University Hospitals of Leicester NHS

NHS Trust

Quality Account
2012 / 2013

Caring at its best

Contents

1 2012/2013 Achievements

We are proud to have some of the lowest rates of hospital-acquired infections, such as C.Difficile and MRSA, in the country.

All three hospital sites have been visited this year and found to be compliant with the essential quality and safety standards.

University Hospitals of Leicester NHS
NHS Trust

We have been awarded £246,200, to improve and upgrade the maternity units at the Royal and General hospitals.

In December 2012 our Children's Hospital opened its Teenage and Young Adult (TYA) cancer unit, funded by support from the Teenage Cancer Trust and our own Ourspace appeal.

In the next five years, we will become a successful, patient centred, Foundation Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience.

We call this... *Caring at it's best*

1 Statement on quality from the Chief Executive

Caring at its best

1 Statement from the Chief Executive

Hello and welcome to our Quality Account for 2012/13.

The Quality Account is the equivalent of the annual report and accounts but differs in that it is solely concerned with issues of quality and safety, rather than finance and performance figures.

In recent months Sir Robert Francis QC has published his findings into the events which took place in Mid Staffordshire NHS Foundation Trust and which led to the unnecessary deaths of patients treated in those hospitals.

The report and subsequent coverage and discussion has led commentators to ask whether the NHS has lost track of what is most important? Are targets and financial performance being pursued at the expense of good quality patient care? Has the NHS hit targets but missed the point?

They are all good questions but like so much of what we see and hear in the media and other forums they are a simplified version of reality.

The Francis report should not be seen as the end of a public enquiry but the beginning of something much larger, a conversation for both the public and the professionals to take part in as owners and guardians of our most cherished national asset, the NHS.

It is all too easy to be wise after the event. Yes, looking back we can all see that what happened in Mid Staffs was as a result of a particular set of circumstances coming together to create a fog of accountability . The mortality data, showed that there was potentially a problem but it was explained away; the public and pressure groups said there was a problem but they were not listened to; the doctors and nurses individually raised concerns but not in a way that reverberated in the Board room. Overall, Bevan's promise that if a bedpan was dropped on a ward the sound would be heard in Whitehall was shown to be false, not least because there was no chance that 'Whitehall' would hear it if the local board did not.

The failings at Mid Staffs have been said to be as a consequence of management, the Board, the regulator, the commissioners, the Strategic Health Authority, but surely the ultimate failure was more profound; it was the failure by anybody involved in the running of the Trust to pause and say to themselves, 'maybe there's something in this, maybe the mortality data and maybe the concerns raised by families cannot be explained away'. In that sense the real failure was the failure to maintain an open mind.

1 Statement from the Chief Executive

Are there lessons in here for Leicester? Yes, it would be foolish and arrogant to think otherwise. One of the biggest lessons is that we should all, public and professionals alike make a concerted effort to tolerate less and question more. One of the most powerful words in the NHS is 'why?' Why do I have to wait? Why can't I get an appointment? Healthy scepticism is different from cynicism. Sceptics ask why because they want to contribute to creating something better; cynics ask why because they want to prove a point.

We have been asking 'why?' a lot recently. Why don't more patients and staff say they would recommend the Trust to their families? Why can't we improve our mortality rates? Why do some patients come to harm in hospital as a result of a fall or a bed sore?

The complacent response to these questions would involve looking at the data on mortality or complaints and hospital falls and looking for assurance that they happen because, for example, we treat too many older patients who ought not to be in hospital in the first place. Whilst that is no doubt the case, it is not the real answer!

This Quality Account describes the real answers to those questions. It shows that we will over the next 5 years save 1,000 more lives by working hard on specific care pathways which we know could be improved. It shows that we will reduce by 5,000 the numbers of patients in our hospitals who slip, trip, fall or otherwise come to harm whilst in our care and it describes how by doing these things and focusing on quality and compassionate care, more patients and staff will feel confident to recommend us to their families and loved ones.

We have worked with staff, patients and stakeholder on this. We call it the 'Quality and Safety Commitment', and I would like to thank all those people who have contributed, kept an open mind and asked 'why' as we developed our approach to quality and safety.

This report also describes the details and our performance on some of these important measures over the last 12 months.

Finally, I want to take this opportunity to thank our staff in Leicester's Hospitals, they do a tough job, in sometimes difficult circumstances but always with the patient in mind.

I am pleased to confirm that the Board of Directors has reviewed the 2012/13 Quality Account and confirm that it is a true and fair reflection of our performance. We hope that this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at Leicester's Hospitals.

John Adler

Chief Executive

University Hospitals of Leicester

2 Review of quality performance in 2012/13

Our aims 2012/2013 – a review of last year's quality priorities

Last year (2012/13) we set the following three priorities for improvement:

- To improve mortality rates further
- To improve readmission rates
- To improve patients' experience in our hospitals.

In addition to these three main priorities for improvement we also identified other specific areas for improvement as detailed below.

- Improving the use of the World Health Organisation (WHO) checklist and team briefings in all our operating theatres
- Reducing cancellations on the day of elective surgery
- Improving standards of end of life care
- Improving awareness and diagnosis of dementia
- Implementation of the 5 Critical Safety Actions programme

	TARGET ACHIEVED ON PLAN	CLOSE TO TARGET	BEHIND PLAN
SAVE LIVES			
Reducing mortality (SHMI) in year reduction*	✓		
Reducing mortality (SHMI) better than the majority of other Trusts in UK.*			✗
VTE Assessment	✓		
AVOID HARM			
The Safety Thermometer	✓		
5 Critical Safety Actions *	✓		
PATIENT CENTRED CARE			
*Improving patient experience**	✓		
*Improving readmission rates**			✗
*Reducing cancellations on the day of surgery**			✗
*End of Life Care**	✓		
*Diagnosis of Dementia**		✓	
*WHO check list**	✓		

* Selected as priorities in the 2012/2013 Quality Account

2 Save lives

Reducing mortality (SHMI*)

The Summary Hospital-level Indicator (SHMI) is the standardised measure of mortality developed by the Department of Health; this compares our actual number of deaths with the expected number of deaths and includes patients that die either in hospital or within 30 days of discharge.

Our SHMI value reported in the 2011/12 Quality Account was 106.12 (this covered the 2010/11 Period). The SHMI for 2011/12 was published in December last year and was 104.7 (105). The most recent published SHMI covers the period October 2011 to September 2012 and our SHMI was 104.53 (105). All values have been 'within expected'.

We also monitors its 'in-hospital mortality rate' by using the Dr Foster 'Real Time Monitoring' Tool and their 'Hospital Standardised Mortality Ratio' (HSMR).

Our HSMR for 2012/13 is currently 96 which is anticipated to be 103 after the annual rebasing is carried out by Dr Fosters once all trusts' data has been submitted. At 103 our HSMR will still be 'within expected' albeit we had been aiming to be below 100.

What:
1. We said that we wanted to 'achieve an in year reduction' in our SHMI
2. Be better than the majority of other Trusts in the UK.

By When: April 2013

Progress:
1. Achieved ☑
2. Behind plan ☒

Due to our population we have also reviewed our mortality data for patients in 'Black and Minority Ethnic' Groups (BME) entered into the trust's Patient Administrative System (HISS). 18% of in-hospital deaths are patients from BME groups, most from the Asian/Asian British Indian Group.

Our mortality rate for 2012 was 1.4%. The mortality rate, during the same time period, for patients in the 'other' BME groups was 0.9% whilst the rate for patients from 'White British' group was 1.5%.

Improvements achieved

- Achieved 'in year reduction' and although we are still in the 'middle of other trusts' for performance, we have slightly improved our position.
- Improved the pathway for patients admitted with stroke, in line with National Institute for Health and Care Excellence (NICE) Guideline. CT scans carried out within an hour of arrival for 'high risk' patients and direct admission to the Stroke Unit.
- Joined the British Thoracic Society 'Pneumonia Care Bundle' project to reduce delays in the accurate diagnosis of pneumonia and ensure earlier treatment.

2 Save lives

Reducing mortality (SHMI*)

- Participated in the Heart Failure GOAL in the international Dr Foster Global Comparators project focused on the implementation of a discharge care bundle. This includes patient education and discharge advice to support better self-management once patients are discharged.
- Our crude and risk adjusted mortality rates are reviewed at both divisional and trust level on a monthly basis. Each speciality has embedded their processes for undertaking mortality and morbidity reviews to include acting on any learning outcomes.

Further improvements required

- Analysis of SHMI data, showed our emergency 'out of hours' admissions were associated with a higher mortality rate, similar to other trusts – as reported in the latest Dr Foster 'Hospital Guide'.
- Following this analysis, which also looked at diagnostic groups, two priorities were identified for action as part of the 2013/14 Trust's Quality & Safety Commitment 'Reducing Mortality' work stream – 'out of hours admissions' and 'respiratory patients'.

2 Save lives

Case study: Alcohol related liver disease

Patients admitted with alcohol related liver disease formed a diagnostic group with a significantly 'higher than expected mortality' during 2012/13.

Nationally, there has been an increase in mortality associated with alcoholic liver disease and poor health due to alcohol abuse. Compared to the national mortality rate, chronic liver disease mortality in Leicester is significantly higher than other areas in the United Kingdom, and this is associated with deprivation seen in Leicester.

Improvements achieved

We already have an Alcohol Liaison Worker who has developed and implemented guidelines and a referral process for patients presenting with alcohol problems. We have recently appointed two additional staff to the team who will be working closely with community services to reduce the harm associated with alcoholic liver disease.

In order to ensure early specialist management of patients admitted with gastrointestinal problems, the Gastroenterology team has established a Registrar lead 'Outreach service' which can be accessed by other clinical teams caring for patients on non gastroenterology wards, including those with alcoholic liver disease.

Further improvements required

A review was undertaken of patients who had died during the 'alert period' (according to Dr. Foster analysis there were 50 deaths at the trust between Nov 2010- Nov 2011compared to an expected 33.9). Most deaths were expected and the care and management was considered to have been appropriate for all patients. Four of the patients were wrongly coded as having a primary diagnosis of alcohol related liver disease. For two of these patients, there were some issues around appropriateness of investigations which led to delays in their diagnosis, but it is considered that the delays would not have affected the outcome.

Another area identified for improvement was clarity around communication channels regarding patients in need of central line insertion or high dependency unit care. This was discussed with the critical care intensivists and a process was agreed in respect of patients admitted with alcoholic related liver disease who are potentially in need of a high dependency unit bed or central line insertion.

2 Save lives

VTE assessment

Venous thromboembolism (VTE) is a term that covers both deep vein thrombosis and its possible consequence: pulmonary embolism (PE). A deep vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg and if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a potentially fatal blockage (PE). In 2005 the House of Commons Health Committee reported that an estimated 25,000 people die from preventable hospital-acquired VTE in the UK every year. The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients and prescribing them appropriate prophylaxis (preventative measures).

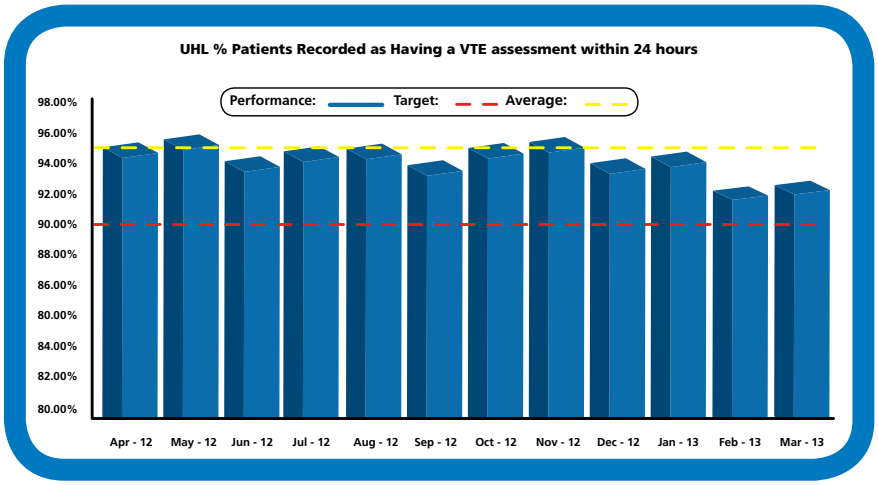
What: Minimum 90% compliance in line with national guidance

By When: April 2013

Progress: On plan ☑

94.5% of patients have VTE risk assessment have now been achieved.

Improvements achieved



- Sustained audit of VTE assessment rates and completed trust wide audits of compliance.
- Increased accuracy relating to VTE assessment rates using electronic prescribing record.
- Matrons and Lead Nurses review VTE assessment rates and VTE occurrence monthly as part of the Safety Thermometer.
- Increased response of root cause analysis for potential hospital acquired VTE.
- Through induction and training all new nursing and medical staff, staff are aware that VTE risk assessments are recorded on Patient Centre for all adult patients.
- Expanded surveillance for VTE into community care environments.

Further improvements required

- Sustain high compliance with assessment and appropriate preventative measures.
- Review and maximise, and where possible automate, use of surveillance and reporting mechanisms to fully embed VTE standards.
- Robust involvement with community partners.
- Achieve CQUIN target for 2013/14 via:
  - Increase VTE assessments to a sustained 95% of eligible patients.
  - Provide pharmacological and/or mechanical thromboprophylaxis to all eligible patients.
  - Carry out root cause analysis for all in-patients who experience a potentially hospital acquired VTE.

2 Avoid harm

The safety thermometer

We understand it is essential that the care we provide to patients is free from harm. Harm is suboptimal care which reaches the patient either because of something we shouldn't have done or something we didn't do that we should have done. Hospital acquired infections, medication errors, surgical infections, pressure sores and other complications are examples of harm which can occur within a healthcare setting.

The Safety Thermometer allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportion of patients that are 'harm free' in relation to:

- Grade 2, 3 and 4 pressure ulcers
- Venous thrombo-embolism (VTE)
- Catheter acquired urinary infections (CAUTI)
- Falls.

The Safety Thermometer was fully implemented across our Hospitals in March 2012 and 'harms data' is now collected for every patient on the same day, once a month with the exceptions of patients in theatres, day case areas, emergency department, and outpatients.

What: Use of the Safety Thermometer tool to measure local improvement and reduction in harms over time

How much: The Department of Health target is 95% of patients should experience harm free care.

Progress: Close to target ☑

Improvements achieved

- Current position compares favourably with national data for March 2013 (93.33%).
- We submit the largest number of returns compared to any other Trust across the Midlands and East Region, even when taking additional capacity into account.
- More patients have received 'harm free' care in Leicester's Hospitals in March 2013 compared to the beginning of the year.

Further improvements required

- Significant focus on reducing avoidable pressure ulcers over the last 12 months and the Safety Thermometer data has been used to measure success of pressure ulcer prevention strategies for hospitals and the community.

2 Avoid harm

5 critical safety actions*

The 5 Critical Safety Actions programme seeks to embed safety processes across all our clinical business units to ensure systematic, consistent and high quality care. The 5 actions have been integrated into our Quality and Safety Commitment priorities which will provide increased application and progress.

What: The primary objective for the 5 Critical Safety Actions programme is to see a reduction in avoidable mortality and morbidity across the organisation and an improvement in organisational safety culture.

By When: April 2013- roll out to April 2014

Progress: On plan ☑

The 5 Critical Safety Actions are:

1. Improving clinical handover; to provide a systematic, safe and effective handover of care.
2. Acting upon results; all results to be reviewed and acted upon in a timely manner.
3. Relentless attention to Early Warning Score (EWS) triggers and actions; to improve the care delivery and management of the deteriorating patient.
4. Implement and embed mortality and morbidity standards; to have standardised process for reviewing in hospital deaths within 3 months and archiving the completed reviews.
5. Senior clinical review, ward rounds and notation; to provide timely senior clinical reviews and to set minimum standards for ward rounds and documentation to meet national guidance.

Improvements Achieved

- Reduction of 25% in Serious Untoward Incident's (SUI's) related to the 5 Critical Safety Actions.
- Reduction in EWS non escalation incidents of 3.5% (against inpatient hospital episode).
- Reduction in SUI's specifically associated with non escalation of EWS by 40%.
- Use of electronic handover by nursing staff in inpatient areas.
- Development of robust guidance for screening and diagnostic testing.
- All HCA's assessed competent for undertaking EWS observations across the organisation.
- 100% of specialities now undertaking mortality and morbidity review meetings.

Further improvements required

- Focus on senior clinical review, ward rounds and notation by setting standards to make certain our patients receive a regular senior clinical review.
- Implementation of a more structured approach to our ward rounds with the use of a checklist and improving medical documentation in adherence with Royal College guidance.
- Prioritise Acting Upon Results, and ensuring that every speciality has an agreed process for the management of their diagnostic test results for both inpatients and outpatients.

2 Case study:
Grade 2, 3 and 4 pressure ulcers

The Safety Thermometer records the prevalence of 'old' pressure ulcers (defined as being a pressure ulcer that was present when the patient was admitted to hospital or developed within 72 hours of coming into hospital) and 'new' pressure ulcers (defined as being a pressure ulcer that developed 72 hours or more after the patient was admitted to hospital i.e. hospital acquired). Table one below illustrates our prevalence data for hospital acquired or new grade 2, 3 and 4 ulcers from April 2012 to March 2013.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec 12	Jan-13	Feb-13	Mar-13
Number of patients	1533	1570	1593	1551	1554	1475	1626	1617	1652	1652	1597	1604
Total No of Harms	189	181	141	160	137	109	98	99	126	118	147	112
No of patients with no Harms	1359	1401	1457	1404	1426	1373	1533	1522	1546	1536	1455	1497
% Harm Free	88.65	89.24	91.46	90.52	91.76	93.08	94.28	94.12	92.98	92.98	91.11	93.33
Total No of New Harms	107	82	62	86	59	41	33	40	45	32	50	56
All Pressure Ulcers (Grades 2, 3 or 4)	108	113	90	85	78	61	62	70	90	95	98	66
New Pressure Ulcers (Grade 2, 3 or 4)	43	40	27	29	20	13	12	27	29	18	16	19
Patients admitted with PUs	65	73	63	56	58	48	50	43	61	77	82	47

Grade 2 Pressure Ulcers
The outer layer of the skin (the epidermis) and part of the underlying layer of the skin (dermis) is damaged or lost. The ulcer is superficial and presents clinically as an abrasion or blister.

Grade 3 Pressure Ulcers
At this stage, the ulcer is a deep wound and will involve full thickness skin loss. The damage may extend beyond the primary wound beyond layers of healthy skin.

Grade 4 Pressure Ulcers
There will be a large scale loss of tissue with a grade 4 ulcer. The damage with this grade of ulcer often extends beyond the primary wound below layers of healthy skin and the wound may expose muscle, bone and tendons.

2 Patient centred care

Improving patient experience*

We believe that care for patients will be improved, making "Caring at its best" a daily reality for every patient in every part of our organisation. This encompasses working with our patients and their families, helping us to fulfil truly patient centred care to enhance patient experience.

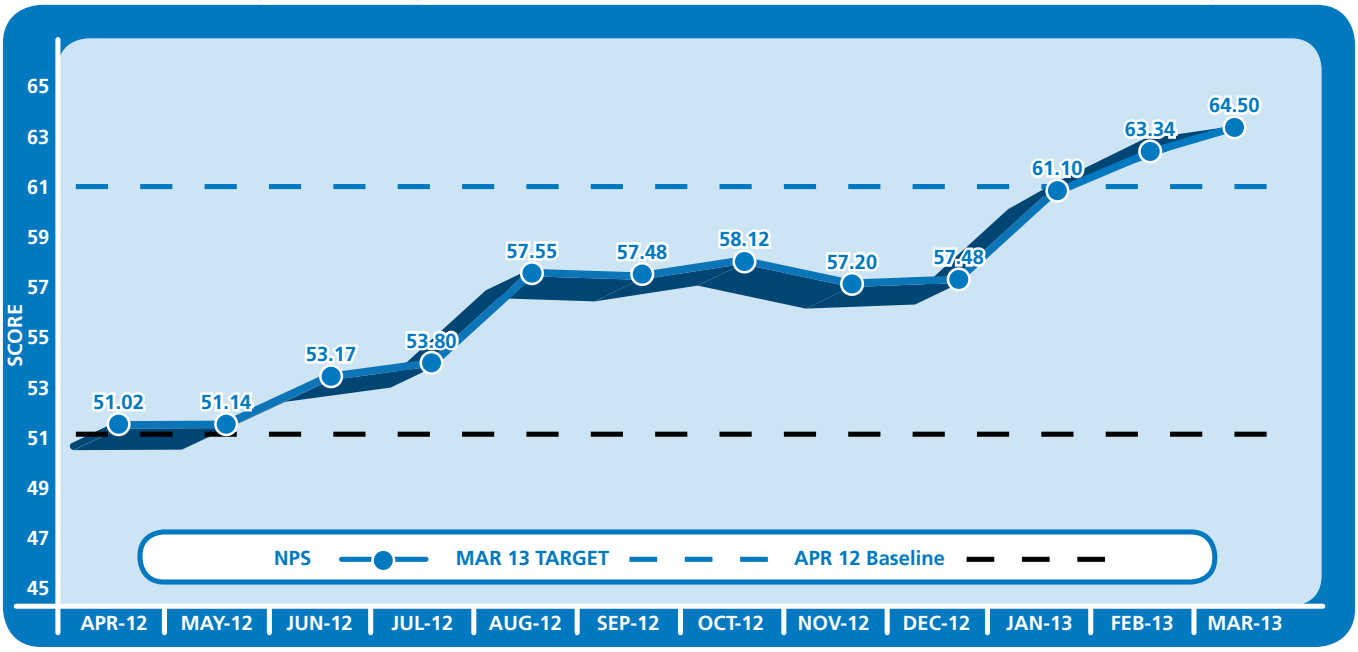
What: To continually improve the patient experience

How much: Improvement of 10 points in our inpatient wards Friends and Family Test Score from an April 2012 baseline score of 51

Progress: Achieved. ☑

Score of 64.5 in March 2013, a 13.5 improvement from baseline

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



Feedback gathered through a variety of methods, including; paper and electronic surveys, Message to Matron postcards and patient stories.

Improvements achieved

- We have worked hard to get a workforce that has the right staff in the right place doing the right job. We have developed ward leaders to have the necessary skills to lead their teams and provide high quality care. Key to this is making part of the ward leaders time supervisory.
- Inpatient survey returns numbers improved by an average of 16.3% over the last financial year. This equates to approximately 3,266 extra surveys throughout the year, giving us valuable feedback.

2 Patient centred care

Improving patient experience*

- In addition to the existing 'Caring at its best' ward dashboards, we have implemented a simplified ward dashboard aimed at the public to see at a glance both performance and ward/area focus for the next quarter.
- Expanded and developed our networks to ensure we are engaging regularly and widely with our staff, our patients, their carers and families. This is both at an organisational level, and locally in divisional activity.
- We continue to engage with Black and Minority Ethnic groups across the county to ensure we capture information on views and opinions to improve our services including; information giving, food provision, interpretation services as well as raising staff awareness in cultural issues. We regularly review Patient Experience Survey results within different demographic groups.
- Older People's Champions are members of staff who voluntarily attend training in older people's issues to learn more on how they can help support older people in the trust. To date, over 1,700 members of staff have been trained to become an Older People's Champions in the trust. We held three successful Older People's Champions Forums and an Older People's Champions Celebration Event, entitled 'Dignity and Dementia' to support world Alzheimer's Day. Staff are recognised for their commitment and drive to improve care for older people in hospital with an award being presented for the 'Champion of Champions' at the annual Older Peoples Champions Celebration Event.

Further improvements required

- Ensuring we are focusing on the key areas of dignity for our patients. We have recently engaged with staff and public asking the question "What does dignity mean to you?" Utilising this information, alongside our patient feedback and complaint themes means we will be able to align our activity in this area ensuring "we focus on what matters most".
- We know carers want and need access to information, signposting and support. We have worked with the Leicestershire Local Involvement Networks group (LINKs) to co create a carers charter which was launched in March 2013. Commitment was agreed from Leicester LINks, Leicestershire Partnership Trust (LPT), city and county councils, the Clinical Commissioning Groups (CCGs) and our hospitals.
- The carer's survey asks key questions and the results form the annual plan for both local and specialty engagement both internally and externally. Responsiveness to the survey results, as well as taking heed of the increasing numbers of people caring within Leicestershire means that focus is imperative, and may impact on other outcomes such as readmission due to carer breakdown.

2 Case study:
Mealtime and ward support volunteers

Volunteers within our hospitals are recruited through the volunteer services department and contribute greatly to the patient experience. The volunteers follow a strict recruitment and selection process and are subject to screening appropriate for their role.

Those choosing to volunteer in a ward environment receive specific mealtime training which includes input from speech and language therapy, dietetics and nutrition and infection prevention experts. They also receive training about assisting patients with dementia.

Volunteers support the mealtime experience for adult patients, including serving food, opening packages, cutting up food or sitting with a patient and assisting them to eat and drink. Volunteers also encourage and motivate patients to eat. They receive instruction in how to make the mealtime experience more positive and to enable patients to eat independently wherever possible. We currently have 252 active volunteers who have completed our mealtime and ward support training course. We continue to work across the Trust identifying areas where volunteer support would benefit patients and developing volunteer's roles to meet these needs, across a number of selected wards.

2 Patient centred care

Improving readmission rates*

Patients can be readmitted to hospital within 28 days of discharge for many reasons. Sometimes these readmissions are unavoidable but often we can do things to help prevent the readmission. Examples of things that can be done to help stop a patient from being readmitted include clearly explaining medication (and making sure that the patient understands their medication) or making sure a clinician follows up with the patient after they have been discharged (so that the patient can ask any questions or discuss any worries that they may have).

What: Reduce readmissions in elective and emergency admissions for both adults and children

How much: By 5%

By when: March 2013

Progress: Behind plan [X]

Our 28 day emergency readmissions rates increased from 7.6% in 2011 to 7.8% in 2012 (no exclusions).

Improvements achieved

- In women's services the readmission target (which mainly comprises gynaecology) has been met and exceeded to date (February 2013). For children's there has been a decrease in readmissions in part due to the improvements due to the new pathways of care and the increased consultant presence on children's acute unit.

Further improvements indentified

- New Advanced Recovery Unit the General Hospital

  The new unit, costing £480k, opened mid March 2013. It will provide extended post operative care to patients undergoing major surgery, who would need an intensive treatment unit bed if specialist anaesthetic and nursing care was not available immediately post operatively. It will be able to provide care for up to 12 patients each day. Upon discharge patients will be transferred back to their ward bed which will reduce inpatient stays, reduce intensive treatment unit bed days and support the reduction in readmissions as the right care will be provided in the right place.

- A recent readmissions audit report has been received by Executive Team and the key recommendations are as follows:

1. Earlier senior review on admission
2. Improved discharge planning with early involvement of patients and carers
3. Increased awareness of and liaison with community services
4. Availability of Consultant telephone advice for GPs post discharge
5. Accessibility of end of life care plans from primary care

This forms the basis of the plans that will be implemented during the coming year. This work will be led by senior clinicians in both primary and secondary care.

2 Patient centred care

Reducing cancellations on the day of surgery*

Reducing cancellations on the day of surgery is important to the Trust from both a quality and cost perspective. At Leicester's Hospitals we try our best to identify the different type of cancellations, understand the reasons and then tackle them appropriately, thus improving the patient pathway. Department of Health guidelines suggests patients who have their operation cancelled (for a non clinical reason) on the day of surgery should be readmitted within 28 days.

What: Last year we aimed to reduce cancellations on the day of elective surgery by ensuring that elective surgical patients receive their procedure on the intended date and working collaboratively across the organisation to maximise theatre use.

How Much: Reduce cancellations on the day of surgery by 50%

Progress: Behind Target ☒

The main reasons for short notice cancellations during the year are due to an increase in emergency demand creating pressure on the bed capacity, theatre scheduling issues and intensive treatment unit/high dependency unit capacity.

The last minute cancellation rate against all elective activity this year is 1.2% against a cancellation rate of 1.4% last year.

Improvements achieved:

- New advanced recovery unit at the General Hospital. The development will improve the patient flow within the General's main operating theatres and reduce the risk of surgical cancellations due to limited intensive treatment unit/high dependency unit capacity.

Further improvement required:

- To ensure that patients have been offered another date for surgery within 28 days (target of 95%), every cancellation will be reviewed at the weekly access meeting to confirm that patients have already been re-dated. The re-dating of cancellations within 28 days (95%) will be delivered from 1st April onwards.
- Additional capacity/space is being created at the Glenfield site to minimise risk of day case surgery being cancelled.
- During 2013/14 a Trust wide theatre project is being launched which will improve scheduling and usage of theatres with a particular focus on reducing number of short notice cancellations.
- Additional intensive care beds are due to be opened during 2013/14 which will reduce the number of cancellation due to unavailability of these beds reducing number of short notice cancellations.

Operations Cancelled by Hospital at 'Last Minute' for non clinical reason April - March 2012/13

Operations cancelled for non-clinical reasons on or after the day of admission	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan- 13	Feb-13	Mar -13	YTD
	1.1%	1.2%	1.2%	0.9%	0.5%	0.9%	1.1%	1.6%	1.2%	1.6%	1.5%	1.6%	1.2%

2 Patient centred care

End of life care*

To improve the quality of end of life care, we are participating in the national pilot of Route to Success, "Transforming End of Life Care in Acute Trusts", developed by the National End of Life Care Programme.

What: Improving standards of End of Life Care by ensuring patients and carers receive the highest possible standards of end of life care through advance care planning and training of staff in End of Life Care.

Outcome: In progress

By when: September 2013

Progress: On target ☑

The pilot involves implementation of five key enablers into clinical areas to facilitate best practice for those approaching end of life.

- AMBER Care Bundle
- Liverpool Care Pathway
- Rapid discharge home to die pathway
- Advance care planning
- EPaCCS (formerly known as Electronic locality register)

Improvements achieved

› The AMBER Care Bundle provides a systematic approach to manage the care of our patients who are facing an uncertain recovery. It encourages a multi-disciplinary approach to decision making while promoting documentation of a clear medical plan, escalation of treatment and 'do not resuscitate' orders (DNAR). The AMBER care bundle has been implemented on 4 older people's care wards at the Royal Infirmary.
Initial feedback has been positive with 59 patients having their care supported by the AMBER care bundle.

› The Liverpool Care Pathway was implemented in 2005 and is currently used in all adult wards across our hospitals. We participated in the Marie Curie National Care of the Dying Audits for hospitals (NCDAH).

› We have supported a rapid discharge home to die pathway since August 2010 in conjunction with the Hospice at Home Team and our Discharge Team. Our specialist palliative care team have extended their service to seven days a week which means advice is now available at a weekend.

› We are involved in a working party across Leicester, Leicestershire and Rutland to implement an adaptation of the "Deciding Right" tool for advance care planning for adults who may be in their last year of life. A training package is being developed for this tool.

2 Patient centred care

End of life care*

Further improvements required

- Further roll out of Route to Success to engage other clinical areas in the initiative and devise a plan for wider implementation.
- Continue to work in collaboration with the Leicestershire and Rutland Organisation for the Relief of Suffering (LOROS) to offer further training opportunities.
- Continue to implement the AMBER Care Bundle into clinical areas.
- Introduce surveys to gather quality data from staff, patients and carers about their views and experiences of the End of Life Care.
- Introduce a step by step guide for nurses, identifying what to do following a death on the ward. The aim is for this to be pocket sized and accessible to all nurses.
- Implement Volunteers at Life's End (VALE) to provide companionship and support to patients and their families at end of life. Volunteers will already be experienced within the hospital environment and will receive training and support from the specialist palliative care team who will coordinate their activity.

2 Case study:
End Of life care*

Quality End of Life Care for All (QELCA)

As part of the Route to Success initiative and in collaboration with Help the Hospices a specially designed end of life care programme entitled Quality End of Life Care for All (QELCA) has been developed.

This programme comprises of a one week training course including classroom teaching, practical experiences and 6 action learning sets which are held monthly.

This has given generalist nurses the skills and confidence to identify improvement within their own clinical areas in relation to End of Life Care. Action learning sets offer ongoing support when implementing changes in their clinical practice within our hospitals.

Progress to date

Following completion of QELCA training, individuals have developed ward based projects which include:

Sally's bag of comforts –

Comfort bags have been introduced for dying patients who have little or no family. These have kindly been donated by the family of Sally Bean who died in 2010 aged 42. Fundraising events to support this charity are being arranged.

Poster and staff leaflet -

A poster has been developed to raise awareness of the Route to Success initiative and displayed on each of the Route to Success wards.

Roll out of the butterfly initiative -

Our emergency department currently use a picture of a blue butterfly to signify to other staff in the department that peace and quiet should be paramount in a particular area, usually when a patient is very unwell or nearing end of life. This is starting to be used within the medical wards and other Route to Success wards are keen to adopt it.

EOLC study day -

The end of life project facilitator is working with 2 wards that are keen to develop a study day to be run several times throughout the year, enabling all staff on the wards to attend. The aim is to educate staff and raise awareness of the importance of quality end of life care. If this is successful it will be offered to other wards.

Help the Hospices

2 Patient centred care

Diagnosis of dementia*

Dementia can affect anyone and is not an age related condition. About 750,000 people in the UK have dementia – and this number is expected to double in the next thirty years. Statistics indicate that two thirds of people living with dementia never receive a diagnosis

What: To improve awareness and diagnosis of dementia through increased risk assessment.

How much: 90% compliance in the three stages of dementia screening.

By when: March 2013

Progress: Close to target ☑

The target for the CQUIN is 90% compliance in the three stages of dementia screening. Leicester Hospital's results are as follows.

Stage 1 – 60% of patients that meet the criteria are being identified as having a prior diagnosis of dementia or being asked the dementia case finding question.

Stage 2 – 90% of patients that identify memory problems are being assessed for dementia.

Stage 3 – 100% of patients whose risk assessment is suggestive of dementia is being referred to their GP appropriately.

Improvements achieved

- Protocols are now in place for staff caring for people with dementia following the report of National Audit of Dementia care in general hospital (November 2010).
- Dementia care pathway developed in line with National Institute for Health and Clinical Excellence (NICE) and Social Care Institute for Excellence (SCIE) guidelines. It incorporates NICE quality standards for dementia (2010) and aims to provide standardised care for people with dementia admitted to our hospital.
- Screening of patients for dementia. A new Commissioning for Quality and Innovation (CQUIN) target has been published to ensure that every adult admitted as an inpatient to hospital that is aged 75 or over should be screened for dementia.
- Our emergency department and the emergency frailty unit have have worked together to create two specialist treatment rooms for our elderly patients.

2 Patient centred care

Diagnosis of dementia*

Further improvements required

› We have met with people with dementia and their carers across Leicester and Leicestershire with support from the Alzheimer's Society, Age UK and Support for Carers to gain feedback of their experiences in hospital as well as making suggestions in how we can improve our services.

› In 2013/14 improvement plans will be designed to reflect 'what matters most' to people with dementia and their carers including:

- Enhancing the hospital environment to be 'dementia friendly'.
- Promoting the 'Patient Profile' to give staff a better understanding and insight into the person with dementia's life, likes and dislikes.
- Providing support with meaningful activities.
- Increasing staff training.
- Reviewing service delivery to accommodate the needs of people with dementia and their carers.
- Introducing a Dementia Champion Network across the organisation.

2 Patient centred care

World health organisation (WHO) – Surgical safety checklist

The WHO checklist is used so that staff go through a systematic check to make sure that everything is in place to ensure a patient's surgery goes ahead safely. It covers areas such as antibiotics and keeping patients warm, whether the right equipment for the procedure is present and working,the patients' identity, the site and type of procedure so that errors can be avoided. By following these few critical steps, staff can minimize the most common and avoidable risks which can endanger the lives and well-being of their patients. The WHO checklist has been designed for routine use in operating theatres as a "standard operating procedure".

What: Improving the use of the WHO checklist and team briefings in all our operating theatres

How much: Achieving 97% compliance with WHO checklist usage in patients having operations in our theatres

By when: March 2013

Progress: Achieved ☑

The checklist is split into four main stages:

Stage 1 - Theatre reception check

Stage 2 - Sign in – Operating theatre - Completed before anaesthetic induction & confirms safety to proceed.

Stage 3 - Time out– Operating room- Surgical pause before 'knife to skin' ensuring safety checks are completed.

Stage 4 - Sign out– Operating room - Completed before patient leaves theatre, ensures final safety checks completed.

Improvements achieved

- At the end of March 2013 we successfully achieved 100% compliance. For the reporting year 2013/14 the target is now 100% compliance with WHO checklist usage in patients having operations in our theatres.
- Supported Safer Surgery Week (24 - 30 September 2012). Throughout the week we promoted safer practices and ways to eliminate harm to patients. Infection prevention advice and refresher training given.

Further improvements required

- Validation audits have been carried out to determine the reason for not achieving 100% compliance.
- Safer Surgery policy 2013 updated and awaiting sign off by the Policy and Guideline Committee for May 2013. The updated policy explains that exclusions are to be made for areas where it is not always possible to complete the WHO checklist e.g. in an emergency situation and that a "not applicable" check box be added to future ORMIS* Care Plans.

*ORMIS *is the theatre system/record*

2 The NHS outcomes framework indicators

2 The NHS outcomes framework indicators

The NHS Outcomes Framework for 2012/13 sets out high level national outcomes which the NHS should be aiming to improve. The Framework provides indicators which have been chosen to measure these outcomes. All Quality Accounts will report these indicators.

An overview of the indicators is provided in the table below.

NHS OUTCOMES FRAMEWORK	INDICATOR	2011/2012	2012/2013	NATIONAL AVERAGE	HIGHEST SCORE ACHIEVED	LOWEST SCORE ACHIEVED
Preventing people from dying prematurely	SHMI value and banding (Dr. Fosters)	104.53 (105) (Oct11-Sept12) Band 2 – within expected	Data not available	100 (Oct11-Sept12)	121 (Oct11-Sept12)	69 (Oct11-Sept12)
	%of admitted patients whose treatment included palliative care (contextual indicator)*	0.78% (Oct11-Sept12)	Data not available	1.05% (Oct11-Sept12)	3.2% (Oct11-Sept12)	0% (Oct11-Sept12)
	% of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (contextual indicator).	13.5% (Oct11-Sept 12)	Data not available	19% (Oct11-Sept 12)	43.3% Oct11-Sept 12)	0.2% Oct11-Sept 12)
Helping people to recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery (EQ-5D Index) (local data)	0.085	0.085	0.086	0.143	-0.002
	Patient reported outcome scores for hip replacement surgery (EQ-5D Index) (local data)	0.42	0.41	0.42	0.53	0.32
	Patient reported outcome scores for knee replacement surgery(EQ-5D Index) (local data)	0.33	Data not available	0.30	0.39	0.018
	Patient reported outcome scores for varicose vein surgery. (EQ-5D Index) (local data)	Insufficient questionnaires submitted		0.09	0.17	0.05
	% of patients of all ages and genders readmitted to hospital within 28 days of discharge 16+	11.9% (2010/11)	No data available	10.98% (2010/11)	6.31% (2010/11)	15.33% (2010/11)
	% of patients of all ages and genders readmitted to hospital within 28 days of discharge <16,	9.71% (2010/11)	No data available	9.59% (2010/11)	14.34% (2010/11)	3.53% (2010/11)
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs	6.7/10	6.7/10	6.8/10	Data not available	Data not available
	% of staff who would recommend the provider to friends or family needing care	54%	55%	64%	35% (all) 35% (acute)	94% (all) 86% (acute)
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of admitted patients risk-assessed for Venous Thromboembolism	No data for this period	94.8% (Q3 2012/13)	94.1% (Q3 2012/13)	100% (Q3 2012/13)	93.9% (Q3 2012/13)
	Rate of C. difficile (local data- uploaded to HPA)	108 cases*	94 cases*	2012/13 national figures not yet available	2012/13 national figures not yet available	2012/13 national figures not yet
	Rate of patient safety incidents per 100 admissions	7.9 (local data DATIX)*	9.6 (local data DATIX)*	1st April 2012- 30 Sept 2012 9.5 (NRLS)	Comparative data not available	Comparative data not available
	% of patient safety incidents reported that resulted in severe harm or death (local data)	0.3% (2011/12)	0.25% (2012/13)*	Data not available	Data not available	Data not available

Data sourced, where possible, from NSCIC. Where data is not available through NSCIC local information has been sourced (*)

2 The NHS outcomes framework indicators

Domain: Preventing people from dying prematurely.

The Summary Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with our expected number of deaths. Each hospital is placed into a band based upon their SHMI. The most recently published SHMI is for the period October 11 to September 12. Our SHMI was 105 and is in band 2 which is "within expected".

The University Hospitals of Leicester considers that this data is as described for the following reasons; we have a high proportion of emergency admissions which have an associated increase in mortality, especially patients admitted 'out of hours'. A large proportion of deaths are patients with pneumonia and this has a recognised high mortality rate. Many deaths are patients at the 'end stage' of their illness and who have either not had an 'end of life pathway' implemented or this has not been followed. We provide day case palliative treatments in the Cancer Centre and these patients will then be included in our SHMI even if they die in LOROS or at home.

The University Hospitals of Leicester has taken the following actions to improve this number, and so the quality of its services, by reviewing and revising the emergency pathway for patients admitted with respiratory conditions, implementing 'Hospital 24/7' to maintain continuity of care 'out of hours', and the revision of the emergency admissions process, to ensure earlier senior review and plan of care. We are working closely with Dr Fosters and the Boston Consultancy Group to further analyse and better understand our HSMR and SHMI data in order to confirm priorities for action, and are embedding a standardised 'mortality and morbidity' review process in each speciality. We are also working with Public Health colleagues and GPs to review pathways of care both within the hospital and post discharge.

Domain: Helping people to recover from episodes of ill health or following injury patient reported outcome scores.

A patient reported outcome measure (PROM) is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of groin hernia, knee replacement, hip replacement and varicose vein surgery patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery.
The University Hospitals of Leicester considers that this data is as described for the following reasons; the data provided gives the average difference between the first score (pre-surgery) and second score (post-surgery) that patients give themselves. Outcome data is not available for varicose veins due to the relatively low participation in PROMs programme resulting in the small number of patient questionnaires returned.

The University Hospitals of Leicester has taken the following actions to improve this; the process for inviting patients to participate in the varicose veins Proms programme has been reviewed and revised and participation has now increased in line with the national average for January to March 2013.

The percentage of patients of all ages and genders readmitted to hospital within 28 days of discharge: The University Hospitals of Leicester considers that this data is as described for the following reasons: readmission rates (using the operating framework definitions) are published monthly in the Divisional Heat Maps and monitored at the monthly Confirm and Challenge meetings.

The University Hospitals of Leicester has taken the following actions to improve this; we hope to implement an earlier senior review on admission, improved discharge planning with early involvement of patients and carers, increased awareness of and liaison with community services and the availability of Consultant telephone advice for GPs post discharge.

2 The NHS outcomes framework indicators

Domain: Ensuring that people have a positive experience of care responsiveness to inpatients' personal needs

Responsiveness to inpatients' personal needs: This indicator provides a measure of quality based on the Care Quality Commission national inpatient survey. The score is calculated by averaging the answers to five questions in the inpatient survey.

The University Hospitals of Leicester considers that this data is as described for the following reasons; we have been focusing upon the Friend and Family Test score results and the general experience of patients and have successfully improved the experience of care in this area. This success now needs to be built upon by focusing upon the specific elements of care that make up this domain.
The University Hospitals of Leicester has taken the following actions to improve this score, and so the quality of its services, by including the elements of this domain within our Quality and Safety Commitment for 2013/14. The projected outcomes of this initiative will be a demonstrable improvement in the responsiveness to patient's personal needs.

Percentage of staff who would recommend the provider to friends or family needing care:
The NHS Staff Survey is conducted on behalf of the Care Quality Commission (CQC) and is recognised as an important way of ensuring that the views of staff working within the NHS inform local improvements. As previously reported to the Joint Staff Consultation and Negotiating Committee (JSCNC), analysis by the CQC of the survey results is undertaken through a self-completed questionnaire by a random sample of staff selected from across the whole Trust. 1700 staff were selected to receive the survey and 840 completed responses were returned, giving a response rate of 52% (2012). The University Hospitals of Leicester considers that this data is as described for the following reasons; our performance is based on the 2012 national staff survey results (February 2013). This information is presented to the JSCNC and Trust Board, summarising analysis of 2012 staff survey results. We also reference the 'full comparison report' compiled by the Care Quality Commission.

The University Hospitals of Leicester has taken the following actions to improve this: work is underway in setting improvement targets for 2013 and 2014 with corporate directorates, divisions and clinical business units, based on 2012 performance. Working closely with engagement groups or forums, we need to understand key factors that have influenced positive or negative response rates. Key next steps in the Listening in Action (LiA) process entail holding six LiA events that the Chief Executive is hosting from the end of April and early May 2013. These events are designed to give Trust staff a chance to share their views and ideas openly and have them captured and analysed.
Outputs from the LiA events will be synthesised and grouped into key themes. These will be framed into a simple view of 'What Matters to Our Staff' to inform accelerated, big impact actions. It is expected that the adoption of LiA will result in marked improvements in future staff survey scores.

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

Risk assessing inpatients for Venous Thromboembolism (VTE) is important in reducing hospital acquired VTE. We have worked hard to ensure that not only are our patients risk assessed promptly but that any prophylaxis is given reliably. The University Hospitals of Leicester considers that this data is as described for the following reasons; we have completed sustained audit of VTE assessment rates over the past year and completed trust wide audits of compliance. Data is presented to Clinical Quality Review Group monthly and matrons and lead nurses review VTE assessment rates and VTE occurrence monthly as part of the Safety Thermometer.

2 The NHS outcomes framework indicators

The University Hospitals of Leicester has taken the following actions to improve this: we aim to increase VTE assessments to a sustained 95% of eligible patients, provide pharmacological and/or mechanical thromboprophylaxis to all eligible patients, and to carry out root cause analysis for all in-patients who experience a potentially hospital acquired VTE.

Rate of clostridium difficile: As an organisation our nationally set target for the number of clostridium difficile cases in 2012/13 was 93. We were able to report 87 cases at the end of the year. We will continue to strive to reduce the number of C-diff infections acquired at Leicester Hospitals.

The University Hospitals of Leicester has taken the following actions to improve this via the production of an MRSA bacteraemia and CDT reduction action plan that Clinical Business Units reporting to the divisions within the organisation have worked towards. This plan is reviewed on a quarterly basis and revised yearly.

Patient safety incidents are reported within the trust using Datix-web, and then reported onwards to the National Reporting and Learning System (NRLS). The rate of patient safety incidents per 100 admissions reported by Leicester's hospitals is 9.6. The University Hospitals of Leicester considers that this data is as described as staff are positively encouraged and supported in the reporting of incidents. The NHS Commissioning Board believe "Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problem is". We are the in top third of the highest 25% of reporters. The University Hospitals of Leicester has taken the following actions to improve this score: we will continue to work with staff to improve reporting and action learning from incidents.

2 Performance against national standards

	Performance Against National Targets and Regulatory Requirements 2012/13				
	Performance Indicator	Target 2012/13	2012/13	2011/12	2010/11
Access to A&E	A&E - Total Time in A&E	95%	91.9%	93.9%	91.0%
Infection Control	MRSA	6	2	8	12
	Clostridium Difficile	113	94	108	200
Access - 18 week wait	RTT waiting times – admitted	90%	91.3%	84.0%	92.3%
	RTT waiting times – non-admitted	95%	97.0%	96.0%	97.2%
	RTT - incomplete 92% in 18 weeks	92%	92.6%	Not Applicable	Not Applicable
	RTT delivery in all specialities	0	2	Not Applicable	Not Applicable
	Diagnostic Test Waiting Times	<1%	0.5%	Not Applicable	Not Applicable
Access -Cancer	Cancer: 2 week wait from referral to date first seen - all cancers	93%	93.4%	94.0%	93.4%
	Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	94.5%	95.9%	95.9%
	All Cancers: 31-day wait from diagnosis to first treatment	96%	97.4%	97.4%	97.0%
	All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	95.8%	94.5%	95.2%
	All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	100%	99.9%	100%
	All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	98.5%	99.0%	99.5%
	All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	83.5%	83.8%	86.4%
	All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	94.5%	93.8%	91.6%
	Performance Against National Targets and Regulatory Requirements 2012/13				

Red=Target Failed Amber=Target Underachieved Green=Target Achieved

2 Performance against national standards

Performance indicator: ED 4hr Wait Performance

In 2012/13 we said we would achieve the 4hr target of 95% throughout the year by implementing a number of actions which were jointly agreed by Leciester Hospitals and the local commissioners. Our actual performance was 91.9%.

Despite implementing the agreed actions Leciester Hospitals has experienced significant problems in achieving this target throughout the year. The target has been delivered for 3 out of the 12 months of the year. For 2013/14 achieving the 95% target on a sustainable basis continues to remain the top priority for both Leciester Hospitals and the local health economy.

Part of this challenge has been around recruiting substantive staff across the acute care pathway and in particular the Emergency Department. We focussed attention on this challenge and sought a variety of solutions to this national problem.

Performance indicator: Infection Control

We continue to achieve a year on year reduction in our numbers of methicillin resistant staphylococcus aureus (MRSA) bacteraemia and clostridium difficile infection (CDIFF).

Hospitals are given a target figure beyond which they are not expected to exceed. For MRSA bacteraemia this was 6 cases and for CDIFF this was 113 cases. Both these targets were exceeded.

In the last 12 months, there have only been 2 UHL-associated MRSA bloodstream isolates. One was probably a contaminant and the other was a late presentation of a community acquired MRSA soft tissue infection and not preventable. In a very real sense, it can be claimed that MRSA bacteraemias have reduced to zero. This contrasts with 161 cases in 2001.

Performance indicator: RTT – 18 week performance

In 2012/13 we said we would deliver the following referral to treatment (18 week wait) standards on a monthly basis:-

- 90 per cent of admitted patients should be treated within 18 weeks. Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment.
- 95% of non-admitted patients should 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% incomplete within 18 weeks. The percentage of patients waiting for treatment within 18 weeks should equal or exceed 92%.

We achieved all three of these standards at Trust level on a monthly basis.

In 2013/14 we are developing additional activity plans to reduce the admitted and non-admitted backlog in General Surgery, Ophthalmology, ENT, Gastroenterology, Orthopaedics and Urology. In addition commissioners have funded a central RTT validation team for a year which will focus on real time validation and additional training of our administrative staff. These additional actions will ensure that by July 2013 all specialties will deliver the 92% incomplete pathway target and < 1% of incomplete pathways will be waiting 26+ weeks from referral to treatment.

Performance indicator: Cancer Targets

In 2012/13 we said we would deliver the target for all 8 cancer targets. We have delivered 7 out of the 8 standards for the full year as the 62 day referral to treatment standard was not achieved.

In 2013/14 we are developing plans that aim to deliver improvements to patient experience of being on an urgent cancer pathway. These will focus in particular on reducing unnecessary delays for early diagnosis. Work is underway to make sure that the Trust delivers waiting time performance that is at least as good as the national average at tumour site level. Where we already achieve this already we aim to improve further.

2 Case study:
The UHL emergency care pathway programme

The primary focus of the UHL Emergency Care Pathway programme is to improve quality of patient experience and clinical outcomes by ensuring timely access to the appropriate emergency care. We aim to implement process improvements across the end-to-end patient flow for emergency department attendees and medical non-elective patients.

The programme has been divided into two phases. The first phase will include emergency department and assessment unit processes, whilst phase two will focus upon ward management, patient flow and bed configuration.

The programme will deliver:

- Systems in the emergency department that enable delivery of high quality processes for rapid streaming and assessment of walk-in and ambulance patients to the most appropriate care setting.
- An acute model of care that enables medically referred patients to be assessed and a treatment plan developed within 6-14 hours of admission, supported by clinicians with the right skill mix to manage the case mix and internal support services.
- Consistently applied, consultant led ward processes that enable optimal length of stay to be achieved for all patients based on their clinical need within right-sized bed base.
- Robust capacity management function underpinned by accurate and timely information, a team with clear roles and responsibilities and Trust wide focus on the efficient use of capacity to deliver services.

The Emergency Care Pathway programme aims to support the Trust to create an optimum medical model of care. This includes a portfolio of services that are clinically safe, of a high quality for patients, economically viable and support the wider local health economy. In doing this, patient flow will be improved and patients will consistently receive high quality, safe care in the most appropriate setting.

2 NPSA alert compliance 2012/13

Through analysis of reports of patient safety incidents and safety information from other sources, the National Patient Safety Agency (NPSA) develops advice for the NHS that can help to ensure the safety of patients. As advice becomes available the NPSA issue alerts on potential safety risks. Since 1 June 2012 the NPSA's patient safety function has transferred to the NHS Commissioning Board Authority.

We monitor these alerts through the Risk and Assurance Manager who then works with clinicians and managers to make sure that actions recommended in the alert are implemented within prescribed timescales wherever possible.

We currently have two alerts for which deadlines for actions to be completed have passed and these are being actively managed at a local level and monitored by the Quality and Performance Management Group to ensure completion as soon as possible.

Table 1 below lists the status of NPSA alerts with a due date during 2012/13.

Alert reference	Alert Title	Response	Deadline
NPSA/2011/PSA001	Safer spinal (intrathecal), epidural and regional devices Part A: update	Ongoing	2/4/12
NPSA/2011/RRR003	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors	Completed	2/4/12
NPSA/2011/RRR002	Keeping newborn babies with a family history of MCADD safe in the first hours and days of life	Completed	26/4/12
NPSA/2011/PSA/003	The adult patient's passport to safer use of insulin	Completed	31/8/12
NPSA/2012/RRR001	Harm from flushing of nasogastric tubes before confirmation of placement	Completed	21/9/12

Table 2 shows ongoing NPSA alerts from previous years.

Alert reference	Alert Title	Response	Deadline
NPSA/2008/SPN14	Right Patient, Right Blood (Update)	Ongoing	1/5/10

Table 3 shows NPSA alerts with a due date during 2013/14

Alert reference	Alert Title	Response	Deadline
NPSA/2009/PSA004B	Safer spinal (intrathecal), epidural and regional devices - Part B	Ongoing	1/4/13

2 Never events 2012/2013

We have a strong reporting culture for patient safety incidents ensuring lessons are learnt whenever possible. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

During the period 2012/13, six incidents were reported which met the definition of a Never Event. In all cases a thorough root cause analysis investigation was undertaken with robust action plans developed to prevent similar occurrences. No serious harm was caused to any of the patients.

The following table shows a description of the Never Events together with the primary root causation and key recommendations to prevent reoccurrence. None of these incidents resulted in long term harm to the patient and the patients were all involved/ informed in the subsequent investigations.

Never Event	Description	Key findings following recurrence	Key actions to prevent recurrence
Wrong implant/ Prosthesis April 2012	Wrong lens implant	There was a failure in the checking process immediately prior to implantation to ensure the correct lens had been selected	• Development of an intra-ocular lens protocol which includes the responsibility of the surgeon to select the appropriate lens • Shared report and outcomes with clinical staff
Wrong site surgery April 2012	Surgery commenced on the wrong finger	The marking on the finger nail of the correct digit became washed off or obscured by the skin prep. A definitive "STOP" to check and verbalise the correct operation and site did not occur	• Review of marking policy and implementation of a verbal "STOP" before incision • Shared report and outcomes with clinical staff
Wrong dental extraction May 2012	The wrong tooth was extracted	The procedure was undertaken by 2 doctors who did not utilise a definitive "STOP" moment to assure they were removing the correct tooth	• Implementation of the "STOP" moment prior to extraction. • Shared report and outcomes with clinical staff
Inappropriate administration of daily oral Methotrexate August 2012	Once a week medication of Methotrexate was administered on 2 consecutive day	Use of patient's own medication and failure to prescribe medication correctly on day chart	• Introduction of electronic prescribing • Shared report and outcomes with clinical staff
Retained vaginal pack November 2012	Retention of vaginal swab following management of massive obstetric haemorrhage	Failure to follow Trust polices and procedures	• Vaginal swabs to be included in the swab count & audit compliance • Memo to all staff reminding of the need to include removal of pack in the management plan • Review of the obstetric emergency guideline with reference to guidance about vaginal packing when a Bakri balloon is used for the management of post parton hemorage. Including documentation • Formulate a post-operative sticker
Retained foreign object post operation October 2012	During closurer of the wound the needle snapped and was retained in the patient	Failure to follow agreed procedure not to move patient out of theatre before x-ray of patient	• Re-enforced safer surgery policy •Shared report and outcomes with clinical staff

2 How we keep everyone informed

We use a wide range of communication methods to inform and engage our patients and the public about our quality initiatives and service improvements. We produce a magazine called Together, we profile good news on our public website, send emails and news alerts, talk with the public through social networking sites Twitter and Facebook, produce leaflets and posters and articles regularly feature in local newspapers, radio and television.

We have a large public membership of over 13,500 people. To engage with our members and the wider public we provide opportunities for them to participate in focus groups and meetings and hold regular talks on a range of health topics. We have developed good relationships with our local involvement networks (LINks) with whom we engage on a range of quality issues. In December 2012 the City LINk conducted an "enter and view" visit to our emergency department and acute medical unit. The overview scrutiny commitee have heard presentations from the Trust regarding the children's cardiac surgery unit at Glenfield. A Trust representative sits on the LINk UHL subgroup to engage with LINk on matters pertaining to Leicester's Hospitals.

We also have a group of lay people known as Patient Advisors who participate in some of our Boards and Committees to represent the patient's perspective. Patient Advisors were recently involved in the development of our Quality and Safety Commitment.

2 Members have their say

We are always keen to hear what our members think of our services and get them more involved in plans for the future.

- Our Planned Care division, which manages most of our surgical services, held a special event in December to talk about what their services would look like in the coming years. More than 30 members came along to meet with consultants and senior managers. During the evening they discussed the way forward for our chemotherapy, emergency surgery, plastic surgery and vascular surgery services.

- Julia Ball, Lead Nurse for Planned Care, said: "The evening was a real success, we were delighted with the turn out and with how engaged people were. The feedback we got from the evening will help us to develop our plans for these services."

- The team will be building on the success of this event by going out to community groups and continuing to involve patients.

2 What do our patients tell us?

We gather feedback from patient surveys, NHS Choices, complaints and Friends and Family Test score. These highlight several areas where we are currently doing well, including several specialty areas and planned care.

"Everyone was helpful and friendly and the Doctors and Consultants all listened to me" ❖

The table below shows our performance on five Commissioning for Quality and Innovation (CQUIN) payment framework questions asked each year in the National Inpatient Survey run by the Care Quality Commission. Improvement has been demonstrated with regard to inpatients perception of privacy during discussions of their condition or treatment, and also in regard to their feeling involved in care and treatment. The overall combined score for all five questions has stayed the same.

	2012/13	2011/12
Were you involved as much as you wanted to be about your care and treatment	72.2	71.6
Did you find someone to talk to about worries and fears?	56.1	56.5
Were you given enough privacy when discussing your condition or treatment?	82.7	81.4
Were you told about medication side effects to watch out for when you went home?	45.9	46
Were you told who to contact if you were worried about your condition after you left hospital?	79.7	80.9
Composite scores	67.3	67.3

Further feedback identifies a number of areas we can improve in order to positively affect patients overall experience of care. In particular, improved information and decision making (particularly on discharge), improved efficiency of care processes (e.g. waiting times), understanding and care for people at end of life, patients with dementia and the older patient; hospital car parking and food, and reducing unnecessary pain.

"I left in a state of confusion, not really understanding" ❖

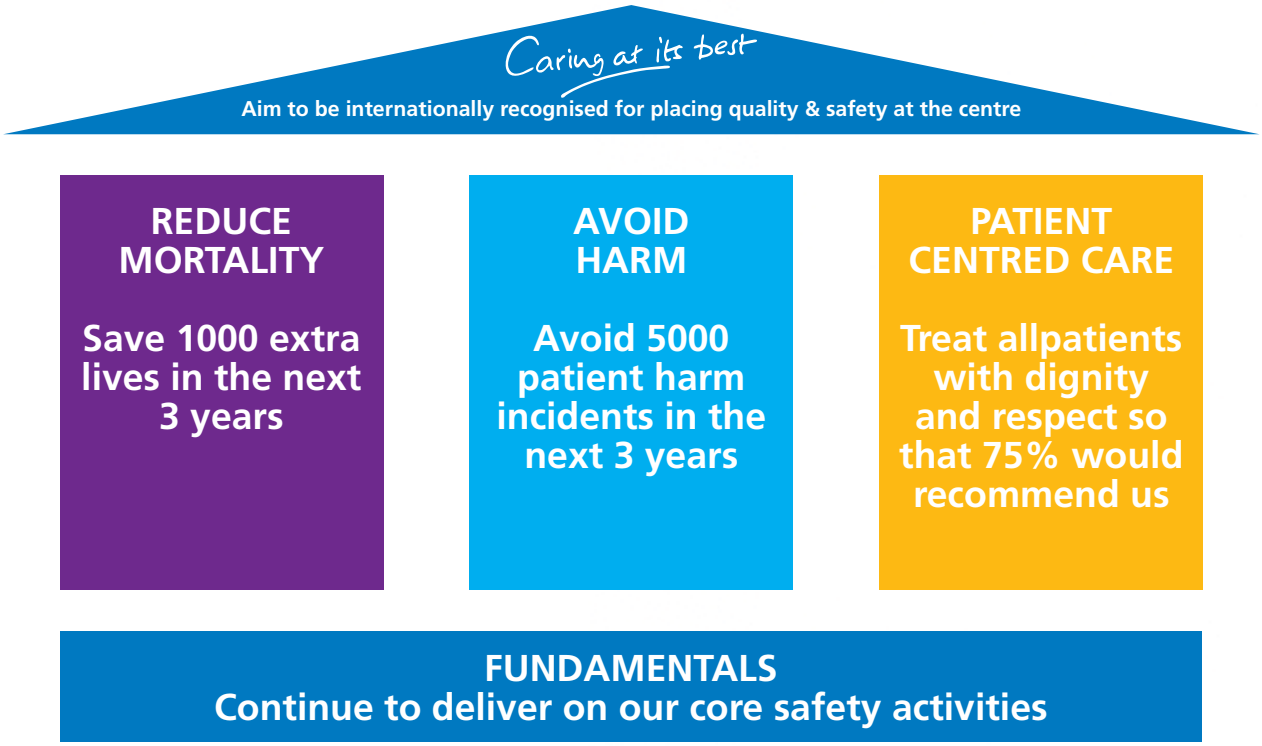
❖'Quality and Safety Commitment 2013/2016'

3 Our plans for the future

The quality and safety commitment 2013/16

To deliver our vision of 'Caring at its best' we are laying out an ambitious Quality and Safety Commitment for our Hospitals. Our priorities will be led through three over-arching strategic goals, each with a target to be delivered over the next 3 years. By 2016 we will aim to deliver a programme of quality improvements which will:

- Save 1000 extra lives
- Avoid 5000 harm events
- Provide patient centred care so that 75% of our patients would recommend us



We will particularly focus our efforts on a few targeted projects that are relevant to patients and staff, reflect local and national requirements and which we believe will have the largest impact on delivering against these commitments.

This will be supported by continuing focus on fundamental areas of quality that are ongoing and key for delivering our vision.

A central enabler of delivering against these goals will be improvement of our emergency pathway. This area has been identified as a key priority for improvement by the trust and is already a focus of the emergency care pathway programme.

3 Our plans for the future

The quality and safety commitment 2013/16

Save Lives – save 1000 extra lives in the next 3 years

Out-of-hours

- Reinforce and accelerate roll-out of hospital we care 24/7*.
- Detailed audit and process mapping to identify causes of higher mortality out-of-hours.
- Encourage communication between junior doctors and consultants out-of-hours.

*We care 24/7' is a new initiative to ensure that Leicester's hospitals have an out of hours multidisciplinary team that possesses the full range of skills and competencies required to manage the immediate needs of the patients after 5pm, and over-night during the week and 24 hours a day at weekends.

Respiratory pathway

- Redirect more respiratory pathway patients to Glenfield Hospital.
- Reinforce best practice, including respiratory registrar secondments between Glenfield and Royal Infirmary.
- Increase transparency on key metrics.

Fundamentals: perinatal mortality; escalation processes; coding

Measurement

We will use Summary Hospital Mortality Indicator (SHMI) to measure progress. SHMI is the recommended measure of mortality by both the National Quality Dashboard and the first Francis Inquiry and will be used across the NHS.

SHMI includes the number of patients who die in hospital and within 30 days post discharge. A SHMI of 100 means that the number of patient who died is as exactly as predicted based on the average outcome in other Trusts. A SHMI of below 100 means fewer patients died than predicted. w A 1 point change in SHMI equates to ~39 patients at UHL. Our current SHMI is 105 (within expected).

Avoid Harm – avoid 5000 patient harm incidents in the next 3 years

Falls

- Agree standards and focus roll-out on wards with greatest need.
- Dedicated staff training, linked to older people and dementia training.
- Transparent tracking, older people's team to coach under-performing wards and postcards to celebrate success.

Acting on results in ED

- Agree standards for checking blood results and reporting imaging.
- Communicate standards and engage staff.
- Increase transparency through monthly league table; reward high performers.

Senior review, ward rounds & notation

- Agree standards for review; conduct spot-checks.
- Pilot and audit ward-round checklists and template; review and roll-out further.
- Agree standards for notation; engage doctors and track improvement.

3 Our plans for the future

The quality and safety commitment 2013/16

Fundamentals: 4 harms and 5 Critical Safety Actions.

Measurement

We currently use multiple ways to measure harm. We encourage staff to report harm through incident reporting. The 'Safety Thermometer,' is used to assess the prevalence of the 4 harms on one day of every month. Infections are picked up through our microbiology laboratories. It will soon be possible to audit medication errors more easily with electronic prescribing, which is currently being rolled out.

Patient Centred Care – treat all patients with dignity and respect so that 75% would recommend us.

Older people and dementia

- Ward-based multi-professional staff training.
- Expand Older People's Champions; set up resource centre and meaningful activities team.
- Patient profiles for all patients with dementia; white board communication tool.
- Increase patient / carer involvement: matrons on ward at visiting times; doctors to employ communication tools (e.g. Teach-back).
- Track and hold to account (e.g. post ward net promoter scores on notice board).

Discharge experience

- Agree standards for discharge plans; conduct spot-checks.
- Employ communication tools: develop 'Ticket Home' and add board round check for communication with family / carer.
- Increase discharge co-ordinators.
- Track improvement and hold to account.

Fundamentals: pain management; end of life; patient information and choices.

Measurement

We will use information within the Family and Friends Test score to assess our progress improving patient experience. Patients are asked " How likely is it that you would recommend this service to a friend or family?" scoring on a scale of 0-10. Those scoring between 0-6 are identified as detractors, between 7-8 are neutral, and between 9-10 are promoters. The Friends and Family Test Score is the difference between the percentage of users who would recommend our services minus the percentage of those who would not. Our goal is to ensure that 75% of patients would recommend us (i.e. scoring 9-10). Our baseline score is 63%.

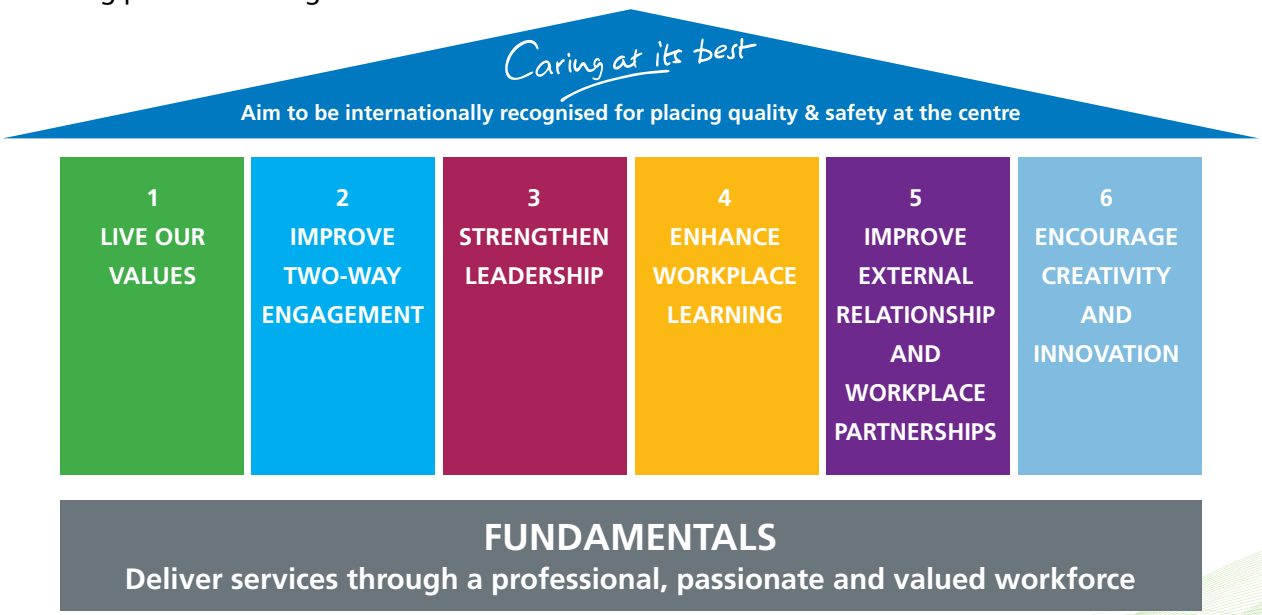
We will use other patient experience measures, such as qualitative feedback, patient recorded outcome measures to further inform continuous improvements in the quality of care received by patients.

3 Our plans for the future

Leadership, culture and workforce capability

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

To deliver our vision of 'Caring at its best' and to facilitate change we are laying out an ambitious Organisational Development Plan for Leicester's Hospitals. Our priorities will be led through six substantial work streams. For each theme there are a series of priorities that are designed to build on current strengths and address gaps to improve the organisational performance and culture of Leicester's Hospitals. The work streams have been aligned to Leicester's Hospitals values and support building pride in our organisation.



3 Our plans for the future

Leadership, culture and workforce capability

A central enabler of delivering against these work streams will be embarking upon our new venture, 'Listening into Action (LiA)'. This has been developed through intensive, hands-on work with over 75,000 staff and leaders from across more than 90 NHS Trusts since 2007, with national endorsement and the backing of the Department of Health.

Listening into Action

LiA will introduce a new and ambitious way of working and give our staff the power to transform our hospitals to deliver "Caring at its best". This new way of working will raise the bar on the quality of care we provide to our patients, creating a revolution in staff and patient experience.

The foundations for LiA are based on:

- The need for senior leaders to connect the right people around all our major challenges.
- Providing service teams with the opportunity to collaborate and share ideas.
- Having 'permission' to get on and deliver actions which will benefit patients and staff.
- Fostering a sense of collective ownership by the teams themselves for delivery of results.

A sponsor group personally led by our Chief Executive including managerial and clinical influencers has been established. This important group will meet without fail every two weeks for 90 minutes to focus entirely on navigating this journey of adoption across our Trust and ensuring it is a success.

A fundamental requirement to delivering 'Caring at its best' is to ensure we have the right numbers of staff, working in the right place at the right time. This means we need a robust workforce planning approach which seeks to ensure efficient, creative and innovative approaches to service planning are supported by robust and sustainable workforce plans. We will do this by engaging in care pathway approaches to workforce planning with our partners in Leicester, Leicestershire and Rutland and using systems and tools available to us to test that our plans will deliver high quality, safe and affordable care.

3 Divisional case studies: Quality at Leicester's Hospitals.

Women's service

Patients and carers have told us that communication problems are often the root cause of any concerns that they may have during their care or stay with us. The women's clinical business unit have listened to these concerns and have introduced a number of staff training initiatives including training on customer care, communication and perceptions relating to staff attitude. 'U Help us Learn' (patient feedback cards) have helped us to feedback to staff via unit meetings and newsletters about how poor communication can affect the patients whole experience. Since April 2012, communication related complaints have reduced by 34% in comparison to 2011. We will continue to monitor this very closely with the aim to reduce these complaints further.

The rising birth rate is a national concern, especially as there is a national shortage of midwives. Within our maternity services we have recruited midwives and have now reached our full establishment to achieve a 1:32 midwife to birth ratio. This is a considerable improvement on the midwifery staffing numbers. We are also recruiting more support staff with the aim that our expectant mothers feel they receive more individual care and support whilst they are with us.

Image supplied with permission of Leicester mercury.

3 Divisional case studies: Quality at Leicester's Hospitals.

Gynaecology services

In response to patient feedback about delays in scans and waiting times we reconfigured our gynaecology services during 2012. We now have a dedicated elective service at the General site which includes a pre assessment unit ensuring all the necessary pre-surgery reviews and investigations are completed during one visit and a dedicated day surgery ward, which has reduced waiting times and cancellation of theatre lists.

At the Royal Infirmary we have a dedicated emergency service. This includes Early Pregnancy Admissions Unit appointments available within 24 hours with same day ultrasound scans, a Gynaecology Admissions Unit which is consultant led with same day scanning. Both of these mean that women do not have to wait as long for scans and consultant input in their care.

3 Divisional case studies: Quality at Leicester's Hospitals.

Children's services

Following guidance from NICE (Improving Outcomes Guidance for Children and Young People), the oncology ward in children's services has been refurbished and a new facility for teenagers and young adults was opened in December 2012. The success of this has been due to the 'Ourspace' project group, working in partnership with the Teenage Cancer Trust. This means that we now have facilities that are specific to the needs of children as well as teenagers and young adults. It helps us meet their psychological and physical needs and provides networking opportunities for patients as well as families at a time when they can feel so isolated and alone.

With the help of patients, the public and staff, the project is forecast to reach the 1.4 million target by June 2013. In addition further contributions have been received from the Teenage Cancer Trust, Leicester Hospitals Charity as well as other groups and charitable trusts.

Throughout the project young people, children and families have been involved in creating the facility by giving their opinion on designs, wall art and furniture. The impact of the new ward has been great for patients and staff.

Emily a three year old has been treated since August 2012 for Acute Lymphoblastic Leukaemia. Her father said: "The new unit is amazing! We have been in and out of hospital since Emily was diagnosed and in that time we have been on several different wards, but this is by far the best"

Gemma, 23, is in remission but knows from her experience what a difference the new unit will make to teenagers and young adults. She said: "It is absolutely incredible! Thankfully I have now finished treatment but I'm so happy to think that other people of my age will have this fantastic new space. During my treatment, I was on an adult ward, which sometimes feels isolating and lonely. This new unit will allow teenagers and young people, like me to be treated alongside people of their own age, so they know you are not alone".

Clinical support services

The clinical support division has several specialist nurse groups, all of whom are experts in their field of care. We have had some enormous successes this year. The nurse led vascular access service have expanded their care delivery to two of the hospital sites and are now supporting patients within the community to remain out of a hospital inpatient environment. The team ensure these patients can have their antibiotics administered via central lines at home. The team assist in the care of the lines as well and will visit patients to ensure that lines remain unblocked.

The vascular access team have had an article published in the 'Nursing Standard' describing their service, improvements to patient care and efficiency. They are seen as a leading the way forward amongst many other trusts.

The nutrition specialist nurse team work collaboratively with their dietician and pharmacy colleagues to provide nutritional support to very complex patients within our hospitals. We were delighted when the Department of Health (DH) visited the trust in September 2012 to undertake a peer review. The review was to ensure that our teams at the trust could continue to provide parental nutrition to very ill and complex patients. Had we not been so successful at the review it could have meant that our complex patients requiring this type of support would have to be transferred to Nottingham for this specialist care. The DH team were very impressed with our care when they visited and we are delighted that we attained the status required.

We are also delighted to share that the lead nutrition specialist nurse has been nominated for the Ann Barson Award for champion and innovation within gastroenterology by a senior lecturer at the De Montfort University.

3 Divisional case studies: Quality at Leicester's Hospitals.

Planned care services

The hope cancer research trials unit

The Hope Cancer Research Trials Unit opened in May 2012 . Under the Directorship of Professor Anne Thomas the area combines both a clinical environment and an administrative space thus permitting the opportunity to conduct high quality research in an appropriate setting. There is capacity to treat up to 8 patients at any one time, and up to 20 patients in a day. We are able to offer patients the opportunity to participate in early phase trials for solid tumours as well as haematological cancers. Whist the expectation is that patients will be treated on a day case basis, we are also able to accommodate patients overnight in a safe and secure setting in instances when intense monitoring is required. Having a dedicated space has also meant that we have been able to extend our practice and set up dedicated nurse led genetic trial clinics.

Radiotherapy

Intensity modulated radiotherapy (IMRT) can be used for treating cancers in the prostate, neck, brain and abdomen, amongst others.
We use advanced technology to direct the x-ray beam and allow the pattern of radiation to be more carefully controlled, targeting only the areas inside the patient that need treatment and avoiding the surrounding sensitive organs. With IMRT we can achieve quite complex patterns of radiation.

There are huge benefits of being treated this way, including fewer side effects than with standard radiotherapy.
Over the last 12 months we have seen an increase in the number of patients undergoing IMRT at UHL.

We have been actively engaged with the EMSCG CQUIN Scheme for IMRT delivery and this has led to a final position of 41.9%, well in excess of the 33% target.

In December 2012 we were successful in our bid for £304, 000 of funding from the national Radiotherapy Innovation Fund, this fund was specifically for increasing IMRT delivery.
We still anticipate the need for IMRT will continue to increase and the levels reached this year will place us strongly to deliver on meeting these demands.

3 Divisional case studies: Quality at Leicester's Hospitals.

Development of an acute oncology service

Half of the patients presenting to hospital with acute oncology problems are managed outside the oncology bed base and these patients often have a longer length of stay in hospital. We have developed a Consultant led acute oncology service. This service is supported by an Advanced Nurse Practitioner to provide assessment of all acute oncology admissions within 24 hours of their admission on a Monday to Friday at the LRI site. This service commenced in January 2013 and an audit of the first five weeks of the service being operational, indicated that there had been 37 referrals to the service, with 30 of these patients who were seen by a member of the acute oncology service within 24 hours of referral with a further 5 referrals being provided with telephone advice.

Healthcare at home

Within the last year we have successfully set up the healthcare at home service, which offers choice to our patients with breast cancer receiving Herceptin treatment. Patients now have choice about whether they want to receive this treatment within their own home rather than come into hospital for it. To date approximately two thirds of patients have opted to receive Herceptin at home. Those patients that continue to receive this treatment in hospital either do so because they prefer this or because there is a clinical need for this.

We hope to build on this model of care for other treatments that we provide, in order to reduce the number of visits to hospital for patients with cancer undergoing treatment.

Macmillan information and support centre

The new Macmillan information and support centre opened in June 2012 within the Osborne building which allows us to provide improved services to anyone affected by or seeking information about cancer. The centre is run by two Macmillan information staff, assisted by a team of volunteers.

The centre also provides a number of supplementary services to patients including weekly benefits and money advice clinics supported by a member of staff from the Department of Work and Pensions and a citizen's advice bureau representative. Over 160 patients have been seen in these clinics to date. The centre also provides the UHL hair loss and wig service and an alternative headwear shop for clients suffering from hair loss. The Macmillan supported refurbishment of this centre has considerably improved these facilities for patients.

4 Statements of assurance from the board

Review of services

During 2012/13 University Hospitals of Leicester NHS Trust provided and / or sub-contracted 438 NHS services. These include:

- Inpatient = 67 specialties
- Outpatient = 92 specialties
- Day case = 67 specialties
- Emergency = 82 specialties
- Non-elective = 60 specialties
- Direct access* to 5 specialties
- Non Face to Face appointments in 23 specialties
- Out Patient Procedure services in 31 specialties
- Critical care services in = CICU,HDU, ITU, ITU PACU, PICU, SCBU and NIC
- 4 national screening programmes[1]

[1]The screening schemes are retinal screening (diabetes), breast screening including age extension (cancer) bowel screening (cancer) and abdominal Aortic Aneurism AAA (vascular)

The University Hospitals of Leicester are three acute hospitals, the Leicester Royal Infirmary having approximately 956 beds, the Leicester General Hospital (LGH) having 377 beds and Glenfield Hospital having 417 beds. Each hospital has its own specialty. The Leicester Royal Infirmary has the only Accident and Emergency Department, which covers the area of Leicester and Leicestershire. The Leicester General has the Renal Unit and Glenfield has the Cardiac Surgery Unit.

During 2012/13 Leicester's Hospitals provided and/ or sub-contracted 438 NHS services.

The University Hospitals of Leicester NHS Trust has reviewed the data available to them on the quality of care across the four divisions.

The income generated by the NHS services reviewed in 2012/13 represents 100% per cent of the total income generated from the provision of NHS services by Leicester's Hospitals for 2012/13.

4 Statements of assurance from the board

Examples of how we reviewed our services in 2012/13

A variety of standards and performance against these are considered in detail at the Quality Assurance Committee. These include performance against the Safety Thermometer, the Quality Commitment, staffing levels, nursing metrics and the world health check. This allows the Quality Assurance Committee to review any variation in practice and the actions in place to ensure high standards of care are in place/maintained.

We review our Cost Improvement Programme through Quality Impact Assessments. The Quality Assurance Committee has agreed a process for CIP schemes to be quality assured ensuring sign off by senior clinicians, the Medical Director and Chief Nurse. Any significant risks to patient safety or quality of care are regularly monitored and mitigated to acceptable levels.

A quarterly patient safety report is produced at divisional level so that any themes or trends can be identified and actions taken to reduce further risk.

We record and monitor key performance indicators which are presented in the quality and performance report and reviewed at each Board meeting and sub committees of the Board.

As a direct result of patient postcard feedback, the following quality improvements have been made:

- New wheelchairs have been purchased for Balmoral reception
- A number of higher chairs with arms have been purchased for use by those with restricted mobility for the Royal Infirmary
- There are dedicated breast feeding area on all three sites
- A number of improvements have been made to car parking provision including signage, information and better hospital maps.

The Clinical Pathology Accreditation (CPA) is an effective system for assessing and monitoring the quality of the services. Each pathology department has a full inspection on a four yearly cycle and a 'surveillance visit' on the intermediate 2 year point.

Participation in clinical audits and confidential enquiries

Participation in clinical audit is an effective way of monitoring and improving patient care and Leicester's Hospitals have a very active clinical audit programme.
Part of the programme includes national clinical audits which are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Advisory Group on Clinical Audit and Enquiries (NAGCAE) (formerly known as National Clinical Audit Advisory Group (NCAAG)).
During 2012/13, 44 national clinical audits and 2 national confidential enquiries covered NHS services that University Hospitals of Leicester NHS Trust (UHL) provides.

During that period UHL participated in 98% (n=42/43) national clinical audits and 100% (n=5/5) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHL participated in, and for which data collection was completed during 2012/13, are listed in Appendix 1.1 and 1.2 alongside the percentage of the number of registered cases required by the terms of that audit or enquiry (where known or the data collection period is complete).

4 Statements of assurance from the board

The reports of 429 national clinical audits and local clinical audits were reviewed by Leicester's Hospitals in 2012/13. Appendix 2 provides some examples of these audits and improvements made as a result of these projects that have led to improvements to patient care.

Participation in clinical research

The number of patients receiving NHS services provided by or sub¬contracted by University Hospitals of Leicester NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 9334.

University Hospitals of Leicester NHS Trust was involved in conducting 917 clinical research studies.

Of these 546 (60%) were adopted and 371 (40%) non-adopted. 241 (24%) of the total were commercially sponsored studies.

University Hospitals of Leicester NHS Trust used national systems to manage the studies in proportion to risk.

Of the studies given approval 43% were established and managed under national model agreements.

In 2012/13 the National Institute for Health Research (NIHR) supported 546 (60%) of the total number of research studies through its research networks.

In 2012 there were 323 full papers published in peer reviewed journals.

Goals Agreed with Commissioners Use of the CQUIN payment framework

A proportion of Leicester's Hospitals income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Leicester's Hospitals and the Commissioners, through the Commissioning for Quality and Innovation payment framework (CQUIN).

For 2012/13 the baseline value of the CQUIN was £14.1m for acute and £0m for community services (i.e. 2.5% of contract value). This means that when Leicester's Hospitals agreed contracts with commissioners it was agreed that 2.5% of contract value would be received upon achieving certain quality indicators. If these quality indicators were not met or the outturn contract value was lower than the baseline contract, then the monies would be withheld.

For 2012/13 Leicester's Hospitals has received sign off by the Primary Care Trust for 85.39% achieved (payment rate of 2.13%) of LLR CCGs CQUIN monies and 87.09% achieved (payment rate of 2.18%) LLR Specialised CQUIN monies.

4 Statements of assurance from the board

Data Quality: NHS Number of General Medical Practice Code Validity

Good quality information underpins the effective delivery of patient care and is essential to improvements in the quality of care and for patient safety. Data that is accurate, timely and relevant supports efficient patient care and reduces clinical risk. Reliable information on all aspects of performance means that planning of future services can be carried out with confidence.

Data quality is managed via an established set of routine daily checks, management reporting and audit.

Daily checks include:

- Researching the identity of all new patients and ensuring that new registrations are not duplications of patient records that already exist. This includes checks on records with significant changes to information such as patient name, date of birth and address which are essential to assignment and verification of the NHS number for each patient. Patients with no number are typically overseas visitors or patients who were unable to provide reliable information during their hospital visit.
- Validation of General Medical Practice (GP) is undertaken, by comparing local data against national GP databases. Anomalies are amended to support good communication from the Trust and ensure accurate commissioning of activity.

Management reports are regularly collated to feed back on data quality to front line services, using local and external sources. The Trust submits records to the Secondary Uses Service for inclusion in Hospital Episode Statistics which are included in the latest published data.

4 Statements of assurance from the board

Data published by the Secondary Uses Service for the period April 2012 to January 2013 shows validity of data for Leicester's Hospitals as follows:

		Trust
NHS Number	Admitted patient care	99.7%
	Outpatient care	99.8%
	Accident and Emergency care	97.8%

		Trust
General Medical Practice	Admitted patient care	100%
	Outpatient care	100%
	Accident and Emergency care	100%

		Trust
Ethnicity Code	Admitted patient care	100%
	Outpatient care	98.1%
	Accident and Emergency care	76.6%

A regular programme of audit is undertaken reviewing at least 300 patient records each month. This covers both outpatient and admitted patient data, comparing information held in the paper case notes to electronic data collected. Validity checks on data show high compliance of national NHS code sets being accurately applied with local information systems.

Clinical Coding Error Rate

University Hospitals of Leicester NHS Trust was subject to the Payment by Results clinical coding audit in January 2013 and the final percentages and report are awaited. The audit sample was 400 spells; 200 admissions for unexplained symptoms and other specified admissions and counselling and 200 emergency cardiac disorders admitted and discharged on the same day.

The Information Governance Toolkit Requirement 9-505 specifies assessment of clinical coding based on this audit framework, developed by the NHS Classifications Service in consultation with Department of Health and NHS Health Informatics Professionals.

The Information Governance audit was a sample of 200 General Surgery episodes.

The error rates identified were:

- Primary diagnoses incorrect 8.0%
- Secondary diagnoses incorrect 3.6%
- Primary procedure incorrect 6.4%
- Secondary procedure incorrect 4.5%

Due to the targeted nature of these audits and the small sample of activity audited it is not recommended that these results be extrapolated further than the actual sample audited. However, they do provide information that will help both commissioners and providers decide if the controls over the accuracy of their activity data are adequate, and highlights areas of concern that they may wish to investigate further.

4 Statements of assurance from the board

Plans to restructure the Clinical Coding Team which will include development of site manager roles and a dedicated system manager and audit lead.

The development of a site manager role will facilitate improved localised expert support and closer management of staff and improved team communication. This will enable better management of the variation in workload and facilitate improved cross-cover e.g. around Bank holidays, improving the overall timeliness of coding. More time spent with clinicians will ensure that complete information to support coding is documented.

A dedicated role of System Manager and Audit Lead will be introduced. There is currently no dedicated system manager of the Medicode system that was commissioned in 2011. The role is undertaken by the coding supervisor (alongside a generic coding role) and as a result, the full functionality is poorly utilised. Medicode itself supports a separate audit function for locally coded data, which will provide an effective support to a dedicated Audit Lead. There is currently no dedicated audit lead, as is common in other Trusts. Increased local audit will facilitate better governance and drive improvements in coding, highlight training needs and enable the service to undertake continual self assessment of quality.

Information Governance Toolkit Attainment Level

The Trust continues to improve compliance with the standards set in the annual information governance toolkit, including training all staff and introducing new guidance to increase privacy management across all three hospitals. Our information governance strategy also aims to help us be consistent in the way we handle personal and corporate information and avoid duplication of effort, leading to improvements in:

- Information security controls to protect patient confidentiality;
- Records management practices to reduce burden arising from too many paper records;
- Employee training and development.

The Trust's Information Governance Assessment Report score overall score for 2012/13 was 82% and was graded satisfactory.

4 Statements of assurance from the board

What Others Say About Leicester's Hospitals NHS: Statements from the Care Quality Commission (CQC):

Leicester's Hospitals are required to register with the Care Quality Commission and our current registration status is registered without conditions.

The Care Quality Commission has taken enforcement action against Leicester's Hospitals during 2012/2013 with warning notices issued, one in April 2012 and another in June 2012, both relating to Leicester Royal Infirmary. Both warning notices were complied with during the required time frame.

The Leicester Royal Infirmary, Glenfield General and Leicester General were inspected between November and December 2012 and all found to be compliant with the essential standards of quality and safety.

Leicester's Hospitals has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/2013;

- Termination of pregnancies review in May 2012:
  The Termination of Pregnancies review assessed the Trust's compliance with Outcome 21 (Records). The CQC found that the Trust failed to ensure that people were protected against the risks of unsafe or inappropriate care and treatment. There was a lack of proper information about people in so far as certificates of opinion (HSA1 forms), required as part of the management of the regulated activity of termination of pregnancy, were not properly maintained.

Leicester's Hospitals took the immediate remedial action to address requirements reported by the CQC and regular audit undertaken. This resulted in a judgement of compliance by the CQC.

4 Statement of directors' responsibilities in respect of the quality report

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

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

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.
By order of the Board
NB: sign and date in any colour ink except black

27 / 06 / 13 Date  Chair

27 / 06 / 13 Date  Chief Executive

5 Statements from our stakeholders and external auditors

The following organisations were invited to provide commentaries, Healthwatch, Health Overview and Scrutiny Committees and Clinical Commissioning Groups. Where received this commentary has been included. The draft Quality Account has been amended to address commentary from the CCG's in respect of the 1st and 2nd bullet points.

NHS Leicester City, East Leicestershire & Rutland and West Leicestershire CCGs statement for UHL Quality Account

The following statement has been prepared for the NHS Leicester City, East Leicestershire & Rutland and West Leicestershire CCGs for approval for the UHL Quality Account.

We welcome the opportunity to comment on the annual Quality Account for University Hospitals of Leicester NHS Trust (UHL) regarding the quality of services provided by UHL during 2012-13. We also welcome the opening letter from the new Chief Executive; this was felt to be an honest appraisal of the challenges facing the local Health Community. The presentation of the new style Quality Account was easy to read and the visuals aided understanding.

It is, however, disappointing to note that the Quality Account demonstrates that the Trust has not achieved all their priorities set for 2012/13. Commissioners are supportive of the Trust's focus on the UHL Quality and Safety Commitment for 2013 -15, to reduce mortality, avoid harm and patient centred care (dignity and respect).

In the 2011/12 Quality Account Commissioners expressed concern regarding the experience and outcome for patients in two areas of activity in the Trust; compliance with the 62 day cancer wait target, and the acute care pathway including challenges within the emergency department. Commissioners remain concerned that there are areas where the trust has continued to fail to meet the required position; such as A&E waiting times, cancer waiting times and stroke performance. Individually these areas of performance are very disappointing, however collectively this gives the CCGs cause for concern regarding the impact on the experience of patients using the Trust's services. Commissioners are also concerned that the Trust did not achieve the plans to reduce avoidable Grade 2,3 and 4 pressure ulcers for 12/13 despite the significant focus on this in year. This remains a priority area for the Trust and Commissioners during 13/14.

In addition we are concerned about the six Never Events that occurred in year. Commissioners wish to see progress in organisational learning across the Trust to prevent "Never Events". This extends to embedding the learning from all serious incidents which are recurring themes already identified within the "5 critical safety actions" work stream.

The Trust reported in the Quality Account for 11/12 that the CQC issued a Warning Notice to UHL regarding the care of patients within the acute medical assessment units, we are pleased that, following the CQC visit in year, the warning notice has been lifted.

We have been encouraged by the attitude of the Trust staff who have shown an open approach to the quality monitoring visits undertaken by the CCG staff. Such visits have given commissioners the opportunity to talk to patients, carers, relatives and staff to hear first hand their experiences of UHL. We have been impressed with the response of the Trust following the recent visits in February and March 2013 where Commissioners concerns with regard to quality and safety for patients were addressed quickly and remain under close scrutiny by the Executive Team.

5 Statements from our stakeholders and external auditors

As commissioners we feel that the Quality Account would benefit from further explanation on the achievements and challenges faced in the following areas:

- The account focuses on overall quality performance, however we feel it could be strengthened by recognising the variation between wards and the actions that are already in place to raise standards.
- There is no mention of the challenges facing the Trust with regard to the recruitment of substantive staff, particularly across the acute care pathway. Commissioners feel this merits a particular focus, alongside the work programmes which have commenced to improve ward leadership and the commitment to the supervisory status of ward leaders; specifically in light of the findings of the Francis publication in February 2013.
- The Quality Account gives a generally positive picture which does not adequately describe some of the significant challenges facing the Trust.

Commissioners will continue to work in partnership with UHL and seek and obtain assurance of quality improvements through our existing governance arrangements.

5 Statements from our stakeholders and external auditors

healthwatch Leicester and Leicestershire

HEALTHWATCH LEICESTERSHIRE AND HEALTHWATCH LEICESTER

QUALITY ACCOUNT OF THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST 2012-13

Introduction

A Healthwatch each for Leicester City, Leicestershire County and Rutland County was established on 1st April 2013 under the provisions of the Health and Social Care Act 2012. Healthwatch succeeds each Local Involvement Network (LINk) and this commentary is based on the information collected by the LINks in 2012-2013. In view of the independence of each Healthwatch, for this year only, the submission will be made on behalf of Healthwatch Leicestershire and Healthwatch Leicester City, as some of the previous joint LINks working relationship covered both.

Comment

We have been concerned about the potential impact of changes in the senior management of the Trust over the year. We welcome the appointment of John Adler as Chief Executive and the appointments of other Executive Directors and look forward to a period of stability in which the Trust can consolidate and develop its services for the people of the County, City and Rutland.

The working relationship between the LINks and UHL in a number of key Boards, groups or bodies we believe was highly effective, evidenced by the Emergency Care Network Board, Paediatric Congenital Cardiac Care Safe and Sustainable review, Frail Elderly, Designated nurse time, and Patient's dignity in Care. Other key areas, for example Dementia care and engagement in ED floor redesign, we believe could benefit from greater patient and public engagement.

We are of the view that the primary use of UHL's Patient Advisors to represent the patient and public perspective in approving the initial draft is inadequate and should have involved the LINk/Healthwatch-earlier. This denied a proper hearing to the wider community public view. We believe the new Management has recognised this and the approach to building upon the previous independent working relationship is going to be strengthened following the Francis report's demand for transparency and wide public engagement. The Trust's desire to work closely with statutory and voluntary stakeholder colleagues, principal among which is Healthwatch, will ensure the patient and public voice is at the centre of engagement and consultation.

5 Statements from our stakeholders and external auditors

We recognise the significant achievement of the Trust in infection control and its recognition that not all the targets it set for improvement in 2012-2013 have been met along with the acknowledgement of the number of 'Never Events' during the year. We look forward to discussing with the Trust robust action plans that will address the shortfalls and ensure that the targets set for the coming year are fully met. We welcome the Trust's current priorities and those requiring further work from previous years' priorities. The measurement toolkit we believe will bring about the required changes. Clarification on the various mortality statistics has greatly improved the understanding of a true reflection of the data.

Healthwatch recognises its key role in having evidence-based challenges or comment and will develop a strong engagement ethic in carrying out Healthwatch requirements. We are cognisant of the vital importance of improved working relationships and joint planning with the Acute Mental Health and Community Services Trusts, EMAS, Local Authority Social Care, District and Borough Councils, Voluntary sector, and public Health.

The well-publicised difficulties faced by the Trust in meeting the demand on its Emergency Department (ED) are a continuing concern for us. While we appreciate the high level of increased attendances to ED's nationally and locally, this does cause difficulties for the Trust in delivering acceptable standards of service. This has impact upon morale, retention and quality. We note however, that overall the patient satisfaction levels throughout the past year remain high.

We are disappointed that planned improvements to ED and the actions needed to be taken by Primary Care in diverting or alternative provision in all but Emergency cases have not yet shown results and this clearly affects the Trust service provision. The impact on patients awaiting planned care, not least deferment at short notice of operations and other procedures, is a major concern to us. We believe greater Primary and Local Authority Care provision needs to be included within the secondary care sector provision and better care pathways developed which are appropriate to the patient needs. The working of the Better Care Together Board, which includes Healthwatch representatives, we believe will achieve many improvements, but will need further work in ensuring continuity, joint working and impact of other stakeholder decision making processes.

The LINk was glad to be represented at the Trust's meeting with Stakeholders on the Francis Report. Healthwatch has a major role, as the public's independent consumer champion for health and social care, in ensuring that the spirit as well as the detail of the recommendations made by Robert Francis are fully understood and implemented. We look forward to the Trust's full response.

We have noted the Trust's implementation of the 'Listening into Action' initiative. The LINk drew attention in previous years to the importance of the Trust being seen to have a 'Listening policy' that encourages patients, families, carer's, friends and

5 Statements from our stakeholders and external auditors

visitors to give feedback on their experiences and their perceptions of their treatment, raise concerns without fear and know that they are being taken seriously and responded to promptly. We endorse this and hope that 'Listening into action' will address our concerns.

Healthwatch Leicestershire and Healthwatch Leicester City will be 'critical friends' and partners to the Trust and looks forward to a continuing constructive, albeit challenging but constructive relationship with it.

Philip Parkinson
Interim Chair,
Healthwatch Leicester

Vijay Sharma
Interim Chair
Healthwatch Leicestershire

7th June 2013

To:
Sharon Hotson, Director of Clinical Quality
John Adler, Chief Executive
University Hospitals of Leicester (UHL)

RE: COMMENTS OF THE HEALTH SCRUTINY COMMISSION ON THE UNIVERSITY HOSPITALS LEICESTER TRUST (UHL) - DRAFT QUALITY ACCOUNT 2012-13

Thank you for attending our Health and Well-being Scrutiny Commission meeting at Leicester City Council, on 28th May 2013 to present the University Hospitals of Leicester Trust report on its Draft Annual Quality Account 2012/13. We welcomed your presentation and also the attendance of John Adler, Chief Executive, who presented the UHL Strategic Direction report.

Please accept the following minute extract to form the comments of the Health and Wellbeing Scrutiny Commission:

5 Statements from our stakeholders and external auditors

Members made the following observations on the draft Quality Account Report:-

- It was pleasing to see improvements of some of the local indicators even if these were still no so good compared to the national average. The direction of travel in improvement was welcomed.
- Additional support facilities, including parking, should be provided for family and relatives as part of 'End of Life Care.'
- The low level of staff (55%) who would recommend the provider to friends or family needing care was disappointing when compared to the national average (64%).
- A breakdown and better understanding of the differing groups involved and how they inter-play with each other would be useful, together with an understanding of proposals to target hard to reach groups.

In response, it was stated that:-

- The improvement in mortality rates was pleasing but the Trust wished to continue this improvement so that it was in the national top 25 quartile.
- The issue of staff recommending the provider to friends and family would be addressed through the Listening Into Action and Quality Care initiatives. It was however, pleasing that the equivalent rate for patient recommendations had risen from 51% in 2012 to 64% in 2013.
- An open invitation was extended to any member of the Commission to visit the hospital to see how services were provided.

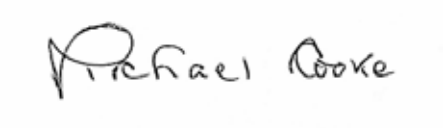
The Healthwatch representative expressed appreciation to the 20 LINk members in the City and County who had been involved in consultations on the Quality Account and for Health watch to be involved in the future.

RESOLVED:

that the draft Quality Accounts 2013/16 be received and the invitation for Members of the Commission to visit the hospital to see how services are provided be welcomed.

The commission found the quality accounts 2012/13 report format to be easily accessible and reader friendly. The Health and Wellbeing Scrutiny Commission at Leicester City Council, welcomes the opportunity to continue to provide their comments each year.

Many thanks,



Councillor Michael Cooke
Chair of Health and Wellbeing Scrutiny Commission
LEICESTER CITY COUNCIL.

5 Statements from our stakeholders and external auditors

Leicestershire County Council

Mr. John Adler
Chief Executive
University Hospitals of Leicester NHS Trust
Trust HQ
Level 3 Balmoral Building
Leicester Royal Infirmary
Infirmary Square
Leicester LE1 5WW

15 May 2013
AM/UHL/QA
0116 3057299
amitchell@leics.gov.uk

Dear John,

Quality Account 2012/13

As you will be aware, the County Council elections took place on 2 May and the new Scrutiny Committee structure will only be in place later this month. As a result, the County Council's Scrutiny Committee will not be in a position to make formal comments on your draft Quality Account 2012/13.

I will write to you shortly to advise you of the scrutiny arrangements which are in the process of being revised. I hope we can continue to build on our previous relationship and look forward to meeting with you soon.

Yours Sincerely,

Anne Mitchell
Senior Policy and Research Officer - Health

Chief Executive's Department
Leicestershire County Council, County Hall, Glenfield, Leicestershire, LE3 8RA
Telephone: 0116 232 3232 Fax: 0116 305 6260 Minicom: 0116 265 6160

John Sinnott CBE, MA, Dipl. PA, Chief Executive
David Morgan, BA, LL.M, County Solicitor

www.leics.gov.uk

5 Independent auditors report on annual quality account

KPMG

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of University Hospitals of Leicester NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(c) of the Audit Commission Act 1998 ("the Act"). NHS Trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Number of Clostridium difficile infections ("CDIs"), for patients aged two or more on the date the specimen was taken.

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

- The Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- The Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and

5 Independent auditors report on annual quality account

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

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

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

- Board minutes for the period April 2012 to June 2013;
- Papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- Feedback from the Commissioners dated 31/05/2013;
- Feedback from Local Healthwatch dated 23/05/2013;
- Feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- The latest national patient survey dated 21/02/2013;
- The latest national staff survey dated 15/02/2013;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 28/06/2013;
- The Annual Governance Statement dated 30/05/2013; and
- Care Quality Commission quality and risk profiles dated 18/04/2013.

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

This report, including the conclusion, is made solely to the Board of Directors of University Hospitals of Leicester NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and University Hospitals of Leicester NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content of the Quality Account to the requirements of the Regulations; and
- Reading the documents.

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

5 Independent auditors report on annual quality account

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- The Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- The Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- The indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP

Chartered Accountants

One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

27 June 2013

6 Appendices

6 Appendices

Appendix 1.1 UHL Clinical Audit Section for Quality Account 2012-13

Category	Name of audit / confidential enquiry	Did the trust participate?	% of cases submitted
Acute	Adult community acquired pneumonia (British Thoracic Society)	Yes	100% (n=66)
Acute	Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Data collection ongoing
Acute	Emergency use of oxygen (British Thoracic Society)	Yes	100%
Acute	National Joint Registry (NJR)	Yes	Data collection ongoing
Acute	Non-invasive ventilation - adults (British Thoracic Society)	Yes	100% (n=65)
Acute	Renal colic (College of Emergency Medicine)	Yes	100%
Acute	Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Data collection ongoing
Blood and Transplant	Intra-thoracic transplantation (NHSBT UK Transplant Registry)	NA	UHL have not been invited to take part in this study
Blood and Transplant	National Comparative Audit of Blood Transfusion - programme	Yes	UHL takes part in audits that are relevant
Blood and Transplant	Potential donor audit (NHS Blood & Transplant)	Yes	100%
Cancer	Bowel cancer (NBOCAP)	Yes	Data collection ongoing
Cancer	Head and neck oncology (DAHNO)	Yes	Data collection ongoing
Cancer	Lung cancer (NLCA)	Yes	Data collection ongoing
Cancer	Oesophago-gastric cancer (NAOGC)	Yes	Data collection ongoing
Heart	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Data collection ongoing
Heart	Adult cardiac surgery audit (ACS)	Yes	Data collection ongoing
Heart	Cardiac arrhythmia (HRM)	Yes	Data collection ongoing
Heart	Congenital heart disease (CHD) (Paediatric cardiac surgery)	Yes	Data collection ongoing

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Category	Name of audit / confidential enquiry	Did the trust participate?	% of cases submitted
Heart	Coronary angioplasty	Yes	Data collection ongoing
Heart	Heart failure (HF)	Yes	Data collection ongoing
Heart	National Cardiac Arrest Audit (NCAA)	No	Currently undertake local audit – discussions currently taking place around signing up for the audit next year.
Heart	National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Data collection ongoing
Heart	Pulmonary hypertension (Pulmonary Hypertension Audit)	NA	UHL don't provide this clinical service
Long term conditions	Adult asthma (British Thoracic Society)	Yes	100%
Long term conditions	Bronchiectasis (British Thoracic Society)	Yes	100%
Long term conditions	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	100%
Long term conditions	Diabetes (Paediatric) (NPDA)	Yes	100%
Long term conditions	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services	Yes	Data collection ongoing
Long term conditions	National Review of Asthma Deaths (NRAD)	Yes	100%
Long term conditions	Pain database	Yes	Data collection ongoing
Long term conditions	Renal transplantation (NHSBT UK Transplant Registry)	Yes	100%
Mental Health	National audit of psychological therapies (NAPT)	NA	
Older People	Carotid interventions audit (CIA)	Yes	Data collection ongoing
Older People	Fractured neck of femur	Yes	100%
Older People	Hip fracture database (NHFD)	Yes	Data collection ongoing
Older People	National audit of dementia (NAD)	Yes	Minimum dataset
Older People	Parkinson's disease (National Parkinson's Audit)	Yes	100%

6 Appendices

Category	Name of audit / confidential enquiry	Did the trust participate?	% of cases submitted
Older People	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection ongoing
Other	Elective surgery (National PROMs Programme)	Yes	Data collection ongoing
Women's & Children's Health	Epilepsy 12 audit (Childhood Epilepsy)	Yes	Data collection ongoing
Women's & Children's Health	Neonatal intensive and special care (NNAP)	Yes	Data collection ongoing
Women's & Children's Health	Paediatric asthma (British Thoracic Society)	Yes	100%
Women's & Children's Health	Paediatric fever (College of Emergency Medicine)	Yes	100%
Women's & Children's Health	Paediatric intensive care (PICANet)	Yes	Data collection ongoing
Women's & Children's Health	Paediatric pneumonia (British Thoracic Society)	Yes	Data collection ongoing

Appendix 1.2 National Confidential Enquiries

Name of audit / confidential enquiry	Did the trust participate?	% of cases submitted	% of cases submitted
Subarachnoid Haemorrhage (National Confidential Enquiry	Elective surgery (National PROMs Programme)	Yes	Data collection ongoing
Alcohol Related Liver Disease (NCEPOD)	Yes	Min dataset	Data collection ongoing
Bariatric Surgery (NCEPOD)	Yes	Min dataset	Data collection ongoing
Cardiac Arrest Procedures (NCEPOD)	Yes	Min dataset	100%
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NA		100%
Maternal, infant and newborn programme (MBRRACE-UK)	Paediatric intensive care (PICANet)	Yes	Data collection ongoing

6 Appendix 2:
Examples of improvements to patient care as a result of Clinical Audit

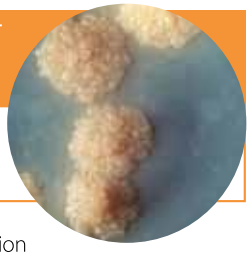
This section gives some detail around the improvements to patient care that have occurred as a result of clinical audits undertaken within each of the 4 clinical divisions. For the purpose of this report a brief overview has been provided however each story has a reference number so if you would like any further details around the audit please contact Carl Walker, Clinical Audit Manager.

6 2.1 Acute division

Successes in Acute Care

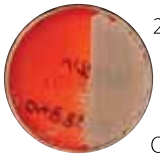
Test proves effective at preventing tuberculosis in local population

A large scale prospective audit/study conducted by Leicester Tuberculosis (Tb) Services has led to a change in local screening policies to further prevent the spread of Tb.



Mycobacterium tuberculosis CDC/Dr. George Kubic image no 4428

The audit looked at how well single-step delayed **Interferon Gamma Release Assay (IGRA) testing** predicted whether a person who had recent contact with infectious and non-infectious Tb cases would go on to develop Tb within a 2-year period.



2401 Tb contacts were identified from 628 Tb cases and their progress was tracked over 2 years.

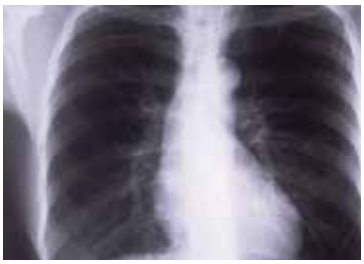
Of those subjects who gave a positive IGRA test, 12.5% developed Tb within 2 years. 99% of subjects giving a negative IGRA test stayed clear of Tb within the same period.

The test is a useful indictor of who would benefit from chemoprevention treatment following Tb contact, particularly for young people. The number of positives needed to treat was found to be as low as 8.

The audit also found that no adult contacts receiving chemoprophylaxis developed Tb or treatment-related side effects severe enough to abort the treatment.

In response to the audit, local screening policies have been adjusted to include subjects above the age of 35 for consideration of prophylactic treatment. Much earlier screening by IGRA and earlier prophylactic treatment have been introduced in contacts of the most infectious index cases. Repeat testing in this group will be introduced at 3 months if initially IGRA-negative.

UHL's enhanced screening services saw a 11% reduction of Tb case notifications for Leicester/ Leicestershire last year despite a greater than 7% increase of notification cross England. Overall notification rates in Leicester and Leicestershire are 25% lower than in 2005. (#4153)



New finding

An audit has shown that **educational intervention by clinical immunology can make a significant difference** to the number of patients being considered as potentially having primary immunodeficiency in adults admitted with chest infection. Primary immunodeficiency has a low prevalence and awareness of it is low among doctors. Diagnostic delay is not uncommon, which may contribute to morbidity or increase complications. (#4983)

Change to practice

An audit of the management of moderate and severe asthma in adults presenting in ED showed that compliance with the national standards was variable. The following changes were made: (1) introduced an ED audit / management proforma for adult patients with asthma; (2) improved medical staff education - asthma management integrated into induction program and rotating daily teaching topics; (3) improved nurse education about what to do at initial and repeat assessment, and the need for rapid initiation of treatment. (#4635)

Success story

An audit of NICE guidelines in managing patients with chronic heart failure on ward 24 at the Glenfield showed that the **majority of patients were discharged with the recommended combination of B blocker, ACE I or ARB and diuretics.** Following the audit it was agreed that all patients with moderate to severe left-sided heart failure should be referred to a community specialist nurse. (#5636)

6 2.2 Clinical support division

Successes in Clinical Support

Food for thought

The Nutrition and Dietetics service has set up a scheme with Nottingham University to enable fourth year Dietetics students to undertake their dissertations on a clinical audit in dietetic clinical practice.

This is as well as winning the Clinical Support Division's Clinical Audit annual prize (page 3). The scheme provides a welcome alternative to laboratory or systematic reviews for students and has identified improvements that can be made to benefit patients in the care of UHL.

Monthly medicines bulletin in response to poor methotrexate knowledge

In 2006 the National Patient Safety Authority (NPSA) issued an alert about the safe prescribing and administration of methotrexate, commonly used to treat rheumatoid arthritis. A methotrexate booklet for recording blood results and doses was introduced and only 2.5mg tablets issued to non-cancer patients.

A questionnaire was issued to nursing staff to evaluate the level of knowledge of this potentially toxic medicine, which has an unusual weekly dosage. The results were disappointing, especially about the side effects of methotrexate.


MAKE MEDICINES SAFE

Medicine of the month
METHOTREXATE

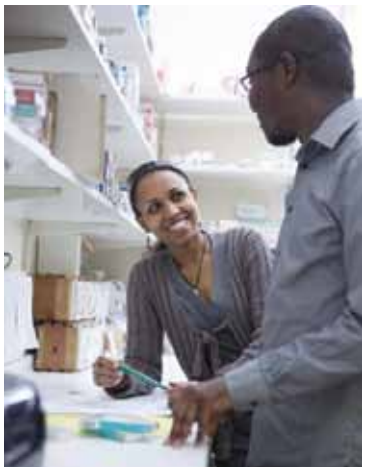
General information

5 key points

UHL incidents

As a result, a monthly medicines bulletin has been produced focussing on one drug or class of drug, the first one being methotrexate. The bulletin is widely circulated and placed on the intranet for reference. Medicine management days for nurses have been updated and now include methotrexate, which is included in the Never Events list updated earlier this year.

A Never Event bulletin on medicines was produced, is circulated widely and given to all newly qualified nurses on their medicines management study days. (#4184)



A weighty issue

Pre-registration pharmacists and students have carried out a small audit in surgery that has identified a problem with how patients' weights are recorded. This is an issue for the safe prescribing of many medicines, including IV paracetamol, as patients below 50kg require a reduced dose. As a result, new rules for paracetamol have been introduced in the electronic prescribing and administration system in the Trust. (#5699)

Success stories

Pathology departments carry out approximately 100 audits per year – that's nearly 2 a week!

In one of their audits, UHL was shown to perform well at accurately identifying important skin cancers for discussion at weekly multidisciplinary skin cancer meetings (#5666).

Another simple audit of adherence to the guidelines for sputum samples in cases of suspected tuberculosis has resulted in a real improvement in to service quality. (#5404)

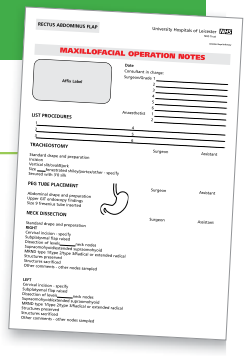
There has been a reduction in the need for postoperative blood transfusions in elective orthopaedic patients following the introduction of a new tranexamic acid regime (#5527).

6 2.3 Planned care division

Successes in Planned Care

Maxillofacial surgery team improve patient care through new proforma

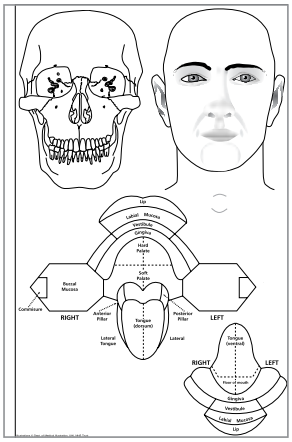
The maxillofacial surgery team has conducted the largest ever study of oncology surgeons using a structured planning proforma to manage the care of patients requiring major surgery.



The audit randomly selected three groups of 30 patient case records from 3 separate 2- to 3-year periods over the last decade. The first period was prior to the use of proformas, the second was soon after their introduction and the third period from when their use should have been fully established.

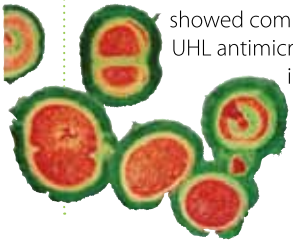
Success stories

A national report on oesophago-gastric cancer showed that the LNR network and UHL results are within the control limits of national rates for each of the standards audited. The national report makes 7 recommendations, of which the LNR network have implemented 6 (the 7th recommendation about brachytherapy would not be cost effective to set up for a tiny number of patients, given the good range of alternative treatments offered). Minimally invasive oesophagectomy is starting soon within UHL, with NIPAG approval. (#4336)



The proforma, which was developed here in Leicester, covered many aspects of clinical care, such as diagnosis, staging disease, investigations, surgical treatment plan and advice to be given to patient. The audit found a statistically significant improvement in a number of the variables measured for and in the overall percentage of variables documented. (#5963)

An audit of MRSA status known in trauma patients on arrival at theatre showed that 89% of patients with fractured neck of femur reached theatre too early for MRSA swab results. It was agreed that best practise tariff exacerbated the problem. Following the audit, Teicoplanin is used if MRSA status is unknown. Reaudit results showed compliance with UHL antimicrobial policy improved from 15% to 76% (#5717)

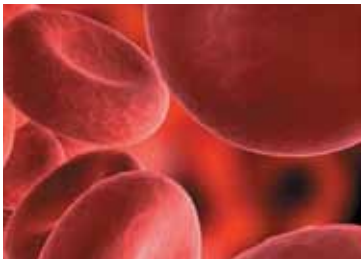


Change to Practice

An audit showed that patients undergoing bone marrow aspirate and trephine (BMAT) were not provided with sufficient analgesia during this painful procedure. An excessive number of patients (29%) experienced severe pain and the majority of patients undergoing this procedure during the test period (56%) wanted more analgesia. After consideration, Entonox has now been made available to cover BMAT routinely, with retraining for nurses who carry out this procedure. A further audit is planned this summer to assess if these changes have improved pain control. (#5167)

New finding

An audit of venous thromboembolism in patients receiving perioperative chemotherapy for oesophagogastric cancer showed that 12.5% of patients treated with potentially curative intent will develop venous thromboembolism. This adverse event can occur at any time during the patient journey. In contrast to the commonly held view, this did not translate into a poorer prognosis. (#5708)



6 2.4 Women's & children's division

Successes in Women's & Children's

New clinical audit lead in Women's CBU has big impact

Congratulations to Dr Fatima W Ibrahim, consultant in GUM, who has been appointed clinical audit lead for the Women's CBU.

Since Dr Ibrahim came into post, the Women's CBU has made huge advances in their clinical audit processes, including:

- Sexual health, HIV and family planning participating in mandatory UHL audits
- Clinical genetics starting its own clinical audit programme
- Obstetrics and gynaecology re-establishing its clinical audit programme and team

With all this activity, the Women's CBU now has one of the most exciting, interesting and productive programmes within UHL – watch this space for further developments (#ca in divisions)

PCT commission Caesarean section audit

A Caesarean section (CS) audit was commissioned by the PCT in light of recent NICE guidance on Caesarean section by maternal request. The audit was also used to measure infection control and thromboprophylaxis at CS which are CQUIN targets, together with an audit on vaginal birth after Caesarean section (VBAC).

The audit showed that targets were met for VTE prophylaxis, diabetic control, use of clippers and antimicrobial prophylaxis (except stellisept prescription). 100% UHL patients had a discussion about mode of delivery in the antenatal period. The CS rate was 21% across UHL and VBAC success rate was 64.3%.

Targets were met for counselling against CS for maternal request, with all CS carried out in the respect only done so after adequately exploring the reasons with patients. The vast majority of patients felt they were given sufficient information to make their decision.

Further work is required to meet the target for written and verbal debriefing post-CS. (#5613)

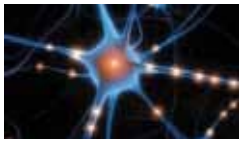
Success story

The neonatal service has conducted 12 re-audits in 2011, all demonstrating an improvement in standards. Here are just some of their achievements:

- 100% (previously 90%) of neonatal admissions registered temperature within 1 hour of admission (#5299)
- Adherence to oxygen saturation targets improved from 11% to 89% to 100% (#5355)
- Documentation of communication with parents within 24 hours after admission improved from 55% to 100% (#TBC)
- Assent documentation of blood transfusion improved from 0% to 80% (#5505y)
- Discharge letters to GPs within 48 hours improved from 38% to 70% (#4668)

Change to practice

Paediatric endocrinology team has used UHL Vitamin D deficiency audit data to formulate a Regional Policy for the Screening, Treatment and Prevention of this problem in the absence of accepted national guidelines. (#5585)



Success story

In the National Paediatric Epilepsy Audit 2011, UHL's childrens' epilepsy service performed within or above expected standards in 11 out of 12 categories for 69 patients audited (#4904).

University Hospitals of Leicester NHS
NHS Trust

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

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

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

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

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

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

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

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

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

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