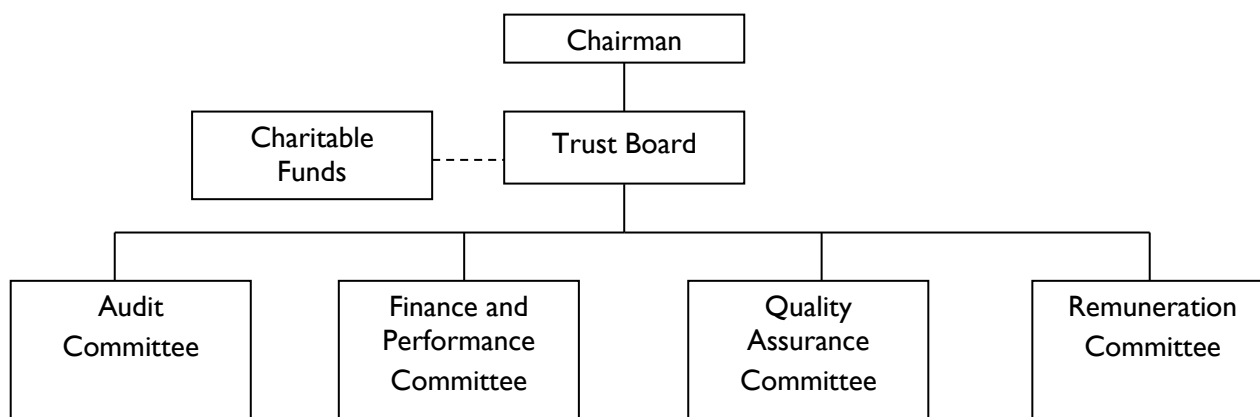
This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- patient stories, which are presented in public at each Board meeting quarter. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement; and
- Board members undertake patient safety walkabouts regularly.

These arrangements allow Board members to help model the Trust's values through direct engagement, as well as ensuring that Board members take back to the boardroom an enriched understanding of the lived reality for staff, public and patients.

### **Committee Structure**

The Trust has operated a well-established committee structure to strengthen its focus on quality governance, finance and performance, and risk management. The structure has been designed to provide effective governance over, and challenge to, the Trust's patient care and other business activities. The committees carry out detailed work of assurance on behalf of the Board. A diagram illustrating the Board committee structure is set out below.



All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Remuneration Committee, which (in accordance with NHS guidance) comprise Non-Executive Directors exclusively.

The Audit Committee is established under powers delegated by the Trust Board with approved terms of reference that are aligned with the NHS Audit Committee Handbook. The Committee consists of three Non-Executive Directors, has met on five occasions throughout the 2013/14 financial year and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business. The Audit Committee receives a report at each of its meetings from the External Auditor, Internal Audit and the Local Counter-Fraud Specialist, the latter providing the Committee with an assurance on the Trust's work programme to deter fraud.

The Finance and Performance Committee meets monthly and oversees the effective management of the Trust's financial resources and operational performance across a range of measures. The Quality Assurance Committee also meets monthly and seeks assurances

that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients.

The Minutes of each meeting of the Board's committees are submitted to the next available Board meeting for consideration. Recommendations made by the Committees to the Trust Board are clearly identified in a cover sheet accompanying the submission of the Minutes to the Board; and the Chairman of each Committee personally presents the Minutes at the Board meeting and highlights material issues arising from the work of the Committee to Board members. In particular, the Chairs provide feedback to the Trust Board on their committees' scrutiny of that month's quality and performance report, thereby complementing the commentaries of the Executive Directors.

### **Attendance at Board and committee Meetings**

The attendance of the Chairman, individual Non-Executive Directors, Executive Directors and Corporate Directors at Board and committee meetings during 2013/14 is set out in an appendix to this Statement. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attenders as detailed in the terms of reference for each committee.

### **Board Effectiveness**

On joining the Board, Non-Executive Directors are given background information describing the Trust and its activities. A full induction programme is arranged.

The Board recognises the importance of effectively gauging its own performance so that it can draw conclusions about its strengths and weaknesses, and take steps to improve. The Board therefore undergoes regular assessment using third party external advisers to ensure that it is:

- operating at maximum efficiency and effectiveness;
- adding value; and
- providing a yardstick by which it can both prioritise its activities for the future and measure itself.

During 2013/14, the Trust Board commissioned The Foresight Partnership to undertake a review of Board effectiveness. The review will culminate with the Trust Board agreeing an updated Board development programme during quarter 1, 2014/15. Board members have received feedback from Foresight on their individual 360 degree reviews.

Outside of its formal meetings, the Board has held development sessions throughout 2013/14. Amongst the topics considered were quality governance; the development of the Trust's 2 year operational plan 2014/15 – 2015/16; refreshing the Trust's quality and safety commitment; and stakeholder engagement.

The Trust Chairman set objectives for the Chief Executive and Non-Executive Directors for 2013/14. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2013/14. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively.

### **Corporate Governance**

In managing the affairs of the Trust, the Trust Board is committed to achieving high standards of integrity, ethics and professionalism across all areas of activity. As a

fundamental part of this commitment, the Board supports the highest standards of corporate governance within the statutory framework.

The Trust has in place a suite of corporate governance policies which are reviewed annually and updated as required. These include standing orders, standing financial instructions, a scheme of delegation, policy on fraud and code of business conduct.

The Trust Board subscribes to the HM Treasury/Cabinet Office Corporate Governance Code, the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'. The Trust Board has adopted a Code of Conduct : "Standards for NHS Board members and members of Clinical Commissioning Group governing bodies in the NHS in England" (Professional Standards Authority : November 2012).

### **Risk Assessment**

The Trust operates a risk management process which enables the identification and control of risks at both a strategic and operational level. Central to this is the Trust's Risk Assessment Policy which sets out details of the risk assessment methodology used across the Trust. This methodology enables a suitable, trained and competent member of staff to identify and quantify risks in their respective area and to decide what action, if any, needs to be taken to reduce or eliminate risks. All risk assessments must be scored and recorded in line with the procedure set out in the Risk Assessment Policy. Completed risk assessments are held at Clinical Management Group and Corporate Directorate level and when they give rise to a significant residual risk must be linked to the Trust's risk register.

A common risk-scoring matrix is used by the Trust to quantify and prioritise risks identified through the risk assessment procedure. It is based on the frequency or likelihood of the harm combined with the possible severity or impact of that harm. The arrangement determines at what level in the organisation a risk should be managed and who needs to be assured management arrangements are in place.

The Trust recognises the importance of robust information governance. During 2013/14, the Director of Finance and Business Services led on information governance issues as the Trust's Senior Information Risk Owner, supported by a Privacy Manager. The Director of Corporate and Legal Affairs has assumed the role of Senior Information Risk Owner from 24 April 2014. The Medical Director continued as the Trust's Caldicott Guardian during 2013/14.

The Trust took further actions during 2013/14 to secure improvement in its information governance arrangements. A Privacy and Information Governance Board monitors and oversees compliance with information governance requirements. The Trust has fully supported the former NHS Midlands and East Strategic Health Authority's 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. Our overall percentage score for 2013/14 was 83%, compared to 82% in 2012/13. This score is deemed to be a 'satisfactory – minimum level 2' standard across all of the information governance standards.

There were no serious untoward incidents involving lapses of data security which were required to be reported to the Information Commissioner's Office in 2013/14. In respect of other personal data related incidents experienced during 2013/14, the Trust has undertaken investigations to ensure that the root causes are properly understood and addressed; in



addition, patients have been contacted to inform them of the lapses and to provide them with assurance about the actions taken by the Trust to prevent recurrence.

### **The Risk and Control Framework**

The Trust's Board-approved Risk Management Strategy describes an organisation-wide approach to risk management supported by effective and efficient systems and processes. The Strategy clearly describes the Trust's approach to risk management and the roles and responsibilities of the Trust Board, management and all staff.

Key strategic risks are documented in the Trust's Board Assurance Framework. Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team and Trust Board review the Framework on a monthly basis to identify and review the Trust's principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed.

The Trust's Annual Operational Plan 2014/15 responds to and addresses the strategic risks facing the Trust. The current Board Assurance Framework is being updated to reflect risks in the 2014/15 Plan and will continue to be reviewed at regular intervals by both the Executive Team and Trust Board.

During January 2014, the Care Quality Commission (CQC) inspected the Trust's hospitals to judge the quality of care. The overall ratings for the Glenfield Hospital and St Mary's Birth Centre, Melton Mowbray were 'good'; the overall ratings for the Leicester Royal Infirmary and Leicester General Hospital were 'requires improvement'. Overall, the CQC assigned a rating of 'requires improvement' to the Trust, while concluding that the Trust was providing services that were safe, effective, responsive, caring and well-led.

The Trust Board has approved a formal action plan to address the findings of the CQC: progress against this plan will be monitored by the Quality Assurance Committee on behalf of the Trust Board during 2014/15.

### **Annual Quality Account**

The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to NHS Trusts on the form and content of annual Quality Accounts which incorporates the above-mentioned legal guidance.

The Director of Clinical Quality, on behalf of the Chief Nurse co-ordinates the preparation of the Trust's Annual Quality Account. This is reviewed in draft form by the Trust's Quality Assurance Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2013/14, the Quality Assurance Committee has noted the Trust's internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – which Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 26 June 2014.

### **Review of the Effectiveness of Risk Management and Internal Control**

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Managers

and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft Quality Account 2013/14 and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance and Performance Committee and Quality Assurance Committee. During 2013/14, each of these bodies has been involved in a series of processes that, individually and collectively, has contributed to the review of the effectiveness of the system of internal control.

In the draft Head of Internal Audit Opinion 2013/14, the Head of Internal Audit notes that Internal Audit's work (to date) has identified low, medium and two high risk rated findings. Based on the work completed, the Head of Internal Audit believes that there is some risk that management's objectives may not be fully achieved and that improvements are required in those areas to enhance the adequacy and/or effectiveness of governance, risk management and control.

As Accountable Officer, I accept this view and note in particular that two of the (eight) reviews carried out by Internal Audit during 2013/14 have resulted in high-risk rated reports, namely, Estates and Facilities Management and Bank and Agency Usage. In each case, the Trust has agreed action plans to meet Internal Audit's recommendations and to strengthen internal control.

In the case of the Estates and Facilities Management review, the Trust has taken action to address the high risk findings of Internal Audit as follows:

- (a) the Trust has formalised performance monitoring mechanisms with NHS Horizons;
- (b) the Trust has retained appropriate facilities management expertise to provide the appropriate level of independent challenge around the service level agreements with Interserve (the Trust's facilities management provider); and
- (c) the respective roles and responsibilities of the Trust and NHS Horizons in all areas of the contract have been clarified.

In respect of the Bank and Agency review, the Trust has taken action to demonstrate appropriate authorisation for bank and agency usage; to ensure that reasons for requests are documented in sufficient detail; and to report on trends in reasons for requests.

Internal Audit also re-raised one high risk issue relating to a review of Business Continuity on IT Disaster Recovery. In this case, the Chief Information Officer has provided assurance to the Audit Committee (on 15 April 2014) on the planned completion of business impact assessments for all areas of the Trust which are part of critical activities; and the development of business recovery plans for the failure of key third party suppliers.

The Head of Internal Audit's Opinion 2013/14 (which, using the terminology set out in the Department of Health guidance to Heads of Internal Audit, equates to "significant assurance") has taken into account the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Using its Board Assurance Framework, which it reviews at each of its monthly public meetings, the Trust Board has also identified actions to mitigate other risks in 2014/15 in relation to:

- (a) failure to transform the emergency care system;
- (b) inability to recruit, retain, develop and motivate staff;
- (c) ineffective organisational transformation;
- (d) ineffective strategic planning and response to external influences;
- (e) failure to maintain productive and effective relationships;

- (f) failure to achieve and sustain quality standards;
- (g) failure to achieve and sustain high standards of operational performance;
- (h) inadequate reconfiguration of buildings and services;
- (i) loss of business continuity;
- (j) failure to exploit the potential of information management and technology;
- (k) failure to enhance education and training culture.

It is important to note that, during 2013/14, Internal Audit did not carry out specific work on the matters identified at (a) and (b) above, nor on the subject of patient experience/satisfaction. Instead, the Trust Board received management assurances on each of these matters at each of its monthly public Board meetings via the quality and performance report, a separate report on emergency care performance and the Board Assurance Framework. In addition, during 2013/14 the Quality Assurance Committee received reports at regular intervals from the Chief Nurse and Director of Nursing on patient experience/satisfaction.

Any changes in the current or target risk scores are highlighted to the Trust Board, and the Board also reviews and seeks assurances on the management actions in place to mitigate the identified risks.

### **Significant Issues**

In respect of performance in 2013/14 against the key financial duties, the Trust:

- (a) failed to deliver its planned surplus, did not meet its breakeven duty and incurred a deficit of £39.8m;
- (b) achieved the External Financing Limit (£20.2m against a target of £20.7m), noting that the limit was adjusted in year by the Department of Health at the request of the Trust;
- (c) achieved the (revised) Capital Resource Limit of £36.7m.

At its meeting on 27 March 2014, the Trust Board assessed the 'going concern' position of the Trust in the light of performance in 2013/14. In making this assessment, the Board received advice from the Executive Directors about the future prospects of the Trust (for a minimum of twelve months), driven by the historical financial position of the organisation and knowledge of the challenges faced by the Trust.

The assessment covered:

- (i) an overview of the 2013/14 financial year;
- (ii) the Trust's financial plan for 2014/15;
- (iii) consideration of each of the following issues in order to determine the appropriateness of the Trust preparing its accounts as a going concern:
  - ability to generate an operating surplus
  - statutory break-even duty
  - cash flow impact on net current assets and meeting liabilities as they fall due;
  - use and/or breach of borrowing facilities;
  - adverse operating conditions;
  - loss of key management positions;
  - compliance with statutory requirements;
  - pending or on-going legal action;
  - potential changes in legislation or government policy;
  - other liabilities.

The following risks to the on-going concern assessment were also considered by the Trust Board:

- (1) failure to receive permanent financing;
- (2) failure to deliver the planned deficit in 2014/15;
- (3) failure to manage working capital.

Having undertaken a robust assessment, the Trust Board concluded that the Trust should prepare its financial statements for 2013/14 on a going concern basis and accepted that steps would be taken to ensure that this remained the case for at least 12 months from the date of the preparation of the annual accounts.

In reaching this decision, the Trust Board noted in particular that provisional agreement had been reached with the NHS Trust Development Authority that the Trust would produce a financial recovery plan by the end of quarter 1 2014/15 with the aim of returning to a recurrent balanced financial position within three years. The financial recovery plan will form an integral component of the Trust's five-year plan, due to be submitted to the NHS Trust Development Authority by 20 June 2014. This will in turn be derived from the Leicester, Leicestershire and Rutland health and social care system's five year strategy which is required to be produced to the same timescale.

### **Emergency Care**

The Trust failed to meet the A&E 4-hour standard in 2013/14. As a member of the Leicester, Leicestershire and Rutland Urgent Care Working Group, the Trust is committed to working with its partners to improve performance against this standard in 2014/15, and has approved an action plan which includes components relating to:

- (a) demand management
- (b) patient flow within A&E
- (c) hospital bed flow
- (d) delayed transfers of care.

During 2014/15, the Trust Board shall continue to monitor performance against the A&E 4 hour standard at each of its monthly public Board meetings.

In addition to the issues identified above, further work will be undertaken in 2014/15 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.

I am of the opinion that the implementation of the actions described above will strengthen the Trust's system of internal control in 2014/15 and beyond.

My review confirms that the 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)

Date .....

## Committee attendance 2013/14

Name	Trust Board maximum - 14	Audit Committee maximum - 5	Finance and Performance Committee maximum - 12	Quality Assurance Committee maximum - 11	Remuneration Committee maximum - 9
Martin Hindle – Chairman <b>(1)</b>	7	N/A	N/A	N/A	4
Richard Kilner – Acting Chairman <b>(2)</b>	14	2	12	N/A	8
Ian Crowe – Non-Executive Director <b>(3)</b>	9	1	9	N/A	7
Sarah Dauncey – Non-Executive Director <b>(4)</b>	4		N/A	1	2
Kiran Jenkins – Non-Executive Director	13	5	N/A	1	8
Prakash Panchal – Non-Executive Director <b>(5)</b>	12	2	2	7	8
Ian Reid – Non-Executive Director <b>(6)</b>	4	2	3	N/A	2
Ian Sadd – Non-Executive Director <b>(7)</b>	2	1	1	N/A	1
Jane Wilson – Non-Executive Director	13	N/A	10	10	7
David Wynford-Thomas – Non-Executive Director	8	N/A	N/A	8	4
John Adler – Chief Executive	13	N/A	10	7	N/A
Kate Bradley – Director of Human Resources	13	N/A	N/A	1	N/A
Kevin Harris – Medical Director	13	N/A	4	8	N/A
Suzanne Hinchliffe – Chief Nurse/Deputy Chief Executive <b>(8)</b>	2	N/A	5	N/A	N/A
Peter Hollinshead – Interim Director of Financial Strategy <b>(9)</b>	3	N/A	3	N/A	N/A
Richard Mitchell – Chief Operating Officer <b>(10)</b>	10	N/A	8	N/A	N/A
Rachel Overfield – Chief Nurse <b>(11)</b>	7	N/A	N/A	4	N/A
Carole Ribbins – Acting Chief Nurse <b>(12)</b>	4	N/A	N/A	3	N/A
Andrew Seddon – Director of Finance and Business Services	11	N/A	9	N/A	N/A
Kate Shields – Director of Strategy <b>(13)</b>	5	N/A	N/A	N/A	N/A
Jez Tozer – Interim Director of Operations <b>(14)</b>	2	N/A	2	N/A	N/A
Stephen Ward – Director of Corporate and Legal Affairs	14	N/A	N/A	N/A	N/A
Mark Wightman – Director of Marketing and Communications	13	N/A	N/A	N/A	N/A

**Notes:-**

- (1) Trust Chairman until 30 September 2013
- (2) Acting Trust Chairman from mid-October 2013 (stepped down from Audit Committee at that point)
- (3) Non-Executive Director from 1 July 2013. Audit Committee member from 30 January 2014
- (4) Non-Executive Director from 1 May 2013 – 17 June 2013 and then from 27 January 2014
- (5) Audit Committee member from September 2013. Finance and Performance Committee member from August 2013 – end October 2013
- (6) Non-Executive Director until 30 June 2013
- (7) Non-Executive Director from October 2013 until 31 December 2013
- (8) Left the Trust on 19 May 2013
- (9) Interim Director of Financial Strategy from 20 January 2014
- (10) Chief Operating Officer from 10 July 2013
- (11) Chief Nurse from 9 September 2013
- (12) Acting Chief Nurse May – September 2013
- (13) Director of Strategy from November 2013
- (14) Interim Director of Operations from October 2012 – 7 June 2013



## INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2014 set out on pages 97 to 108.

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 auditors

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 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.

### Basis of opinion

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 2014 on which we have issued an unqualified opinion. We have not considered the effects of any events between the date on which we signed our report on the statutory financial statements 06 June 2014 and the date of this statement.

Our opinion on the statutory financial statements included an emphasis of matter paragraph because of a material uncertainty relating to the Trust incurring a deficit of £39.7 million during the year ended 31 March 2014 and requiring a significant sum of Public Dividend Capital in 2014/15. These conditions and the other matters explained in the Statement of Comprehensive Income indicate the existence of a material uncertainty which may place significant doubt on the Trust's ability to achieve long-term financial stability.

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

One Snowhill  
Snow Hill Queensway  
Birmingham  
B4 6GH

01 September 2014

## Glossary of terms

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

**Acute Care** is specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

**Care Plan** a plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy.

**Care Quality Commission** the organisation that make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

**CCG (Clinical Commissioning Group)** Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

**Clinical Governance** is a framework that ensures that NHS organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.

**Clinical Negligence Scheme for Trust (CNST)** is a scheme for assessing a Trust's arrangements to minimise clinical risk for service users and staff. Trusts need to pay 'insurance' which can offset the costs of legal claims against the Trust. Achieving CNST Levels (1, 2 or 3) shows the Trust's success in minimising clinical risk and reduces the premium that the Trust must pay.

**Clinician** is a person who provides direct care to a patient such as a doctor, nurse, therapist, pharmacist, psychologist etc.)

**Commissioning** is the process of identifying a community's social and/or health care needs and finding services to meet them.

**Community Care** aims to provide health and social care services in the community to enable people live as independently as possible in their own homes or in other accommodation in the community.

**Co-morbidity** is the presence of two or more disorders at the same time. For example, a person with depression may also have diabetes.

**Diagnosis** is identifying an illness or problem by its symptoms and signs.

**Discharge** is the point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).

**Emergency Admission** when a patient admitted to hospital at short notice because of clinical need or because alternative care is not available.

**Emergency Department** is a hospital department that assesses and treats people with serious and life-threatening injuries and those in need of emergency treatment. Also sometimes called A&E (Accident & Emergency)

**Foundation Trusts** are a type of NHS hospital run by local managers, staff and members of the public, which are tailored to the needs of the local population.



**General Practitioner (GP)** is a family doctor, usually patient's first point of contact with the health service.

**Health Care Assistants** (can also be referred to as Health Care Support Workers) are non-qualified nursing staff who carry out assigned tasks involving direct care in support of a registered/qualified nurse. There are two grades of Health Care Assistants, A and B grade. A grades would expect to be more closely supervised, while B grades may regularly work without supervision for all or most of their shift, or lead on A grade.

**Human Resources** is a department found in most organisations that works to recruit staff, assist in their development (e.g. providing training) and ensure that staff work in good conditions.

**Information Management and Technology (IM&T)** refers to the use of information held by the Trust, in particular computerised information and the department that manages those services.

**Intermediate Care Services** are services that promote independence, prevent hospital admission and/or enable early discharge. Intermediate care typically provides community-based alternatives to traditional hospital care.

**Liverpool Care Pathway** is a care pathway used in the UK covering palliative care options for patients in the final days or hours of life. It has been developed to help doctors and nurses provide quality end-of-life care.

**Multidisciplinary** denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.

**NICE** is the National Institute for Health and Clinical Excellence, an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

**Non-executive Director** is a member of the Trust Board. They act a two way representative. They bring the experiences, views and wishes of the community and patients to the Trust Board. They also represent the interests of the NHS organisation to the Community.

**Out of Hours (OOH)** is the provision of GP services when your local surgery is closed, usually during the night, at weekends and Bank Holidays.

**Palliative care** is an area of healthcare that focuses on relieving and preventing the suffering of patients.

**Peri-natal mortality** is the number of stillbirths and deaths in the first week of life per 1,000 live births, after 24 weeks gestation.

**Primary Care** is the care will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

**Risk assessment** identifies aspects of a service which could lead to injury to a patient or staff member and/or to financial loss for an individual or Trust.

**Secondary care** is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

**Serious Untoward Incidents (SUI)** is a to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.

**Stakeholders** are a range of people and organisations that are affected by or have an interest in, the services offered by an organisation.

**Tertiary Care** is when a hospital consultant decides that more specialist care is needed. Mental Health Services are included in this (see also Secondary care).

**TTO (To-take-out)** are medicines supplied by the hospital pharmacy for patients to take with them when they are discharged (see discharge) from hospital.

**Triage** a system which sorts medical cases in order of urgency to determine how quickly patients receive treatment.

**Walk-in-Centre (WiC)** an NHS medical centre patients can attend without an appointment.

**Whistle blowing** is the act of informing a relevant person in an organisation of instances or services in which patients are at risk.

# Please help us to improve the way we share information with people

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

We would be very grateful if you could answer the questions below and send your response to us by 31 December 2014.

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

**1 The information we give:**

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

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

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**2 Were there any areas of the annual report which you found most useful, please feel free to list and explain why**

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

	<b>Gain a broad understanding</b>	<b>Gain a detailed understanding</b>
The Trust and its achievements		
The Trust's performance against targets		

The Trust's plans for the future		
The Trust's financial position		

**4 Do you have another comments or suggestions about our annual report or any of our other publications?**

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If you would like to be notified when the 2014/15 annual report is available? If so, please give your email address

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Completed questionnaires can be sent to:

**Communications Team**, University Hospitals of Leicester NHS Trust, Medical Illustration, Level 2 Windsor Building, Leicester, LE1 5WW

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

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

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

如果您想用另一种语言或格式来显示本资讯，请致电 0116 250 2959

联系“服务平等化经理” (Service Equality Manager)。

જો તમને આ પત્રકનાં લેખિત અથવા ટેઈપ ઉપર ભાષાંતર જોઈતું હોય તો મહેરબાની કરી સર્વિસ ઈકુવાલિટી મેનેજરનો 0116 250 2959 ઉપર સંપર્ક કરો.

यदि आप को इस लीफलेट का लिखती या टेप पर अनुवाद चाहिए तो कृपया डेव बेकर, सर्विस इक्वालिटी मैनेजर से 0116 250 2959 पर सम्पर्क कीजिए।

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

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

Ak by ste chceli dostať túto informáciu v inom jazyku, alebo formáte, kontaktujte prosím manažéra rovnosti služieb na tel. číslo 0116 250 2959.

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

