

University Hospitals of Leicester



NHS Trust

*Caring at its best*



# Annual Report

& Accounts 2011/2012

*Caring at its best*

# Our Values



## **We treat** people how we would like to be treated

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



## **We do** what we say we are going to do

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



## **We focus** on what matters most

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



## **We are passionate** and creative in our work

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



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

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

## One team shared values

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## Welcome from the Chairman

Hello and welcome to this year's annual report and accounts.

It has been a turbulent year during which our financial position and our battle to keep children's heart surgery in Leicester have dominated the headlines.

We have also said goodbye to our Chief Executive of the last four years, Malcolm Lowe-Lauri and welcomed our interim Chief Executive Jim Birrell... and at the time of writing this we are nearing the end of the search for a successor.

Locally and nationally the NHS has been never far from the news as the implications of the Government's reforms take shape. The old order of Primary Care Trusts and Strategic Health Authorities are being replaced by Clinical Commissioning Groups and the National Commissioning Board. At the same time, the recession, which is now in its fourth year, has meant that the NHS has had to work very hard to meet increased demand for services from static budgets.

Despite the challenging environment we ended the financial year in reasonable shape. We met our financial targets and for the eleventh year in succession, broke even. This was in no small part down to the sheer hard work and resilience of our staff.

More importantly we continued to deliver on those targets which mean most to our patients. We again reduced the levels of infections to the point at which despite seeing over 1 million patients a year we could count on our fingers the numbers of MRSA cases. We set out to achieve a 5 per cent reduction in the incidence of pressure ulcers, and by March of this year had achieved a 36 per cent reduction.

We have also successfully built on Leicester's research heritage. During 11/12 we announced the establishment of two new Biomedical Research Units, (BRUs) looking at respiratory disease and lifestyle factors in chronic illness. The two new BRUs complement the existing Cardiovascular BRU and together make Leicester one of the leading research Trusts in the country. Later in the year and as part of the legacy plans for London 2012, we were part of a successful partnership with other NHS organisations and the universities which should see the creation of a Sports and Exercise Medicine research facility for the East Midlands.

Perhaps the most personally satisfying development of the last year has been the creation of the 'Caring at its Best Awards'. These awards occur every three months and are designed to recognise those staff who, in their commitment, dedication and compassion, exemplify everything that we would want these hospitals to be known for. As I write, we are busily preparing for the presentations to the overall winners and I have to say that when I read the nominations and talk to the teams and individuals involved it is genuinely inspiring.

So, I want to end by saying thank you to our marvellous staff, all those on the front line caring for patients and those who support them behind the scenes.



**Martin Hindle**, Chairman

## Welcome from the Chief Executive

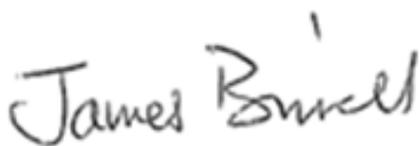
Since arriving in Leicester I have been struck by the high clinical standards and the passion the staff have for their services and their patients. This provides a very solid foundation on which to deliver services.

Much of my time has been spent meeting stakeholders, and again it is striking just how much interest and support there is for these hospitals. Everyone wants us to succeed; whether it's the Clinical Commissioning Groups, the local Councils, the MPs or the LINKs. One of the subjects which highlighted this is Children's Hearts and the campaign to keep surgery at the Glenfield, (more on that subject elsewhere in this annual report). There are many places in England where this kind of support would be considered unusual and looked upon with envy. So, part of our job is to repay this interest with a clear plan for the future and great clinical services which staff and stakeholders can be justifiably proud of.

As the Chairman has said in his introduction, money is tight across the NHS and it will remain so for years. Our focus has to be on providing safe, high quality and affordable care in collaboration with our primary care partners. From the discussions I have had with the doctors who are now leading the Clinical Commissioning Groups I am encouraged, and I know that there is a will to do this, and in doing so, make health services for the people of Leicester, Leicestershire and Rutland 'premier league'.

One of the keys to the long term success of Leicester's Hospitals is the achievement of Foundation Trust status....not as an aim in itself but recognition that the Trust has a clear strategic direction, a total focus on quality and safety and a business plan which is capable of generating surpluses to invest in better services. This has to be the case in Leicester and creating this plan is currently the key task of the Board and leadership team.

I have no doubt that Leicester's Hospitals can look forward to a bright future as a thriving Foundation Trust; it will involve lots of hard work, a relentless focus on quality and safety and bravery in terms of ideas and decision making between the Trust and our community partners but we will get there and by doing so deliver, 'Caring at its Best'

A handwritten signature in black ink that reads "James Birrell". The signature is written in a cursive, slightly slanted style.

**James Birrell**, Interim chief Executive

## About us

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

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

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

We pride ourselves on being at the forefront of many research programmes and new surgical procedures, in areas such as diabetes, genetics, cancer and cardio-respiratory diseases. We are now the home of three NIHR (National Institute of Health Research) Biomedical Research Units and during the year we carried out over 800 clinical trials, bringing further benefits to thousands of our patients.

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

We're proud to have some of the lowest rates of hospital-acquired infections, such as C.Difficile and MRSA, in the country; we have very good hospital standardised mortality rates, which is a good indicator of overall clinical quality; and our food has again been rated as 'excellent' by an independent panel.

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

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

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

## Our values and the NHS Constitution

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

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

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

In March 2012 the Constitution was updated and strengthened in a new commitment to support whistle blowing and tackle poor patient care. The Government published additional duties to the Constitution for NHS staff to raise concerns at the earliest opportunity, be supported by managers and have claims fully investigated.

Health secretary Andrew Lansley said “I believe in the NHS Constitution, which enshrines the principles which will always hold true for the NHS. This isn’t about starting from scratch – this is about revitalising these rights and pledges. Patients are at the centre of our reforms, and with the help of the independent panel we will look to strengthen the NHS Constitution to make sure it is working for the benefit of patients and staff.”

“We have made it easier for staff to raise concerns about poor patient care. Whistle blowing will play an important part in creating a culture of patient safety, and this is why it has been added to the NHS Constitution.”

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

These links will take you to the latest version of the NHS Constitution:

[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132958.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf)

The handbook can be found at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_132960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132960)

## Our priorities for 2011/12

Whilst 2011/12 was a challenging year, we do have a strong track record of delivery. This coupled with the ambition and commitment of our staff puts us in a strong position to deliver our annual plan in 2011/12. These were the priorities we set ourselves last year and how we achieved against them:

### 1. Improving the experience patients have of our hospitals so that we are rated in the top 20 per cent of NHS trusts for patient experience

We wanted to be consistently in the top 20 per cent of Trusts nationally for positive patient feedback, according to local patient experience survey results and the national patient survey.

We said we would use two key indicators of patient experience to track experience over time. These two indicators encompassed a range of quality questions which gave scores to measure improvements. These were:

- Self reported experience of patients
- To be in the top 20 per cent of Trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent.

Based on the 2010 survey although we have not achieved the 20 per cent target we are in the middle 60 per cent of trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent. Encouragingly our local patient experience surveys tell us:

- 99 per cent of our patients said they were always treated with respect and dignity
- On average, three quarters of our patients rate their overall care as excellent or very good, with the vast majority rating it as excellent.

Of course our aim is to provide Caring at its Best for all patients and we continue to use the experiences and views of patients, relatives and carers to guide developments in our services.

We have continued to develop the ways we collect feedback from patients by expanding our inpatient satisfaction survey across all of our wards including day case units. We gathered patient experience feedback from on average 1,272 patients every month from completed patient experience surveys and a further 200-300 email surveys a month from patients who attend the emergency department, outpatients and maternity services.

We have also introduced a message to matron system which is now used across all divisions and gathers data from 145 clinical areas and 40 matrons. The messages have been 76 per cent compliments and 24 per cent suggestions. The top three themes of compliments and suggestions are:

Top three compliment themes	Top three suggestion themes
1. Staff attitudes and behaviours	1. Reduce waiting times
2. Quality of care	2. Staff attitudes and behaviours
3. Communication / providing information	3. Communication / providing information

As a result of feedback we have made many changes to continue to improve the patient experience, including:

- Nurses and health care assistants receive Caring at its Best interactive training
- In appropriate areas patients receive hourly nursing ward rounds
- The nurse in charge is easily identifiable by their large, red badge
- Older people's wards have a ward round by matron and meet matron sessions
- Wards know what volunteer resource they will have to support them by allocating volunteers to specific wards and duties
- Ward managers or sisters are held to account for the performance of their wards when the expected standard of care is not provided
- Dashboards
- Rewards/Awards - the quarterly "Caring at its best Awards" were launched in September and reflect six categories, one for each of our values and one public nominated award.

### ***Specific projects***

Following feedback four specific projects were established:

1. Providing information for patients
2. Staff behaviours and attitude
3. Noise at night
4. Pain and comfort management.

Our surveys show that all four of these areas have improved since their introduction in March 2011, with notable improvements in the noise at night and providing information projects. The action plans and projects will be reviewed in April 2012.

## **2. Making some fundamental changes to our emergency department in order to improve our response to the demands placed upon this department**

It's been a challenging and busy year for our Emergency Department (also known as ED or A&E) and 93.9 per cent of patients seen, treated or discharged within four hours. This figure includes the patients seen within the Urgent Care Centre, co-located to our ED at the Royal Infirmary. In November 2011 we introduced new clinical roles and a new pathway called "Right Place, Right Time" in response to a consistent underachievement of the 4 hour target. This initially resulted in a considerable improvement in our emergency department performance. However, following a number of challenging weeks of activity, with attendances to the department 5 per cent higher and emergency admissions 7 per cent higher this quarter (quarter 4) compared to the same period last year, our achievement of the target deteriorated. We will continue to strengthen our internal processes and will seek additional external support, alongside looking at the design of our ED and how we might increase and improve the footprint.

### **3. Achieving designation for the provision of Paediatric Congenital Cardiac Surgery**

In 2011 the nationally led consultation showed the public in 6 out of 10 regions across the country supported the option that would see our service at Glenfield Hospital designated. Patients with congenital heart disorders also chose our option and overall we were backed by 60 per cent of the public across the country.

Ahead of the decision on which centres will be designated, expected on Wednesday 4 July 2012, we have extended our paediatric intensive care unit, developed on site paediatric ear, nose and throat service and have begun recruitment for additional surgeons, intensive care doctors as well as an anaesthetist and psychologist.

### **4. Investing in our neonatal, paediatric and maternity services**

It's well known that our units at the Royal Infirmary and General Hospitals were built to cope with 8,500 births, and 10 years ago that's how many babies were being born in our hospitals. Over the past few years we have been making changes to our service and maternity units to cope with an increasing birth rate which last year meant nearly 11000 babies were born in the two units. We have invested in the number of doctors and midwives that work for us as well as the estate.

Last year we put an extra £1.4m into recruiting extra midwives and we currently have 334 midwives, more than at any other time in the history of these hospitals. We successfully recruited 24 new midwives last November and another 10 midwives will be joining us this year. We have been working closely with local universities to increase the number of people on our midwifery training programme; 12 student midwives joined our team in March and a further 10 student midwives will start in September.

Just over a year ago we opened our new neonatal unit at the Royal, it cost £10m to create and is the neonatal specialist centre for the East Midlands. Around 1,000 of the 11,000 babies born last year ended up in our neonatal unit for life saving care.

In 2009/10 the Primary Care Trusts led a detailed review of maternity services with our support. The review proposed that we build a new combined maternity unit at the Royal Infirmary and two extra birthing units situated in the community. Unfortunately this plan would have cost at least £80m and at the present time the local health community can not afford this.

So instead a team of doctors and midwives developed an alternative plan to help with the pressures on the service, split into three phases:

1. First in 2010 was the £10m investment into our neonatal unit because it was recognised as being the area of greatest pressure and clinical risk. That was completed at the end of 2010.
2. Last year we invested £1.4m in recruiting extra midwives, and we will continue to recruit more midwives to support pregnant mums.

3. For 2012/13 we began the final and biggest phase of the plan. That was to move all elective (planned) gynaecology from the Royal to the General to free up space at the Royal Infirmary for the development of an elective caesarean section ward and operating theatre and to move the Maternity Assessment Centre (MAC - the assessment and admissions area for women in late pregnancy) away from Delivery Suite. The ward will provide an additional 12 beds than we currently have. As they will be away from the delivery suite, this will allow us to create more space at the Royal for an additional 3 delivery rooms. The separate operating theatre means that the operating theatres in delivery suite can be used only for emergencies and not be “blocked” by elective cases. There is a similar process planned for the General hospital. The gynaecology move is complete and next we will be spending £3m - £4m building the new delivery rooms at the Royal and making the improvements to the MAC.

Obviously, we would have liked to have made all of these changes already, but moving clinical services around is not as simple as that, we have to do it safely and where large amounts of public money are to be spent there is a process that has to be followed to make sure that it is being used wisely to provide the most effective outcome.

#### **5. Investing in our centres of excellence for research and development**

In November 2010 Secretary of State for Health Andrew Lansley opened our Leicester Cardiovascular Biomedical Research Unit (BRU) at the Glenfield Hospital, which successfully received funding for a further five years. The Cardiac BRU research is set to include further studies and trials into better predicting those at risk of heart attack as well as trials to see if drugs can be developed to limit damage to the heart after a heart attack.

We have also been successful in securing funding for a further two BRUs. These prestigious awards were made by the National Institute for Health Research (NIHR) on the basis of a rigorous assessment of the quality of research by peer review panel of international experts. We are the only NHS Trust outside Oxford, Cambridge and London to hold three BRUs. In total we were awarded just over £19m for the three BRUs.

#### **6. Progressing the Pathology joint venture, promoting partnership working with Nottingham University Hospitals NHS Trust and the commercial sector**

To get this project, empath, off the ground, both trusts invested £40,000 (£20,000 each) to support its development.

They have already looked at ways of maximising the benefits of purchasing jointly and seeing the benefits of the economies of scale this partnership brings. So far empath have successfully bid for a portion of the Lincolnshire Coroner’s work, are now delivering specialist Cellular Pathology Services to the Great Western Hospitals NHS Foundation

Trust and successfully bid to retain the North Leicestershire Coroner's Contract and the Northamptonshire Coroner. Continuation of this project during 2012/13 will realise more benefits for the service.

**7. Delivering a £38m cost improvement programme whilst still delivering a quality service to our patients**

We delivered £25.3m of our £38m cost improvement programme in 2011/12. You can read more about this in our Operating and Financial Review on page 91.

**8. Making the best use of our staff and resources through the redesign of patient pathways and transforming our workforce**

This is ongoing, and you will read examples throughout this report of service redesign and transformation which is bringing benefits to staff and patients alike.

**9. Delivery of £1.3m surplus**

Despite the challenging year, we delivered an £88,000 surplus result against a planned outturn of £1.3m. Our plan included our income of £680.4m and expenditure of £679.1m (excluding impairment).

**10. Increasing our cash balance to £25m**

We planned to increase our cash holdings by £7.9m by the end of March 2012, which we have achieved with an actual cash balance of £18.4m at the year end.

**11. Delivering a capital investment programme to improve services and facilities**

We spent £17.8m against a capital plan of £18.5m. We also entered into a land swap in 2011/12 with a local NHS Trust for land and buildings valued at £19.8m. This was cash neutral for both parties therefore both the total fixed asset additions and disposals shown in the Financial Statements for 2011/12 include the £19.8m.

**12. Becoming authorised as an NHS Foundation Trust by April 2012.**

With our financial instability and plans for stabilisation during the year the Trust Board took the decision to put our FT application on hold.

We remain committed to becoming an FT and our immediate focus has been on developing a robust Annual Plan for 2012/13 – which was signed off by our Trust Board on 26 April 2012.

## A year of change...

We achieved a lot within the year, and we've tried to capture the essence of just some of these successes over the coming pages.



### **National award success**

An educational website - [www.spottingthesickchild.com](http://www.spottingthesickchild.com) - developed by child health leads in Leicester won a national patient safety award early last year. The website, funded by the Department of Health, is aimed at frontline doctors and nurses who look after young children. It teaches the basic facts and relevant examination of the seven most common

complaints in acutely ill youngsters.

The site, co created by experts from our Emergency Department, the University of Leicester and Leicestershire Partnership NHS Trust, won the Patient Safety Diagnosis category at the 2011 Patient Safety Awards.

Dr Ffion Davies, consultant in the emergency department and the clinical lead for the project was delighted at winning the award. She said, "With the support of several Royal Colleges in endorsing this learning package we really hope the message spreads to healthcare staff and students that learning about a potentially scary topic has just been made easier!"

Dr Damian Roland, paediatric SpR in the emergency department, designed the interactive self-assessment section of the website called "my waiting room" and has also been awarded a prestigious NIHR fellowship to investigate the benefits that educational tools like "Spotting the Sick Child" ultimately provide for patients. He said: "It is great news to have our work recognised and we will be continuing research into how to improve learning packages like this one."

### **Our Space appeal launched**

In April we embarked on an ambitious project to create a world-class Children and Young People's Cancer Unit for 0-24 year olds at the Royal Infirmary.

Leicester Hospitals Charity and the Teenage Cancer Trust, with support from the Robbie Anderson Cancer Trust, set a target of at least £1.4m for the new unit. Leicester Hospitals Charity set to work generating the much needed funds for the children's element of this project and Teenage Cancer Trust will be using their expertise to raise the funds needed for the new facilities for 13 - 24 year olds.

Currently, children are treated in the children's hospital and our young adult patients have specialist cancer treatment on adult wards across the hospital. This can be particularly difficult for teenagers and young adults, both when first diagnosed and treated for cancer, and if they need to make the transition from children's to adult cancer services.

The new integrated unit will totally transform the environment in which children, teenagers and young adults are treated. The careful use of design, lighting and colour will turn an

ordinary hospital ward into a space that children and young people will find stimulating, whatever their age.

Features of the new unit will include dedicated medical and play facilities, a Teenage Cancer Trust youth support coordinator to ensure that teenagers and young adults get the emotional, social and practical support that they need, dedicated outpatient and day case treatment areas within the children and young people's cancer unit (to avoid the need where possible to use the adult services), an integrated team of specialist nurses, doctors and healthcare professionals from adult and children's medicine, specially trained staff to assist with social activities, education and provide emotional support and support for families with a child or young person on the unit.

Dr Fiona Miall, consultant haematologist at Leicester's Hospitals, said: "The hospital environment can be an intimidating and confusing place for anyone, but especially for children and young adults. The new unit will be a place for children just to be themselves - for younger children that could mean playing games or reading. For teenagers the space will allow them to socialise or study, listen to music or surf the internet. We want to improve the quality of the accommodation and the services we offer to young cancer patients and their families to make a positive impact on their experience with us."

So far we have had nearly a thousand donations to the appeal. Many of these have come from families and patients currently being treated for cancer. We have also had support from Next PLC, Leicester Tigers, Leicester City Football Club, local schools, and from grant-making trusts such as the Edith Murphy Foundation, and the Garfield Weston Foundation. So far we have secured over £1m in gifts and pledges of support towards the £1.4m target. This means we may be able to begin work on the unit as early as this year.

### **Our breast surgery patients now recover in the comfort of their own home**

From April, patients who needed to have breast surgery at the Glenfield were able to go home sooner following a successful pilot which ran from February – March 2011 organised by the East Midlands Cancer Network.

We've changed the pathway so that breast cancer patients can have major breast surgery and be home within a day instead of five days, something welcomed by our patients.

We are now able to discharge patients sooner following a change in the anaesthetics we use which reduces side effects such as nausea, vomiting and pain. Patients come back to hospital usually three days after their operation, to have their wound drain and dressings removed and a soft prosthesis fitted. By reducing their stay in hospital we are also reducing the risk of hospital-acquired infections.

Breast Care Nurses are now also seeing patients at their pre-assessment to see if they are suitable for day case/ 23-hour surgery. The pre-operative assessment looks at risk and provides the opportunity to proactively manage it.

## **Stroke Early Supported Discharge Service (ESDS) Project**

The National Stroke Strategy and the Accelerated Stroke Programme quality indicators include access to an Early Supported Discharge Service or ESDS, offering rehabilitation at home as an alternative to hospital care for patients who've suffered a mild or moderately severe stroke.

The service started taking Leicester City patients in January 2011 and by the end of March it had expanded to take on county patients too.

Our ESDS is run by a team of specialist therapists, nurses, support workers and social care staff with access to a stroke consultant and a clinical psychologist. This collaborative working, which puts the patients and their families at the centre of their care, enables stroke patients with mild to moderate impairment to leave hospital earlier and continue specialist intensive rehabilitation at home (i.e. own home, relatives home or residential care) for an average of six weeks. This not only reduces hospital stays but also improves outcomes by increasing independence and quality of life for the patient and providing appropriate support for the carer and family, at the same time ensuring that the risk of re-admission for stroke related problems is not increased.

## **Groundbreaking genetics study**

This year we took part in a ground breaking research project to uncover the genetic changes that cause unexplained developmental disorders in children. Head of Service, Dr Pradeep Vasudevan, said the four-year Deciphering Developmental Disorders study, was one of the 'most exciting projects that's happening in the world of genetics'.

Our genetics service was launched in 1982 with one clinic and is now four times bigger seeing more than 1,700 patients each year. Patients and families are referred to the service for genetics counselling if they have a known/ suspected genetic condition or family history of known/ suspected genetic condition. Clinical genetics is one of the few hospital based sub-specialities which see individuals of all ages. Patient records are kept separately from other hospital records, within family groupings because of confidentiality. The genetics services has always had a close link to the top-rated, Department of Genetics, University of Leicester.

"Since the 1980s a growing range of conditions have been linked to genetics," says Dr Vasudevan. "This includes hereditary breast and bowel cancers, rare diseases such as Huntingdon's, developmental disorders such as Down's Syndrome, birth defects like cleft lip and palate, genetics conditions affecting eye, heart, bone, blood, skin, brain - in fact, every body system.

"Cancer is one of the largest areas, with five per cent of all breast and bowel cancer diagnoses linked to genes. The cancer genetic services aim to reduce the cancer burden in the East Midlands through education on the reduction of cancer risk by lifestyle adaption and the development of chemo-preventative agents, advice on early detection and detailed

targeted population screening based on molecular genetics to define risk and better treatments through personalised medicine.

"Fetal medicine (or prenatal genetics) is also a large area, where 'at-risk' parents-to-be and their unborn child can be screened for a range of genetic conditions."

Despite the ability to assess risk factors in an ever growing range of conditions, more than 50 per cent of developmental conditions remain genetically undiagnosed. Now the team is working with other clinical genetic teams across the country to help recruit 12,000 children with undiagnosed developmental disorders to try and identify new genetic syndromes. These will be children with a developmental disorder where there may be no family history, or where genetic screening has failed to identify the condition.

The new project will create a genetic database which will help identify shared genetic patterns, helping to identify new syndromes which can be screened for in the future.



### **Improving the care we give our in-patients with diabetes**

We have a number of patients in our hospitals at any one time with diabetes that may be being treated for another health problem. During the past year we have been focusing on a number of different initiatives which will positively impact on the care for these patients. Using data gathered from the

2010 National Diabetes Inpatient Audit 2010 we identified our areas of greatest need, then set up a team with members of staff from different disciplines to implement them.

These included the ThinkGlucose Toolkit; training for staff on the 'Safe Use of Insulin'; Hypoboxes in all clinical areas to identify and treat hypoglycaemia; a self-administration policy allowing appropriate patients to manage their own diabetes whilst in hospital; a programme of teaching our pharmacists to raise awareness regarding prescribing errors relating to Insulin and other glucose lowering treatments and empowering them with skills and confidence to feedback to prescribers if they identify errors; we reviewed our guidelines to bring them in line with National guidance; twice a week a Diabetes Consultant carries out an in-reach round at the Royal as well as the daily diabetes service offer. This round offers consultant input which helps with timely discharge, safe management of diabetes emergencies and specialist care to patients within other specialities; 'Putting Feet First' was introduced giving diabetes patients a foot examination on admission and referring them if its found they have foot problems.

### **Medical records transformation saves £1.2m a year**

A five-year project to overhaul the storage, collection and delivery of medical records at Leicester's Hospitals is making huge savings and improving patient care.

This year our medical records department will deal with around one million requests for records from clinics, wards and external hospitals. Previously requests were made in a range of ways, and notes accessed by a wide range of staff at any time, which led to duplicate notes. Now through a combination of training and campaigning, medical notes are more tightly managed, which has helped improve overall access.

The £1m project refurbished the medical records department – which houses 2.5 million records – and introduced new technology to manage the new system. This has massively reduced the number of ‘missing’ notes from 30 per cent before the project began to just 0.4 per cent. When notes are ‘missing’ it means the notes are not where they should be, and may require time to track down, with some not found in time for appointments, which can waste clinical, and patient, time.

The low figure of ‘missing’ notes is one of the lowest in the country: the national standard is 4 per cent.

Now medical records are automatically requested when an outpatient or other appointment is booked and collection and delivery is carefully organised. Each request costs £2.08 compared £3.27 in 2007. This saving, based on the one million records requested each year, equals a saving of £1.19m.

Cathy Lea, medical records site service manager, said: “We are very proud of what we have achieved. Medical notes help clinicians make accurate diagnoses and important decisions on treatment; by reducing the number of missing notes, the project has improved the safety and reliability of the care that our patients receive. As well as improving patient care, reducing staff and patient frustration, the work has made significant savings – which can be ploughed back into patient care.”



### **Improving the accuracy of patients’ GP practice information**

We are required to record information about which GP practice patients are registered to, and over the year we have been able to significantly improve the quality of this data. At the start of 2011, we gathered incorrect GP information for one in every 46 patients, by December that had reduced to one in 480

because we have invested a significant amount of time checking and correcting information. Errors in data collection occur when patients are unsure of which GP practice they belong to, and there can be confusion over the correct GP registration for patients such as prisoners or Armed Forces personnel.

It’s important that we have accurate information so that we can provide GPs with fast, effective and accurate information about the care and treatment that their patients have received with us. GPs can then provide the right follow-up care when patients have left us and returned home.

Each month we submit data to our commissioners to ensure we are paid for every hospital stay, outpatient and Emergency Department attendance. Payment is at risk if GP practice information is not correct and in April that risk stood at £12m for the full year. Due to the detailed checking done every day by our data quality experts, we have been able to remove that risk.

### **Pioneering tests reduce TB risks**

Our researchers and clinicians are piloting new ways of screening immigrants from countries with high incidence of tuberculosis to reduce the number of active and potentially infectious tuberculosis (TB) cases in the community.

A TB infection when active causes symptoms such as weight loss, persistent cough and night sweats. Latent TB infection causes no symptoms but can develop into active TB at a later date. A recently developed new blood test can detect latent TB, allowing it to be treated to prevent the active disease developing.

Current national guidance suggests screening for latent TB infection should be considered mainly for adults from countries with very high incidence of TB, including most countries from sub-Saharan Africa.

Researchers from Leicester contributed to a high impact publication in the Lancet Infectious Diseases journal in June showing that extending the screening policy to immigrants from South Asian countries including India and Pakistan would capture far more people at risk and still remain cost effective.

There have been more than 20,000 new arrivals from South Asian countries to Leicester over the past ten years and rates of active TB in the city have been high for many years and are only falling slowly with current policies. All newborns in high risk groups are currently vaccinated and all active cases are seen by specialists as quickly as possible. Interestingly rates of TB in Leicestershire county are amongst the lowest anywhere in Europe.

TB specialists in Leicester piloted a programme which expanded the screening programme to young people from the Indian subcontinent. New arrivals were identified when they joined a GP surgery, and tested to see if they are infected with TB. Those identified then are given the opportunity to take preventative treatment supervised by the experts to avoid future TB.

Preliminary results reveal as many as one in three of those tested had the latent form of the disease and would therefore potentially benefit from a short course of treatment.

Dr Gerrit Woltmann, respiratory consultant at Leicester's Hospitals, said: "It is a further facet to our approach to prevent, rather than to treat."

### **A quiet place, far from the madding crowd**

The first of a series of quiet retreats was opened on wards in Leicester's Hospitals in June providing purpose-created private spaces for patients and families as part of our improvements designed to improve end of life care.

The areas are available 24 hours a day for staff and families to use.

Julie Burdett, from Leicester's Hospitals patient experience team, said: "Patients told us that they would value private quality areas to have consultations and discussions with staff about their care and prognosis, as well as a place away from the clinical areas to relax and recover.

"Although these areas will improve care for end of life patients and their families, the dignity 'retreat' spaces will be available to all patients and their visitors who want a quiet, private space to discuss their care."

The project will provide around 20 areas over the coming year and is all down to front line teams who are fully involved in the design and development of these rooms.



### **A better service for patients with skin cancer**

Dermatology staff and the local Brown Dog Charity raised £64,000 to buy specialist skin surgery equipment. This allowed us to create a Mohs Micrographic Surgery Lab in the Department of Dermatology.

Mohs micrographic surgery is a procedure which involves the removal of certain skin tumours in cosmetically important areas, such as on the face. Sometimes described as "slow Mohs" (because of the method used to process the tissue specimen takes 24 hours) this treatment enables us to completely remove the tumour making it less likely that some tumour is left behind. It also means that we only need to remove the smallest amount of surrounding normal skin, providing better quality of care to patients with skin cancer at no extra cost.

Skin cancer specimens are now rapidly analysed by a specially trained skin surgeon, while the patient is still waiting in the department. Previously they would have gone home and waited for several days for a diagnosis.

This method has become essential in treating complex skin cancers of the face, or where other treatment methods have already failed. Patients benefit from an exceptionally high cure rate as we remove only the minimum amount of healthy skin tissue around the cancer, meaning scars are smaller.

The British Association of Dermatologists and NICE have both recommended Mohs Micrographic Surgery be provided in each major city. So it is very important that the facilities now exist in Leicester's Hospitals for this specialist procedure to be performed locally on suitable patients.

### **Leicester's Hospitals at the forefront of hip fracture care**

Leicester Royal Infirmary has excelled in the care of patients with hip fractures, according to a national report out in July 2011.

The National Hip Fracture Database, which reports annually on how acute Trusts are performing, shows that 72 per cent of patients with a hip fracture receive surgery within the first 36 hours of admission to the Royal and that this procedure occurs during normal

working hours, compared to the national average of 61 per cent. Evidence suggests that the sooner patients reach theatre, the quicker they are discharged from hospital and the less likely they are to suffer from complications, or even die.

In addition to this, 87 per cent of patients with hip fractures are assessed by a specialist doctor in age-related conditions, compared to the national average of 42.5 per cent, and are three times less likely to develop a postoperative pressure sore.

Hip fractures are the most common serious injury in older people and the Royal treated over 900 patients for the condition in the last year alone. Some patients needed the surface of their hip joint replacing had the area cemented, 97.4 per cent in fact compared to the 68.2 per cent nationally. The benefits of using this method include reducing pain following the operation and increasing the mobility to get patients back on their feet as quickly as possible. Mr Andrew Furlong, divisional director for planned care at Leicester's Hospitals, said: "We are delighted that all the initiatives we have put in place over the last year have led to significant improvements in the care of patients with hip fractures.

"We recognise that there is always room for improvement and strive to make further progress in this area, fully utilising our multidisciplinary geriatric and orthopaedic team to provide the optimum care possible."



### **Leicester gets record funding for partnership health research**

In August we found out that we had been awarded a combined £15.5m for three biomedical research units.

Two of the awards, with the University of Leicester, are to look at cardiovascular disease and respiratory disease and is set to include studies and trials into better predicting those at risk

of heart attack as well as trials to see if drugs can be developed to limit damage to the heart after a heart attack. It will also focus on the development of new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD).

The third, in conjunction with Loughborough University as well as University of Leicester, will look at nutrition, diet and lifestyle. It will focus on new areas of physical activity research including the potential benefits of short periods of exercise, particularly in patients with type II diabetes and chronic kidney disease.

Professor Bryan Williams, professor of Medicine at Leicester's Hospitals and University of Leicester, was part of the cardiovascular bid. He said: "There are a wide range of important research programmes that will have important and beneficial effects for people in Leicester and Leicestershire. What's even more exciting is that colleagues in respiratory and diabetes have also been successful, we are the only hospital Trust in the country to host three biomedical research units in the next financial year, which is a real testament to the quality and vision of our research."

Health Secretary, Andrew Lansley, added: "This investment will see scientists in Leicester contribute to the UK-wide development of exciting new science into tangible, effective treatments that can be used across the NHS. It means that patients will see real improvements in early diagnosis, survival rates and living a more independent and better quality of life."

### **Top marks for Leicester's Hospitals**

In August we found out that our hospital food had been rated 'excellent' for the fourth year in a row, according to an NHS Information Centre report.

The Royal Infirmary, Glenfield and General hospitals also received 'good' ratings for the quality of the environment and for the levels of privacy and dignity in the Patient Environment Action Team (PEAT) inspection.

PEAT teams consist of nurses, matrons, doctors, catering, domestic service managers as well as groups of patients, their representatives and members of the public who looks at levels of cleanliness, some aspects of infection control, such as hand hygiene, the quality of the environment, such as maintenance and lighting, as well as the standard of food offered to patients. Hospitals are scored in each of the three categories as one of five grades – ranging from "excellent" to "unacceptable".

Dr Abigail Tierney, director of strategy at Leicester's Hospitals, said: "I am delighted that we have continued to maintain our high inspection scores. This demonstrates that we consistently put our patients' needs first.

"We are particularly thrilled with the excellent score for our food for the fourth year in a row because we know how important it is for patients to get a varied and balanced diet during their stay. These results are a credit to our hard working staff and show the importance we place on providing the highest possible standards for our patients."

### **Radical change in blood pressure diagnosis and treatment**

In August our own Professor Bryan Williams was able to announce how, for the first time in over a century, changes in the way that GP's routinely monitor blood pressure.

Following new guidelines for the medical profession issued by NICE and developed in conjunction with the British Hypertension Society (BHS), the way blood pressure is diagnosed and treated was set to be revolutionised. A major feature of the new guideline is the recommendation that high blood pressure should be diagnosed using a technique where the patient wears a monitor for 24 hours to gauge how high their blood pressure is.

Professor Bryan Williams said this new approach will mean that as many as 25 per cent of people diagnosed as having high blood pressure using the current method of diagnosis, i.e. repeated measurement of blood pressure in the doctor's clinic, may not be hypertensive and may not need treatment.

"This new guideline is going to change the way blood pressure is diagnosed and treated for millions of people in the UK and around the world. Working this way will mean we're more

accurate in diagnosing high blood pressure and it will ensure that the right people get treated.

"We are using new more accurate technologies to improve the way we diagnose high blood pressure, meaning we treat those who need it and avoid treating those who don't."

The research highlighted that this new approach would be highly cost-effective and even after taking account of the cost of the new technology, is likely to save the NHS money.

Professor Williams added: "I think the UK is leading the world in developing bold and progressive treatment strategies for high blood pressure so the importance of this research cannot be overstated because treating high blood pressure is one of the most effective ways of reducing the risks of heart disease and stroke."

Leicester is one of the leading high blood pressure centres in Europe and a designated European centre of Excellence.



### **New staff awards launched**

The 'Caring at its Best Awards', are our new awards which were launched in September to reward our inspirational staff, those that live our values and deserve recognition for their amazing success and commitment to providing 'Caring at its Best'.

Award winners will be those staff members who demonstrate that they go the extra mile for colleagues and patients. They will be working examples of our values in action and role models of professionalism and courtesy, caring and compassion.

We have six award categories which reflect our values and our aim, to provide Caring at its Best. The five value categories allow staff to nominate colleagues for work and a positive caring attitude that goes above and beyond. The final category allows patients and the public to nominate a member of staff who has touched their lives and provided best care to them of their loved ones.

The six categories for the Caring at its Best Awards are:

We treat people how we would like to be treated

We do what we say we are going to do

We focus on what matters most

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

We are passionate and creative in our work

Caring at its Best – which will be public nominated

All winners will be invited to the annual Caring at its Best Award Ceremony in September 2012 where a winner of winners will be chosen.

## **Research into the outcomes for vascular disease patients having lower limb amputation**

During the year some research was done into the outcomes for patients having lower limb (leg) amputations, looking at what factors affected their long term recovery.

We performed a retrospective case note review of patients undergoing major lower limb amputation between 2003-2010 for peripheral vascular disease or complications of diabetes. Patients were identified from both theatre and local prosthetic centre databases, but we excluded patients who'd had amputation for trauma or cancer.

We looked at the notes of 355 patients, 249 were men aged between 26 and 92 with an average age of 72 who'd had surgery to remove their limb either above knee, below the knee or a bilateral amputation. 30-day, 90-day, one and five year mortality rates were 12 per cent, 20 per cent, 25 per cent and 73 per cent respectively.

The team found that whilst there was no association between the grade of surgeon, grade of anaesthetist, patient gender, level of amputation and the presence of diabetes, they did discover that 30-day mortality was significantly higher in those patients who underwent surgery outside normal working hours and in those patients with significant existing medical conditions.

Although our early mortality rates compare favourably with other published data, short and long term mortality after lower limb amputation remain high, and relate to patient age, coexisting disease and the time of surgery. This has important implications for pre and post operative management, scheduling of surgery as well as the provision and allocation of rehabilitation services. As far as possible, we are aiming to ensure that patients have surgery on a planned operating list during normal working hours, have a formal clinical assessment by a consultant anaesthetist and are managed by a multidisciplinary vascular specialist team; this should help us see some improvements in our outcomes over the next year.

## **Do patients in intensive care dream?**

In September a team of our staff presented their findings into research on patients in intensive care at the British Association of Critical Care Nurses conference in Newcastle. The study looked into whether there was a possible link between the dreams, nightmares and hallucinations whilst they were patients on the Intensive Care Unit (ICU) and any psychological disturbance once they'd been discharged.

Intensive Care Unit (ICU) patients are commonly sedated and many have very little in the way of explicit memories after they've been discharged. Some studies suggest that as many as 25 per cent experience psychological disturbance at follow-up (Jones et al 2007). Despite apparent amnesia, ICU patients experience high levels of consciousness during their stay, along with pain and emotional distress (Jones et al 2000).

Our research followed 36 patients (23 men and 13 women were recruited, 23 as emergency admissions 13 elective admissions) for up for five weeks after their discharge from ICU

between September 2009 and March 2011. At one-two weeks, patients completed the ICU Memory Tool and a Memory Diary. This was repeated at 4-5 weeks and a Post Traumatic Stress Syndrome Scale (PTSS- 14) assessment was also completed.

There was no significant association between PTSS-14 score at four-five weeks after ICU discharge and age, duration of sedation, ventilation, ICU stay or duration of ICU stay without sedation. Three out of 23 emergency admission patients scored highly on the PTSS-14 and were referred for follow up by a psychologist, but they did not report a higher incidence of dreams, nightmares or hallucinations. Nineteen patients reported experiencing dreams, nightmares and hallucinations whilst on ITU but 17 patients could not recall having any memories. In those patients who had memories of their ITU experience, some common themes were identified. Sensory distortion and disorientation (e.g. computers floating around, sinks moving up and down walls) was experienced by 31 per cent of the patients, 26 per cent said they were being attacked by objects or other people, 21 per cent experienced dreams where they were travelling and 37 per cent reported memories of dreams which involved being trapped or trying to escape.

This study has shown that our ICU unit at the Royal Infirmary has a much lower incidence of psychological disturbance in patients compared to published literature. The team are now looking at a further project into the relationship between post traumatic stress syndrome and intensive care admission.

### **Nursing auxiliaries skills in stroke care improved**

As part of with the National Stroke Strategy, and East Midlands Stroke Network priorities, there is an ambition is for stroke patients to have access to therapy seven days a week. This project aimed to provide enhanced training for our ward nursing auxiliaries giving them more skills and confidence in rehabilitating stroke patients. The competences are based on Leicester's Hospitals core competences for stroke taken from the Skills for Health outline and formalised by the multi-disciplinary teams on the wards who have provided the training via a rolling programme.

Nursing auxiliary staffing levels on ward 8 have been enhanced on weekend days to enable those trained staff to carry out delegated therapy activities with patients.

Feedback from the nursing auxiliaries confirms that they have greater confidence in their skills in supporting and assisting patients during their stay on the unit. Patients benefit from this, not only at weekends when that focus is clearly defined, but also on a day to day basis, as their care needs are now met by staff with increased knowledge and a more enabling focus. Feedback from both patients and staff indicates that patients are more involved in their care and rehabilitation and are actively participating in their individual rehabilitation programmes outside of therapy sessions. The team is planning to find out from patients what they think through a more formal evaluation.

The training programme, delegation processes and work rosters have been agreed with all members of the MDT. The training has been revised following evaluation from the NA's who completed the initial round of the training programme.



### **Visit by Secretary of State to see work of AAA screening team and announce phase three roll out nationally of the programme**

The highlight of the last financial year for the AAA screening service was the visit in October 2011 by the Secretary of State for Health – Andrew Lansley. This was an accolade for the service, which was one of the first wave implementation sites and has consistently been at the forefront of developing this

service both regionally and nationally.

The programme uses a one stop nurse screener model and screened gentlemen receive their results on the day of screening.

Our service polled 98 per cent in a recent customer satisfaction survey who rated their care as excellent.

The programme also links with Leicester based National Research into AAA genetic predisposition placing Leicester at the forefront of Research and development into this potential life threatening disorder.

### **Research supports ECMO as treatment for severe swine flu**

Patients with respiratory failure caused by H1N1 (swine flu) treated with extracorporeal membrane oxygenation (ECMO) had a better survival rate than those who did not receive ECMO, according to a study written by Glenfield Hospital's Giles Peek, along with colleagues from the other centres.

Extracorporeal Membrane Oxygenation (ECMO) uses a heart-lung machine to oxygenate the blood outside the body providing support for the lungs in the intensive care unit.

Experts from Glenfield Hospital worked with colleagues from the three other UK adult ECMO centres the Royal Brompton Hospital, Papworth Hospital and Aberdeen Royal Infirmary to carry out the study, in collaboration with the Intensive Care National Audit and Research Centre (ICNARC).

The study found that hospital mortality for patients referred for ECMO was almost half that of similar patients who were not referred for ECMO during the H1N1 pandemic in winter 2009-2010.

Mr Peek, consultant cardiothoracic surgeon at Glenfield Hospital, said: "From a group of 80 patients with severe H1N1 related respiratory failure that were referred, accepted and transferred to ECMO centres 27.5 per cent died before hospital discharge, that's almost half the number of deaths that occurred in similar matched patients who were not referred to an ECMO centre.

“This shows that ECMO is a clinically effective treatment for adult patients with severe but potentially reversible respiratory failure.”



### **Working with Lloydspharmacy to create a better service for our patients**

From November people using our out-patients pharmacies at the Royal Infirmary and General will have noticed something different.

Having looked around the country at what other NHS Trusts are doing to deliver a better pharmacy service for their patients, we decided to go into partnership with Lloydspharmacy.

Suzanne Khalid, Chief Pharmacist at Leicester’s Hospitals said “By working with an external company who have a proven track record in efficient medicines dispensing, it means Lloydspharmacy can concentrate solely on improvements within outpatient pharmacy services, allowing the rest of our pharmacy team to concentrate their skills and energies on making improvements across the rest of the services we deliver.”

Suzanne finished by adding, “A pilot is something we’ve never done before. It gives us the space and time (12 months) to work on a model that sees the improvements we want to make whilst working through any issues before we make a long term commitment of entering into a contract. During the pilot we will be monitoring the progress of the Lloydspharmacy team and working closely with them to ensure they deliver against the targets we have set them.”

Speaking about the pilot, James Murray, Head of Healthcare Services at Lloydspharmacy, said “We are delighted to be working with Leicester’s Hospitals providing outpatient dispensing services to both Royal Infirmary and General hospitals. We bring with us experience of working successfully with a number of other NHS hospital Trusts, where we have helped create real cost efficiencies as well as reducing patient waiting times by around 30 minutes on average. We look forward to providing a dedicated, efficient, high quality dispensing service for patients, supporting the hospitals’ aims to deliver a more personalised and efficient experience for their patients.”

### **World first heart op changed my life**

A year after his revolutionary heart operation, Patrick Flood wanted to publically thank Dr Andre Ng and his team for changing his life.

In November 2010 Dr Andre Ng, senior lecturer at the University of Leicester and consultant cardiologist and electrophysiologist at Glenfield Hospital, carried out the world’s first heart procedure using a robotic arm alongside 3-D mapping. The procedure was used to cure 64-year-old Patrick Flood’s irregular heart rhythm, a condition called atrial fibrillation (AF).

AF is the commonest heart rhythm disturbance seen in clinical practice, with over half a million sufferers in the UK. It also increases the risk of a person having a stroke by five times and doubles the risk of death.

Patrick, from Alvaston in Derby, underwent the world's first catheter ablation procedure using the robotic arm with 3-D mapping. He said: "One year later, I am free of the pain and breathlessness and fainting I had suffered for years, the operation has proved to be truly life-changing.

"The procedure did not take place in some exclusive private clinic, I have no great wealth or powerful friends, I could not be 'plucked' from the waiting list, nor did I want to be, I was privileged to wait my turn to be an NHS patient at the Glenfield Hospital.

"Throughout my treatment, I was met with courtesy and sensitivity and professionalism. Although a cliché it seems appropriate today to thank the team who cared for me 'with all of my heart'.

"Although this experience reflects specifically on Dr Ng and his fabulous team of professionals at Glenfield, I think it also pays tribute to the National Health Service in general. To be able to access such care and pioneering surgery, free to the patient at the point of need, illustrates why the service is the envy of the world."

Dr Ng said: "I am delighted that Patrick has had such a great benefit from his procedure at Glenfield - this treatment can completely change lives. The system we used when treating Patrick was unique, we were the first centre in the world to use the Amigo system and hence the first to be able to offer this ablation procedure. The news that Patrick has recovered well and is now enjoying life to the full is heartening to our team and only goes to motivate us further in our ongoing research and improvement of this type of technique and equipment."

### **Delivering HIV medication at home**

This month we introduced a project to deliver medications for those with chronic conditions who require long-term medication, like HIV, at home. These patients also continue to attend clinics for regular follow-up visits.

The number of positive HIV patients within Leicester is growing consistently each year with just over 3 people in every 1000 HIV positive. We are currently treating around 900 HIV positive adult patients with around £3m a year on their high cost medicines.

To give our patients a more flexible and convenient option, they can now get their medicines via a private sector partner working with us who deliver their drugs to the patient's home, with additional nursing support if needed.

### **National recognition for one of our anaesthetists**

In November Dr Jonathan Thompson, Senior Lecturer in Anaesthesia and Critical Care at the University of Leicester and Honorary Consultant at Leicester Royal Infirmary was awarded the title of Royal College of Anaesthetists Macintosh Professor of Anaesthesia 2010/11.

This prestigious title and accompanying lecture, *What is the Role of Urotensin II in Cardiovascular Disease?*, was awarded on the recommendation of the Board of the National Institute for Academic Anaesthesia (NIAA), 'in recognition of outstanding contributions to the wider field of anaesthesia by a senior academic or clinician'. The award was based on a series of clinical and laboratory-based studies performed in Leicester's Hospitals over the last few years by himself and colleagues in our Departments of Anaesthesia & Critical Care and the Dept of Cardiovascular Sciences, University of Leicester. These studies investigated the pharmacology and actions of a novel peptide Urotensin II and its receptor system, now thought to be involved in the pathogenesis of heart failure and the metabolic syndrome. The award is a significant achievement, reflecting the importance and quality of the research, performed primarily in Leicester with Professor David Lambert but in close association with Dr Girolamo Calo and other collaborators at the University of Ferrara, Italy.



### **Would you know if someone you loved was having a stroke?**

If you were with someone who was having a stroke would you recognise the symptoms, and would you know what to do?

Whilst many people will have seen or heard of the stroke 'FAST' campaign, researchers at Leicester's Hospitals found that there are two additional signs to look out for which may indicate that you or a loved one is having a stroke. Professor Naylor's team want people to be aware that leg weakness and loss of vision are also strong indicators that you're having a stroke.

Professor Naylor said, "The FAST campaign was very successful, but it's important that people know leg weakness and loss of vision are also signs to look out for. Its my fear are that many people may not be aware that anyone experiencing one or both of these additional signs, on their own or with one of the already recognised symptoms may be an indicator that they or a loved one is having a stroke and should also seek urgent medical advice."

"It's really important that people are aware of all five of the signs and they shouldn't be fooled into thinking that they must be having all five of them at the same time to be experiencing a stroke. You might be having a stroke and only suffering one of the five symptoms, however it's more likely that you will experience one or two signs at the same time."

Mr Francis Dennis from Burton on Trent didn't realise his loss of vision was an indicator that he may have a stroke. Mr Dennis was being treated for a large abdominal aortic aneurysm (AAA) and during the course of work up he happened to mention that he had been having problems with his vision in his left eye. It turns out that he had severe carotid disease and had urgent carotid surgery before his aneurysm was repaired.

Mr Dennis said, "I can't praise Professor Naylor and his team enough. It was like I had a veil coming down over my left eye. I had no idea that loss of vision could be a sign of a stroke, I just happened to mention it when I was at the clinic. I hadn't told anybody because I did not think it was important, the next thing I was in having the surgery and home five days later."

Professor Ross Naylor based at the Leicester Royal Infirmary used a two-year 'Innovation Award' funded by the East Midlands Strategic Health Authority, to do more research into strokes. The research team hopes that the data from their study will increase patient awareness of the need to seek urgent medical advice should anyone suffer; Facial weakness or visual loss, Arm/leg weakness or Speech problems, If they do then dial 999.

### **Lights, camera, action**

Heart surgeon at Leicester's Hospitals is celebrating as state-of-the-art theatre equipment is unveiled.

In December Professor Tom Spyt, consultant cardiothoracic surgeon at Glenfield Hospital, was able to unveil state-of-the-art theatre equipment to help trainee surgeons.

The theatre lights, integrated camera and flat screen TV mean that trainee surgeons can observe extremely complex heart surgery in theatre on screen, rather than clustering around the surgeon performing the procedure.

Leicester Hospitals Charity used funds donated to the Cardio Respiratory Department to buy this innovative equipment. In addition a generous donation of £4,500 from the Captains Charity at Hinckley Gold Club paid for the LCD screen after Lady Captain Judith Cooke's husband John received treatment in 1995.

### **Students break into medicine**

Students from The Lancaster School, aged 13 and 14 that had all been identified as gifted and talented in various subjects across the curriculum, were invited to come along to the Leicester Royal Infirmary to find out more about a career in orthopaedic surgery as part of their development.

During the visit the boys got involved in a design and technology workshop, looking at common fractures and come up with innovative ways to fix broken bones. They then got to showcase their designs to orthopaedic surgeons, chat to a patient who was being treated for a broken bone and quiz surgeons to find out more about life as a medic.

Neil Crook, gifted and talented co-ordinator at The Lancaster School, said: "Many of our boys have a real flair for design, technology and the sciences so I am sure they will come up with some innovative ways of treating fractures. The pupils really enjoyed the visit and I am sure it gave them a real insight into medicine as a career."

### **New mums get expert advice**

Each day around 15 new mums and their babies are discharged home from the Leicester General maternity ward. Historically midwives would meet with each mum in the run up to

their discharge to talk through relevant information. Now mums still meet with midwives who answer specific questions however all of the basic information is shown on a specially designed DVD.

Marian Parrish, maternity ward manager, said: "We need give women some very specific information before they head home with their newborn. Midwives always gave this information however it was a very time consuming part of their day given the number of women who have their babies with us. The DVD means that staff can carry out other duties while women watch the film and can then be on hand to answer any questions afterwards.

"Both mums and midwives have been really positive about us using the DVD, which has been received extremely well and other NHS Trusts have been in touch to find out more."

The DVD, produced by Leicester's Hospitals Medical Illustration team, contains a variety of information including facts about the care women will receive in the community, advice on breastfeeding and the best way to bathe a newborn

### **Award winners**

"I couldn't be more proud of the staff who have won these awards. These staff represent some of the best in our organisation. I know that the judges had a hard time judging the categories because of the high standard on nominations, so congratulations to those who won, and those who were highly commended," said Malcolm Lowe-Lauri, chief executive at Leicester's Hospitals

Both Rachael Berry from Market Harborough and Kam and Rob Palin took the time to nominate consultant paediatric oncologist Dr Johannes Visser for the care he gave to their daughters. Their heartfelt and moving nominations led to Dr Visser winning in the Caring at its Best category and his team taking the Highly Commended place. On hearing that he and his team had won Dr Visser said "I am humbled by these very kind nominations and honoured to win this award. The childhood cancer team at Leicester's Hospitals is a fantastic group of people and I am privileged to work with each of them. We would like to dedicate the award to the parents of our patients who have so much to deal with, but always find time to be kind and generous to us."

Judges felt that Intensive Care Unit deputy sister Joanna Snow epitomised the category We treat people how we like to be treated. Joanna was nominated for her inspirational drive to improve patient care, showing compassion and going the extra mile to deliver a very high standard of care to our sickest patients and their relatives. She was also nominated for the innovative modesty gowns that she's developed for ITU patients who, because of the type of treatment they are receiving, can't wear pyjamas or a hospital gown.

We are passionate and creative in our work and the judges agreed with the nomination of Consultant Embryologist Jane Blower from Leicester Royal Infirmary. Jane was nominated for her dedication and passion to ensuring patients received the best care, and for going out of her way to support and encourage her staff to achieve their passions and goals.

Senior Dietitian Helen Ord, Trauma Matron Kate Machin, Catering & Domestic Manager Vince Humby and Serco Catering Manager Jackie Wilson at Leicester Royal Infirmary all focused on matters most making them the clear winners in the category we focus on what matters most. These individuals came together to work as a team to improve nutritional care and develop the first nutrition care pathway for older fractured neck of femur patients. This group of patients have an average age of 90 and arrive to us underweight and malnourished. This unique service now gives these patients high energy meals and snacks, extra milky drinks, and prescription supplements with energy, protein, vitamins and minerals in order to help their recovery after an operation.

Glenfield Hospital's Lung MDT Coordinator Claire Young represents all the best attributes of a team player and caring human being which is why she won in the category We do what we say we're going to do. Claire was nominated by colleague Sanjay Agrawal, a Consultant Respiratory Intensivist at the Glenfield.

In the final category we're one team and we're best when we work together, judges chose our AMICA Team as winners, nominated for their good cheer and solid, yet flexible team working attitude to delivering the best counselling and mediation service to support all of our staff.

### **Christmas visits – Tigers, Foxes, Starlight and the cast of the Curve's 42<sup>nd</sup> Street**

Every Christmas we are pleased to welcome local stars and celebrities into our hospitals to spread some Christmas cheer. In early December, players from the Leicester Tigers visited signing autographs, having their photographs taken and handing out gifts to children. A couple of week's later patients at Leicester Children's Hospital got the chance to meet Leicester City Football Club players who visited to spread some more festive cheer. Our Children's Hospitals play specialists hosted a festive themed party funded by Starlight where children got the chance to pin the tail on the reindeer, find Santa's nose and sing along to Christmas carols.

The final visit came from the cast of 42nd Street that was playing at The Curve who swapped entertaining audiences for lifting the spirits of elderly patients in hospital. The performers whipped up some festive cheer with a selection of songs from their production, along with Christmas carols. Annette McHale, matron at Leicester's hospitals, said: "We are really pleased that some of the cast of 42nd Street could take time out of their busy schedule to come and spread some Christmas cheer to our older patients. They enjoyed listening to the carols and joining in with some of the singing."

### **Providing Herceptin<sup>®</sup> at home**

We're always looking for ways to improve the experiences of our patients at Leicester's Hospitals, particularly those receiving intensive cancer therapies who would like the opportunity of having their treatment closer to home. With 130 referrals for Herceptin<sup>®</sup> in the

last year alone and an average 70 patients being treated a month, our team in Cancer Services began to look at how they might improve the experience for this particular group of patients.

Patients prescribed Herceptin® receive 17 cycles of the drug every three weeks over a year. Traditionally, their treatment started with an appointment where their Consultant Oncologist who would initially prescribe three cycles of Herceptin®. They were then seen for about two hours every nine weeks by their consultant in our chemotherapy suite at the Royal Infirmary until the course of treatment finished or their disease progressed.

Now these patients can have the majority of their treatment delivered in their own home! They start the process in the same way and need to have cycles one and two delivered in hospital so staff can make sure they don't have any adverse reactions to the treatment. Patients then have the rest of their cycles administered at home, just coming back into hospital every nine weeks to see their consultant so they can monitor their progress.

The first patient was treated on the 12 January 2012 and other patients are currently being referred onto the service.

Dr Samreen Ahmed, said "Learning that you have cancer is a difficult experience. After your cancer diagnosis, people quite obviously feel anxious, afraid or overwhelmed. Being able to help deliver their treatment in a comfortable, familiar environment can help ease the stress of treatment, but also reduce travel expenses, time off work or the impact on their carers. This is just the first step towards giving more patients the choice about having their cancer therapies and treatments delivered in their own homes."

To help deliver this improved service for our patients we have begun working in partnership with Healthcare at Home Ltd, a company with experience of delivering different health services to patients and experience in Oncology Outreach and Chemotherapy at Home. They already work in partnership with Nottingham University Hospitals NHS Trust and Northampton General Hospital.



### **Choose Better campaign/ Twitter day**

Working with the primary care trust's we used social networks to highlight what NHS services there are and when to use them as part of the "Choose Better" campaign. On Tuesday 24 January over 2,000 Twitter and Facebook friends followed as staff "tweeted" live from our emergency department between 8am and 6pm to give everyone a snapshot of the emergencies we deal with every day. The aim of the day was to highlight the cases that need to go to our emergency department at the Royal Infirmary and those that could be dealt with elsewhere, such as walk-in centres, GPs, pharmacies and NHS Direct.

We also answered questions and posted facts to engage our followers throughout the day.

It was something that we'd never tried before, but the day was classed as a success and we hope to emulate it with other services in the future.

### **£10m for sports medicine centre of excellence in the East Midlands**

Health Secretary Andrew Lansley announced, whilst visiting Loughborough University, £10m of funding for the East Midlands to develop one of three hubs, which together will form the country's first ever National Sports and Exercise Medicine Centre of Excellence.

The Centre, which will be made up of three network partners, will promote sport and exercise medicine across the country.

The Centre will help more people to be more active, treat injuries caused by exercise and conditions associated with lack of exercise. This will mean people who are injured return to physical health and work quickly. It will also help people use the benefits of physical activity to cope with existing medical conditions, such as diabetes.

Professor Nigel Brunskill, Professor of Renal Medicine and Deputy Head of the Department of Infection, Immunity and Inflammation at the University of Leicester, said: "This national centre for sports and exercise medicine forms part of the UK's commitment to Olympic legacy projects. The University of Leicester is a key stakeholder in the centre and university researchers will be able to use the facilities provided at the centre, and collaborate productively with other researchers from other stakeholder organisations, including the University Hospitals of Leicester NHS Trust.

"I am delighted and honoured to be associated with this project which will solidify the future legacy of the 2012 Olympics by establishing a critical mass for research into 'exercise as medicine', increasing public awareness and improving the health of patients with chronic diseases".

Professor Brunskill, who is also a consultant at Leicester's Hospitals, added that local patients may be recruited into clinical trials run through the centre. There will also be possibilities for new undergraduate teaching modules and opportunities for post-graduate study at MSc and PhD level.

Professor Mike Morgan from Leicester's Hospitals, who is an honorary Professor of Respiratory Medicine at the University of Leicester, said: "We are proud to be a part of National Centre for Sports and Exercise Medicine. We will be able to help develop specialist clinical sports medicine services and promote research and education into the important expanding role that exercise has in the management of common long term conditions."

The establishment of the Centre will also fulfil one of the Government's key 2012 Games bid commitments and will be a lasting legacy of the Games.

### **Specialist service for our young patients**

Staff and patients got together to officially open the newly designed Paediatric Physiotherapy Gym, specifically with our youngest patients in mind. Matt Hampson, former England Rugby Under-21 and founder of the Matt Hampson Foundation - a charity set up to ensure and

support young people seriously injured through sport – did the honours and officially opened the gym.

Based at Leicester Royal Infirmary, this gym is for the sole use of children referred to our Children's Hospital for physiotherapy or admitted for rehabilitation.

Children from birth to 15 years are assessed and treated for orthopaedic, respiratory and acute neurological problems. Following assessment the young patients then go on to have further treatment, either in groups or individually.

The gym redesign cost just over £10,000 and was funded by Leicester Hospitals Charity thanks to kind donations of the people of Leicester, Leicestershire and Rutland.

Naomi Dunmore, senior paediatric physiotherapist, said: "We are really excited about this new gym and have had some really positive feedback from patients and parents. Children's physiotherapy is very different to the adult service and these new facilities allow us to offer specialist treatment to our smaller patients."

### **Engaging with Black and Minority Ethnic (BME) communities to promote organ donation**

Despite being significantly more likely to need an organ transplant, people from BME communities currently represent just two percent of the national organ donor register. So in January we began work to engage with local BME communities to increase the number of people coming forward as organ donors. This is a significant problem for a city such as Leicester where BME communities make up nearly half of the total population. Our work harmonises and builds on the National Health Service Blood and Transplant's (NHSBT) national campaign.

The first stage of the programme began in earnest when local community and faith leaders attended a meeting with our Chairman, Chief Executive and Dr Mike Ferguson, our organ donation lead to outline the issues, identify barriers and seek their advice and support. Following this staff have been out in local communities to raise awareness and dispel some of the myths surrounding organ donation, creating opportunities for dialogue between medical staff and faith communities.

We are naturally keen to do everything we can to increase the life chances of local people. In the UK three people die every day waiting for a transplant and the longer you wait, the greater your chances of dying.

### **A new Macmillan Cancer information and support centre based at the Royal Infirmary**

We first opened our Cancer Information Centre in July 2002 and since then have seen a steady increase from 1,622 enquiries in the first year, to over 6,000 in 2011. So whilst still providing an excellent service, the space in the Osborne reception just wasn't big enough for all the services our patients say they would like.

On 9<sup>th</sup> January we started work on a new-build project comprising of an information drop-in area, a multi-purpose room, a quiet room, an administration office and a beverage bay. The new centre, due to finish in spring 2012, will allow us to provide improved services to anyone affected by, or seeking information about, cancer. The Hair Loss Service will be based in the new Information Centre, and we will also provide benefits clinics, complementary therapy sessions and support groups. We will be working with other health professionals to increase the range of services offered in the future.

### **Development of an acute Oncology assessment unit**

Following the publication of the National Cancer Peer Review Acute Oncology Measures it was evident that we needed a clear single pathway for patients with acute haemato-oncology conditions. Before changes patients were admitted via various routes as there was no dedicated facility to coordinate care for this patient group.

In January 2011 we set up an assessment unit and began admitting all patients through this dedicated facility. This has improved communication with all healthcare professionals as care is coordinated via one central point. We are seeing and treating patients more promptly, which has improved their experience, and the nursing team have been able to develop a core set of skills in managing acute oncological emergencies and coordinate bed capacity from this assessment unit.

During 2011, the unit has seen 2,576 direct admissions of which 97.24 per cent were direct admissions with only 2.76 per cent coming via the Emergency Department. We were also nominated for An Excellence in Oncology Award.



### **City Mayor Sir Peter Soulsby opens our refurbished Bereavement Centre**

We think that bereaved relatives deserve the best when they come to collect their loved one's valuables and the death certificate, and it's important that we meet them in pleasant, peaceful and comfortable surroundings. The space also allows families to discuss the cause of death, post mortem or any

bereavement support we can provide in the form of consoling, information or signposting to external bereavement support agencies.

On an average day around ten families might be seen, with the office dealing with up to 30 deaths on some Mondays.

Our existing bereavement rooms at the Royal did not fit the bill, so with help the Rotary Club of Leicester and readers of the Leicester Mercury we have been able to improve the area, create additional space and a bereavement garden that can be seen from the family rooms and used by grieving relatives.

## **New hope for cancer patients**

Hard hats and high visibility jackets were donned at the Royal Infirmary as building work started on a new state-of-the-art cancer trials unit. The Hope Against Cancer Clinical Trials Unit will officially open its doors in the spring and will provide the East Midlands with a centre of excellence in clinical cancer research.

The new units were funded by Leicester's Hospitals and Hope Against Cancer, a charity launched in 2002 that raises funds for local cancer research in Leicestershire and Rutland to improve the area's status as a leading centre for cancer research and treatment.

Wendi Stevens of Hope Against Cancer said: "We are delighted to be able to work in partnership with Leicester's Hospitals to provide the very best care for local people suffering from cancer. Our ability to support the construction of this facility is entirely due to the support we have received over the years from local people."

Dr Nicky Rudd, clinical director of cancer services at Leicester's Hospitals, said: "The construction of the unit is a very exciting new development. Our aim is for Leicester to become an established major international centre for oncology research. Building work starting marks the beginning of this exciting project and means that our research work can take place in a purpose built area, designed specifically for our needs."

Our doctors are already leaders in research into cancer and are recognised internationally for their work in the field. Patients from Leicestershire, Rutland and beyond are treated specifically for cancers of the pancreas, lung, and kidney as well as melanomas, leukaemia and lymphoma, all cancers that will be thoroughly researched in the new unit.

The new unit will mean that medics are at the cutting edge of research able to develop and build on the work that they do in a purpose built centre.

## **Get online and play it safe this Valentine's Day**

February 14 marked the launch of a new sexual health website designed by Leicester's Hospitals and NHS Leicester, Leicestershire and Rutland working together. [www.leicestersexualhealth.nhs.uk](http://www.leicestersexualhealth.nhs.uk) includes a state-of-the-art online booking system, meaning patients can book a sexual health screening or contraceptive (family planning) appointment at a convenient time at the click of a mouse. This is a confidential service and patients then receive a discreetly worded text advising them of their appointment date and time.

The website contains information on a wide range of topics including contraception, pregnancy testing, Chlamydia and advice on how to seek help after a sexual assault. There is also the option to hide the website and revert back to Google at the click of a button to avoid prying eyes.

Paul Schober, our consultant in GU medicine, led on developing the service and said: "Sexual health is not the easiest thing for people to talk about and this means there is a tendency not to seek out advice. This fantastic new site is easy to use, completely confidential, contains lots of information and has a simple appointment booking system.

This makes arranging to check your sexual health simple - you can book an appointment discreetly online and avoid having to pop out and make that private phone call.”

The site is for all ages, people can find information on contraception, specific sexual health services for the under 25s, as well as support and advice for anyone who has experienced sexual assault or violence. There is also a discretion button at the top of the webpage so if the person is using the service in a library or university the page can be hidden quickly to protect their privacy. Many people get these services from their GP and can use the website to give them information about contraception in the privacy of their home before or after their GP visit.

### **Improving burns and plastics care for patients**

This year our Burns and Plastic Surgery Specialist Nursing team developed an outreach service to improve the experience of patients. Previously coming into one of our hospitals for treatment, they can now receive specialist burns care within their own home. The specialist team have worked closely with colleagues in the community to improve the transition from hospital to home helping to make the process run quickly and more smoothly and to prevent patients being re-admitted or being called for unnecessary follow ups.

Our service must provide an integrated nursing and therapy service delivering specialised burn care and advice outside of hospital to patients and their families, as well as supporting colleagues in the community.

Our specialist nursing team have also developed more small plastic surgery minor operations and procedures away from main theatres into a clinical environment within our Burns and Plastics Dressing Clinic, a first of its kind within our hospitals. This has been possible because of the close working, help and support of theatre staff.

This initiative allows the specialist nurses to be with the patient throughout their procedure up to discharge. Patients have already shared with us their satisfaction with our service through their positive feedback, which is gathered as part of our regular audit of our service.

### **Clinical Research Report: the ESNEE study**

Working with Liverpool Women's NHS Foundation Trust we began recruiting for the ESNEE (European Study of Neonatal Excipient Exposure: An observational study of excipient kinetics in neonates). Excipients are the ingredients added to medicines to make them able to enter the body. Both ourselves, led by Dr Hitesh Pandya and Liverpool Women's NHS Foundation Trust are investigating the excipient Ethanol (alcohol) in the blood stream of babies taking certain medicines. The study has been designed to ensure that very little extra blood is taken from the baby (less than one ml in total) and any sampling is incorporated into the babies' routine clinical care. ESNEE is an NIHR (National Institute of Health Research) portfolio study and is supported through the MCRN (Medicines for Children Research Network). Although the study uses traditional 'wet' blood samples, Dr Pandya has helped

develop an innovative system using dry blood spots and this approach to testing is also incorporated into this study.

One of our main targets for clinical research is that the hospital, ward/unit and/or research team have the support they need. So far we have recruited successfully to ESNEE. We've got the right infrastructure of support in place for each study which is really important to a successful research and development project, along with strong relationships with the MCRN, LNR CLRN, our research and development department and divisional management.

### **Bed bureau triage**

Bed bureau is a 24/7 service set up to smoothly and speedily arrange emergency admissions from GP's into medical, gynaecology and surgical admissions wards. They also partially book next day outpatient department appointments, are a contact out of hours for our community midwives and arrange for patient rehabilitation in the community hospitals within Leicestershire.

The service launched a new initiative this year to try and successfully manage some of the patients referred to our Acute Medical Unit via Bed Bureau in an ambulatory way (are able to walk in), in line with recommendations from a number of professional bodies.

To help with this new process a new clinical sitting area was opened up between the two existing acute medical units and this was staffed by the medical consultant team, many of whom initially gave up their SPA time to contribute.

Subsequent audits have shown virtually all patients had a senior review within two hours of arrival and approximately 50-60 per cent were able to be discharged home on the same day.

The benefit was a number of patients were seen very promptly by a consultant and were able to be sent home without ever taking up a bed on the Admissions Unit, resulting in better patient flows and more efficient utilisation of the Acute Medicine Unit resources.



### **Revolutionary new transplant procedure could help thousands**

Scientists working for Kidney Research UK have developed a revolutionary new procedure that could improve the prospects of thousands of renal patients by increasing the success rate and longevity of kidney transplants, while also enabling more organs from marginal donors to be used for transplantation.

The project, carried out at Leicester General Hospital, is the first of its kind anywhere in the world and has led to the development of a process called normothermic perfusion - a form of resuscitation which allows doctors to improve the quality of kidneys taken from deceased organ donors.

By flushing donor kidneys with oxygenated blood prior to transplantation, normothermic perfusion reverses the damage done to organs by storing them at low temperatures - optimizing early graft function so that they work better immediately after transplantation.

With kidneys that function well early on proven to last longer, normothermic perfusion could not only reduce rejection rates but also increase the lifespan of transplanted kidneys, which currently only last around 10 to 15 years.

Professor Mike Nicholson, consultant at Leicester's Hospitals and lead researcher for Kidney Research UK, said: "Normothermic perfusion allows us to gradually reintroduce blood flow to donor kidneys outside of the body and in a controlled way. This reverses much of the damage caused by cold storage, while offering us a unique opportunity to treat the organs with anti-inflammatory agents and other drugs before going on to complete the transplant procedure. In short, we're able repair and revive damaged kidneys in a way that would otherwise be impossible."

Early results from the project are extremely encouraging with only one of 17 kidneys treated using normothermic perfusion showing signs of delayed graft function after transplantation. Delayed graft function is a common feature of kidney transplantation and can significantly compromise the long-term success of a transplant.

Normothermic perfusion also has the potential to expand the organ donor pool and reduce the transplant waiting list by utilising more kidneys from marginal donors - people who have suffered uncontrolled cardiac death, as well as elderly donors and those with diabetes, hypertension or renal insufficiency.

At present, 90 per cent of all patients on the UK's transplant waiting list are in need of a kidney, while fewer than 3,000 kidney transplants are carried out each year. With the kidneys of half of all uncontrolled cardiac death donors alone discarded last year, normothermic perfusion could cut the transplant waiting list by more than ten per cent.

Reducing the transplant waiting list would also have profound implications for the NHS, which spends £3.66 billion of its annual budget on treating kidney failure.

The average cost of keeping a patient on dialysis for one year is currently £30,800, while a full kidney transplant incurs a one off cost of around £42,000 per patient, with maintenance costs of £6,500 per year thereafter. This means the cost benefit of kidney transplantation compared to dialysis over a period of ten years is £241,000 per patient, or £24,100 for each year a patient's kidney continues to function.

### **Celebrating treating 100th patient with revolutionary radiotherapy treatment**

Over the past two years Leicester's Hospitals has invested £7m in new technology to treat cancer.

Intensity modulated radiotherapy (IMRT) can be used for treating cancers in the prostate, neck, brain and abdomen, amongst others.

These IMRT machines use advanced technology to direct the x-ray beam used to deliver the treatment. They 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. For certain patients there are huge benefits of being treated this way, including fewer side effects than with standard radiotherapy and less time receiving the treatment.

Ghislaine Boyd, head of radiotherapy, explains: "We were keen to utilise all the available technologies to provide our patients with the most advanced treatments. With IMRT we can achieve quite complex patterns of radiation with a very simple series of exposures. This makes the whole experience for the patient much more straightforward. In fact most of these treatments are now being planned using RapidArc where the treatment is delivered in a continuous sweep around the patient. We're finding it not only gives us greater control over the dose but the actual time patients spent being treated is shorter. This means we are able to deliver very complex treatments within the same amount of time as some of the simpler cancer treatments."

Ian Stubbs from Loughborough is the 100th patient to be treated with this new technology, he said: "I was diagnosed with prostate cancer in August last year and have only just recently started the treatment. I hadn't heard of this type of radiotherapy before and was advised this would be the best option for me. Throughout the process the nurses and doctors have been really nice and helpful."

Dr Claire Esler, Oncology head of service, adds: "Radiotherapy has made huge technological advances recently, which make a real difference to the treatment we can give our patients. We are proud to be able to offer these treatments here at Leicester and we've done all of this with no waiting lists and keeping the supportive environment that our patients need."

Having successfully implemented IMRT for a wide range of different cancers our aim now is to continue to increase the use of this technology so that more of our cancer patients benefit from this type of treatment.

### **Ward-based pharmacy set to reduce waits**

Patients at Leicester's Hospitals are benefiting from speedier access to the medicines they need to take home, thanks to a new ward-based pharmacy.

The satellite dispensary reduces the time it takes for patients in musculoskeletal and surgical wards at the Royal Infirmary to receive the medicine they need when they are discharged.

The satellite dispensary is integrated within ward 8 which means patients receive their medication quicker and can go home sooner because it removes the time it had would have taken for prescriptions to travel to Windsor pharmacy, be dispensed and then travel back to the ward.

Susan Wills, principal pharmacist in surgery at Leicester's Hospitals, said: "Our main pharmacy used to supply take-home medicines but these had to be transferred up to the ward. By having the ward based dispensary it is even quicker because we are so much closer to the patient.

“Our initial figures show that 65 per cent of take home medications were ready within 40 minutes and we are dispensing almost 300 items a week, we are hoping to improve on these figures as the dispensary becomes more established.”

This initiative will also increase the amount of time the surgical and musculoskeletal pharmacy team can spend with patients counselling them about their medicines, which has been shown to improve compliance.

We already have satellite dispensaries in other areas across our hospitals which have improved discharge by reducing waits.

We use a number of methods to reduce waits for medicines across our hospitals, including supplying patients with pre-labelled items in readiness for discharge. Ward staff can also electronically track the progress of the patient’s take-home medicine, once it has been sent to pharmacy, to avoid unnecessary phone calls which could interrupt the dispensing process.

## **Our strategy including our plans to become a foundation trust**

In early 2011, all NHS Trusts were required to sign a formal agreement outlining when they would become a Foundation Trust (FT). Not long after our agreement was signed, we began to experience financial and performance issues and a programme of turnaround and stabilisation was introduced. As a result of this, the Trust Board took the decision to put our FT application on hold.

We remain committed to becoming an FT and our immediate focus has been on developing a robust Annual Plan for 2012/13 – which was signed off by our Trust Board on 26 April 2012. We have recently completed a market assessment (looking at population, prevalence and activity trends and what this could mean for the services we currently provide). This market assessment has helped us to refresh our strategy and ensure we are meeting the needs of our patients. We will be developing our five year Integrated Business Plan (which we need to have for a successful FT application) over the coming months. This Integrated Business Plan will describe how over the next five years, we make our strategy happen.

## **Members**

Our Trust membership has continued to grow with 13,342 people now signed up as members. This year has seen a significant rise in the numbers of young people joining up; largely due to our recent decision to bring membership and volunteering closer together. We now ask that anyone wishing to volunteer with us becomes a member first. This way, they can find out more about the Trust and gain a clearer picture of the many ways in which volunteers support patients, relatives and staff.

Over the last year our members have been involved in the development of a new patient survey, our quality accounts, the design of a new set of hospital maps and some have volunteered to sit on our ethics committee. We have also made some changes to our Medicine for Members talks, which are proving as popular as ever. In January we began alternating the hospital site that the talks are held in and using the sessions to introduce members to the wider hospital team.

## **Quality and performance – how did we do?**

We are monitored by the Department of Health against a range of targets and thresholds which are published in the 2011/12 Operating Framework. This section relates to a mixture of the 2011/12 national and local quality and performance measures which are our priorities. We provide our Trust Board with a monthly quality and performance report summarising quality, operational, finance and human resources performance. This report can be found in the Trust board papers on our website [www.leicestershospitals.nhs.uk](http://www.leicestershospitals.nhs.uk)

## 2011-12 Performance against key targets

<b>PATIENT SAFETY</b>	Target	Actual
MRSA Bacteraemias	9	7
CDIFF in Patients (UHL - All Ages)	165	108
% of all adults who have had VTE risk assessment on adm to hosp	90%	93.8%
MRSA Screening of Elective patients	100%	100.0%
MRSA screening of Non Elective patients	100%	100.0%
<b>CLINICAL EFFECTIVENESS</b>	Target	Actual
% of Fractured Neck of Femurs operated in < 36hrs	75%	64%
2 week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	93%	94.0%
2 Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	95.9%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%	97.4%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%	99.9%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	94.5%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%	99.0%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%	83.8%
62-Day Wait For First Treatment From Consultant Screening Service Referral	90%	93.8%
62-Day Wait For First Treatment From Consultant Upgrade	85%	87.5%
Emergency 30 Day Readmissions (Following Elective Admission)	1.6%	5.1%
Emergency 30 Day Readmissions (Following Emergency Admission)	8.0%	9.6%
Primary PCI Call to Balloon <150 Mins	75.0%	86.7%
Pressure Ulcers (Grade 3 and 4)	197	138
<b>PATIENT EXPERIENCE</b>	Target	Actual
Inpatient Polling - treated with respect and dignity	95.0	96.0
Inpatient Polling - rating the care you receive	91.0	86.9
Outpatient Polling - treated with respect and dignity	95.0	92.9
Outpatient Polling - rating the care you receive	85.0	85.2
% Beds Providing Same Sex Accommodation - Wards	100%	100.0%
% Beds Providing Same Sex Accommodation - Intensivist	100%	100.0%
ED Waits (2011/12 - Type 1 and 2 plus Urgent Care Centre)	95%	93.9%
RTT 18 week - Admitted	90%	83.5%
RTT 18 week - Non admitted	95%	95.9%
Short Notice Cancelled Operations	0.8%	1.4%
<b>NURSING METRICS</b>	Threshold	Actual
Patient Observation	90.0%	97%
Pain Management	90.0%	96%
Falls Assessment	90.0%	96%
Pressure Area Care	90.0%	98%
Nutritional Assessment	90.0%	97%
Medicine Prescribing and Assessment	90.0%	97%
Hand Hygiene	90.0%	96%
Resuscitation Equipment	90.0%	84%
Controlled Medicines	90.0%	100%
VTE	90.0%	89%
Patient Dignity	90.0%	96%
Infection Prevention and Control	90.0%	99%
Discharge	90.0%	86%
Continence	90.0%	99%

**Further reduce health care associated infections:** 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 nine cases and for CDIFF this was 165 cases for 2011/12, and we met both of those targets.

MRSA elective and non-elective screening has been achieved at 100 per cent respectively.

**Reduce venous thromboembolism (VTE):** Many hospital patients are at risk from Venous Thromboembolism (VTE), where blood clots form in the leg veins, (called deep vein thrombosis or DVT) these can break off and block blood vessels in the lungs (pulmonary embolism) which can be fatal.

We now risk assess 93.8 per cent of our adult patients for their risk of VTE. We are one of 22 VTE exemplar sites in the UK and are committed to preventing VTE in patients admitted to our hospitals. We have streamlined pathways of care for patients who come to us with acute thrombosis, focussing on the safe use of anticoagulation therapy and attention to VTE prevention measures.

**Improve performance in trauma - outcomes for fractured neck of femur patients:** We have responded to the improvement target to get patients to theatre within 36 hours of their fractured neck of femur admission/ diagnosis. The monthly target is 70 per cent, increasing to 75 per cent by March 2012. During the year we operated on 64 per cent of patients within 36 hours.

The reasons for this shortfall have been analysed carefully and include:

- insufficient theatre capacity to respond to peak demand, combined with inefficient use and preventable delays;
- an approximate 11 per cent increase in admissions for fractured neck of femur, coupled with increased emergency spinal activity which displaces fractured neck of femur patients;
- some aspects of the agreed process are still not embedded into the clinical service.

We are increasing theatre capacity and creating a dedicated ward which will look after only fractured neck of femur patients to improve our position in 2012/13.

**Same sex accommodation:** We have achieved 100 per cent compliance with the national target to provide same sex accommodation for patients. Every quarter senior staff walk about our same-sex accommodation to:

- access and promote the on-going culture of same sex accommodation;
- review toilet and bathroom signage and facilities to ensure they are available to patients close to their bed area, and

- raise staff awareness around privacy and dignity and the importance of providing same sex accommodation and bathroom facilities for patients.

**Patient polling:** In March 2011, we started gathering feedback from patients across all wards and day case units by expanding our inpatient satisfaction survey. Every month over 1,270 patients complete one of our experience surveys and a further 200-300 email surveys are captured every month from patients who attend the emergency department, outpatients and maternity services.

As a result of feedback we have made many changes to continue to improve the experience of our patients, including:

- Introduction of a message to matron system which is now used across all divisions and gathers data from 145 clinical areas and 40 matrons
- Every nurse and health care assistant receives Caring at its Best interactive training
- Every patient receives hourly nursing ward rounds
- The nurse in charge is easily identifiable by their large, red badge
- Older people's wards have a ward round by matron and meet matron sessions
- We have allocated volunteers to specific wards and duties so wards know what volunteer resource they have to support them
- Ward managers or sisters are held to account for the performance of their wards when the expected standard of care is not provided.

**Cancer waits:** During the year we achieved eight of the nine cancer targets.

Small numbers of patients can disproportionately affect whether we breach the '62 day referral to treatment' target or not so we concentrated our efforts to make improvements.

Supported by a visit from the National Intensive Support Team, we carried out a review of our patient journey in order to reduce waits and improve overall patient waiting times and performance. Additional clinics, theatre sessions and diagnostic activity were also introduced during the year and as a result we have been able to deliver the '62 day target' each month since January 2012.

**Referral to treatment – 18 weeks:** The RTT (18 week wait) standards are that 90 per cent of admitted and 95 per cent of non-admitted patients should start consultant-led treatment within 18 weeks of being referred.

Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment. We agreed with our commissioners to a deliberate reduction in admitted performance to increase activity in quarter 3 and 4 to reduce the number of patients on an 18 week backlog and 26 week backlog.

Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required and we achieved the non-admitted target every month.

**Readmissions to hospital:** A readmission within 30 days of discharge is seen as a quality marker for an organisation. However, not all readmissions are avoidable. There are many readmissions that are necessary for continuing to deliver quality care and save lives. Avoiding readmissions is a key priority for the whole health economy, meaning that hospital teams, GPs, and community teams need to work together to better support patients within the community and reduce readmissions where they are avoidable.

We are continuing to work to reduce the number of readmissions and this work is supported by partners from health and social care. We have carried out work to improve patient pathways, including the Elderly Frailty Unit (EFU). Staffed by a dedicated team of geriatricians this unit enables the transfer of elderly patients to the most appropriate care pathway, either in the acute setting or community.

Working with the Emergency Department team, the unit will have avoided approximately 1,200 admissions through:

- implementing proper assessment and discharge processes
- ensuring appropriately skilled clinical teams for older people
- developing good working relationships with community partners.

The readmissions project will continue next year with the aim of reducing readmissions by ten per cent across Leicester, Leicestershire and Rutland. . This will be delivered by:

- working with clinicians, commissioners, and partners to undertake clinical reviews of readmissions to provide visibility on avoidable readmission groups
- using risk stratification to allow the targeting of such groups for intervention on discharge
- supporting senior medical assessment of potential readmissions
- ensuring improved communication with patients on discharge, ensuring they have a contact point as they leave
- working with partners and commissioners to ensure the effective targeting of resources in the community to support a reduction in readmissions.

**Primary Percutaneous Coronary Intervention (PPCI):** PPCI is the preferred treatment for patients with acute myocardial infarction (more commonly known as a heart attack). By changing our processes we have been able to improve our performance and 86.7 per cent of eligible patients had a PPCI within 150 minutes of calling for professional help (against a target of 75 per cent).

**Avoiding preventable hospital acquired pressure ulcers:** Our aim was to eliminate preventable hospital acquired pressure ulcers by demonstrating a 5 per cent reduction each year. By March 2012 we had reduced incidences by 36 per cent compared to the same period in the previous year.

This was achieved with targeted training in the areas with the most pressure ulcers from the Tissue Viability (TV) teams (nurses who specialise in the prevention and management of

wounds and pressure ulcers). The TV team have also worked with physiotherapists, other therapy teams and theatre staff to improve their knowledge and raise awareness of their impact on maintaining good pressure area care of patients in their care.

Our aim is to maintain a zero tolerance to avoidable pressure ulcers and we will continue to reduce the number of hospital acquired ulcers over the next twelve months.

**Accident and emergency performance:** It has been a challenging year for our A&E (also know as emergency department/ ED) and 93.9 per cent of patients were seen, treated or discharged within four hours. This figure includes the patients seen within the Urgent Care Centre, co-located to ED at the Royal. In November 2011 we introduced new clinical roles and a new pathway called “Right Place, Right Time” in response to a consistent underachievement of the 4 hour target. This initially resulted in a considerable improvement in our emergency department performance. However, following a number of challenging weeks of activity, with attendances to the department 5 per cent higher and emergency admissions 7 per cent higher this quarter (quarter 4) compared to the same period last year, our achievement of the target deteriorated. We will continue to strengthen our internal processes and will seek additional external support.

**Cancelled operations:** We are aware that cancelled operations can result in patient distress and are an inefficient use of our resources. As a result we have redesigned our processes so that every possible effort is made to avoid cancelling operations at the last minute.

During the year we cancelled 1.4 per cent of all of our operations at short notice for non-clinical reasons, which is similar to the previous year. The main reasons for short notice cancellations include ward bed availability, ITU/HDU bed availability, admission of a high priority patient and theatre list over-runs. The target for 2012/13 is to reduce the cancellation rate on day of operation to 0.8 per cent.

**Nursing metrics:** Nursing metrics are collected monthly by the senior nursing team across all clinical areas and include theatres, maternity and outpatients.

These metrics measure our standards of record-keeping for the core activities that we undertake for our patients.

- Pain management
- Patient observations
- Falls assessment
- Pressure area care
- Nutritional assessment
- Medicine prescribing and administration
- Resuscitation equipment
- Controlled medicines
- Venous Thromboembolic Disease (VTE)

- Patient dignity
- Infection prevention and control
- Discharge
- Continence.

The results are reported monthly to our Trust Board via the Quality and Performance report and have consistently improved and sustained their performance through rigorous monitoring led by the Nursing Directorate.

## We're passionate and creative

### **Research and development**

We continue to support research by being responsible for over 800 clinical research studies involving thousands of patients from Leicester and the surrounding area. There have also been notable successes for our research and development programme in the past year. These include the Leicester Cardiovascular Biomedical Research Unit (BRU) at the Glenfield Hospital, opened by the Secretary of State for Health Andrew Lansley in November 2010 which successfully received funding for a further five years. The Cardiac BRU research is set to include further studies and trials into better predicting those at risk of heart attack as well as trials to see if drugs can be developed to limit damage to the heart after a heart attack.

We have also been successful in securing funding for a further two BRUs. These prestigious awards were made by the National Institute for Health Research (NIHR) on the basis of a rigorous assessment of the quality of research by peer review panel of international experts. We are the only NHS Trust outside Oxford, Cambridge and London to hold three BRUs. In total we were awarded just over £19m for the three BRUs.

The Respiratory BRU aims to focus on the development of new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD). The award included just over £2m for a new facility to be built at the Glenfield Hospital site over spring and summer 2012. The wider respiratory research team continue to play a leading role in the Respiratory Translational Research Partnership, a national initiative that brings together the pharmaceutical industry and NHS in order to improve the discovery and development of new treatments. The group are also a major partner in a Medical Research Council funded project on pulmonary rehabilitation and have obtained major European Union funding for their work into the causes of respiratory disease.

The Nutrition, Diet and Lifestyle BRU is a collaboration with Loughborough University and the University of Leicester, focusing on research in new areas of physical activity research including the potential benefits of short periods of exercise, particularly in patients with type II diabetes and chronic kidney disease.

The Nutrition, Diet and Lifestyle BRU will be sited within the Diabetes Centre of Excellence at our General Hospital. Our diabetes research team is already one of the best in the country and leads the world in areas such as diabetes prevention and early detection. The integration of the BRU will serve to further enhance our reputation in this nationally important area of research.

Last year saw the development of plans for a dedicated oncology clinical trials unit and the refurbishment will be complete by April 2012. The Hope Unit has been part funded by the

local Hope Cancer charity and this research facility will be of direct benefit to cancer patients in the Leicester and the surrounding area.

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

The NIHR Collaboration in Leadership for Applied Health Research and Care (CLAHRC) hosted by the Trust involves every NHS Trust in Leicestershire, Northamptonshire and Rutland and continues to make a real difference in understanding how best to manage long term conditions underpinned by evidence-based providers and commissioners.

Success in the research and development arena is important to our patients because a vibrant research culture enables us to attract and retain first-class staff, obtain extra funding, improve quality of care and outcomes, and promote an evidence-based approach to everything we do.

### **Establishing a new dedicated clinical trials unit**

Our cancer centre regards clinical research as an essential part, driving innovation, underpinning quality and attracting high quality staff. We currently run two collaborative clinical trials units with a large portfolio of phase one, two and three National Cancer Research Network (NCRN) and commercial trials. Studies are focussed on National Cancer Research Network protocols, and a variety of early trials in both haematological and solid tumours. A particular strength is the phase I programme of novel agents – many developed as an experimental cancer medicine network centre from laboratory research in Leicester.

The development of this unit will ensure that Leicester consolidates its position as a leading research and trial provider within the East Midlands and will provide the basis for further development in partnership with Cancer Research UK and commercial companies.

Over the next five years we expect to see a ten per cent increase in the numbers of patients recruited to trials every year. In line with the national agenda, the focus will be to engage with industry with a specific focus on randomised controlled trials and earlier phase studies designed through the NCRN alliances with Industry. The development of the unit is crucial so that Cancer Research UK renew our Experimental Cancer Medicine Centre status. The infrastructure provided by the unit will ensure that experimental cancer medicine network study activity continues to progress.

Patients will be given the opportunity to participate in a far greater range of studies, leading to improvements in patient care, and outcomes, in recruitment and in the revenue generated.

## **Releasing time to care, the productive ward**

*Releasing time to care* – the productive ward has been started in 66 wards and areas over the last three years. We currently have 59 wards taking part in the programme as some wards have closed or been relocated and have yet to restart in their new location.

All the wards start with 'Knowing how we are doing' and concentrate initially on auditing of the Early Warning Score (EWS) standards, which has improved in line with the Nursing Quality Metrics. Wards are now developing this module and delving deeper into quality concerns and using the tools of the programme to improve care standards

Areas of improvement can be seen across all the wards, the most noticeable improvements come through the 'Well Organised Ward' module which wards have embraced. It allows them to reorganise their resources around their work processes, creating more space which has been a significant benefit and has helped create much needed Retreat Rooms on wards.

Through the implementation of the medicine module in cancer and haematology, standards have been raised and drug trolleys reintroduced to standardise the process and improve safety and patient experience. This has been adopted by many wards doing this module.

We've been able to improve discharges on the maternity unit at the General Hospital with the development of a DVD for all mums and partners to watch, giving them information on baby care and feeding.

*Releasing time to care* is no longer just for nursing staff. Medical staff are now getting involved through the ward round module by contributing towards improvements in the process with improved communication and better access to information. The facilitators are starting to work with the medical teams in Haematology and the Clinical Decisions Unit to assist them to examine their working processes and how, by using the tools from *Releasing time to care*, these can be improved.

Shift handover is one of the most popular modules and releases significant time on all the wards that implement change allowing the time saved to be reinvested in patient care. One ward increased the time they spend on bedside care by 8 per cent after they changed their handover process by using a new generic electronic handover. We are supporting wards in their transition to this new format.

We developed and piloted a new module with the Patient Experience team to explore if the *Releasing time to care* approach could improve patient experience. Whilst the module itself did not meet our expectations we developed closer links between the teams. Now we encourage all wards to focus on implementing change to improve the experience of their patients.

During 2012 we expect all wards on phase one and two to complete all of the modules. New areas are set to join the programme, and in April we started phase nine with further phases to be rolled out later this year.

## **Volunteering**

Leicester's Hospitals has had volunteers for ten years. We currently have over a 1,000 people who dedicate their time to helping our staff, patients and visitors in many different ways.

Many volunteers help on wards with practical tasks such as helping to make beds, giving out drinks, helping patient's complete surveys and helping with the mealtime process. Others volunteers help in public areas showing people to different locations within the hospital. We have buggy drivers, hairdressers, ward visitors and library volunteers, Time for a Treat volunteers who give hand massage and manicures, as well as those specially trained to support patients with dementia.

When we ask patients what they would most like from volunteers the overwhelming majority ask for volunteers to sit with them, to spend time listening and talking so all of our roles incorporate this as the most important element.

This year the team carried out a review to find out if patients and staff were aware of all of the services that volunteers offer across our hospitals. We carried out surveys carried out on wards and departments asking patients if they had received any support from a volunteer during their stay, how that volunteer had helped them and if they could think of any other ways that we might involve volunteers to support them. We met with senior ward and department staff to ask them about their experience of involving volunteers and the support and guidance that they had in place to manage this.

We also took the opportunity to ask current and past volunteers about their experience of working within Leicester's Hospitals – both good and bad - and how we could improve the structures that we had in place to recruit, train, and support them.

As a result we have formally linked volunteering and membership recognising volunteering as a way of fully engaging in supporting our organisation. This has included a regular section in our membership magazine promoting volunteers and the various roles they carry out. We have introduced a new system for recruiting and registering volunteers and worked harder to raise the profile of the role with the introduction of posters, clearer uniforms, and badges to make them more visible to patients and visitors. We've introduced a pilot project worker supporting ward based volunteers and staff especially around mealtimes, to provide a more comprehensive and effective service for patients and their families.

Finally, we have developed an action plan to ensure that we continue to provide a volunteer service that is flexible and responsive in meeting the needs of patients and staff within our hospitals.

## **Electronic prescribing and medicines administration**

We have introduced a safer and more effective way of prescribing and administering medicines by introducing an electronic Prescribing and Medicines Administration (ePMA) system to the haematology and oncology wards. Staff have told us the system is saving them time looking for prescribing information and also making it very clear what has been prescribed and given to the patient.

The new electronic system removes poor handwriting through replacement of the paper chart with an electronic system. It also saves time not having to find paper drug charts with the patient's medication history recorded electronically and available for both future referencing and the re-populating of subsequent drug charts. The clinical support module helps clinicians safely prescribe medications for patients by alerting them to medications the patient may be allergic to and reducing dosage errors. It helps reduce inappropriate prescribing and improves adherence to our medicines formulary. The electronic formulary\* helps prescription decision-making, providing an accurate electronic notification and recording of drug administration. It has improved communication between clinicians through the use of electronic review requests, alerting pharmacy with an instant notification when any new medications are prescribed. This allows them to order the appropriate drugs, preventing overstocking of our pharmacies, and of course there are the savings made on paper and printing costs!

We plan to roll this out across the rest of the Leicester's Hospitals over the next 12-24 months.

\* The main function of formularies is to specify which medicines are approved to be prescribed for specific conditions. The development of formularies is based on evaluations of efficacy, safety, and cost-effectiveness of medicines.

## **Leicester neonatal simulation training**

Our neonatal service runs one of the largest neonatal 'point of care' simulation training programs in the UK. Our team hold sessions every fortnight, where small teams of doctors and nurses take part in simulated critical events that they may face in their neonatal unit using state of the art high fidelity neonatal simulators. The sessions take place on the neonatal intensive care or on delivery suite, so that teams are trained in their real working environment. Teams get a debrief after each session so that they can reflect on what happened, what they did and what could have been done differently.

Our team were involved in developing neonatal simulation training across all of the neonatal units in the East Midlands. After receiving network funds of £100,000, our neonatal team designed a bespoke neonatal instructor course to develop staff. They bought ten neonatal

mannequins for the region and our simulation experts began to provide support and training to other hospitals in the region.

As a result of this project, the East Midlands became the first region in the UK to have a successful coordinated neonatal simulation training program working across all of the hospitals in the Central Newborn and Trent Perinatal Networks.

Commissioners in the East of England were so impressed with this program that in 2010 they approached our team to see if a similar project could be designed to cover their region. They secured an 'innovation grant' and the East of England 'Sim Plus' project started.

As national experts in simulation based training, our Leicester neonatal service has provided instructor training to senior members of medical and nursing staff from across the East of England. Our courses have been highly acclaimed and led to what is considered a highly regarded program being successfully delivered to staff across hospitals in the East of England.

Our Leicester Team have now trained over 80 instructors as well as providing over 450 simulation sessions to our local neonatal service. The simulation leads are currently working with the Resuscitation Council UK writing a new 'advanced resuscitation course' for newborn infants, are now members of a new technology enhanced learning committee formed by the Royal College of Paediatrics and Child Health and are the simulation representatives for the British Association of Perinatal Medicine.

Our staff receive simulation training every two weeks, particularly focussing on the complex human factors that are involved in a team managing a sick baby and the programme continues to improve the performance of our teams managing our tiniest patients.

## We do what we say we're going to do

### Patient information and liaison service (PILS)

Our patient information and liaison service continues to provide an invaluable service to patients, their relatives and carers when they wish to raise a concern, request specific information or indeed make a formal complaint about their experience in our hospitals.

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

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

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

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

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

### Complaints

During the year we received a total of 1723 formal complaints, 1152 verbal complaints, 66 concerns and 434 requests for information.

We endeavour to respond as quickly as possible to all requests, but to meet the allocated 10, 25 or 60 working day performance targets for formal complaints.

The table below identifies by Division and Clinical Business Unit how well we did:

**10 day and 25 day Formal Complaints April 2011 - March 2012**

Business Unit grouped by Division	10 day				25 day			
	Number received	No. replied within 10 days	No. replied over 10 days	% replied within 10 days	Number received	No. replied within 25 days	No. replied over 25 days	% replied within 25 days
<b>ACUTE</b>								
Emergency Department	7	6	1	86%	94	76	18	81%
Medicine	41	31	10	76%	245	219	26	89%
Cardiac, Critical Care and Renal	7	5	2	71%	85	74	11	87%
Respiratory and Thoracic	3	3	0	100%	56	48	8	86%
<b>Divisional average:</b>	<b>Total 58</b>			<b>78%</b>	<b>Total 480</b>			<b>87%</b>
<b>CORPORATE</b>								
Corporate and Legal Affairs	1	1	0	100%	2	2	0	100%
Facilities	28	20	8	71%	30	29	1	97%

Business Unit grouped by Division	10 day				25 day			
	Number received	No. replied within 10 days	No. replied over 10 days	% replied within 10 days	Number received	No. replied within 25 days	No. replied over 25 days	% replied within 25 days
Finance and Procurement	1	1	0	100%				
Nursing	4	4	0	100%	3	3	0	100%
IM&T	1	1	0	100%				
Operations	1	1	0	100%	2	1	1	50%
<b>Divisional average:</b>	<b>Total 36</b>			<b>78%</b>	<b>Total 37</b>			<b>95%</b>
<b>PLANNED</b>								
Specialist Surgery	87	87	0	100%	130	129	1	99%
GI Medicine/Surgery/Urology	66	65	1	98%	217	206	11	95%
Cancer/Haematology/Oncology	11	11	0	100%	29	29	0	100%
Musculoskeletal	21	21	0	100%	124	122	2	98%
<b>Divisional average:</b>	<b>Total 185</b>			<b>99%</b>	<b>Total 500</b>			<b>97%</b>
<b>CLINICAL SUPPORT</b>								
Theatres, Anaesthesia, Pain Management & Sleep	6	6	0	100%	24	24	0	100%
Pathology	4	4	0	100%	5	4	1	80%
Professional Services	11	10	1	90%	21	20	1	95%
Imaging & Medical Physics	16	16	0	100%	29	29	0	100%
<b>Divisional average:</b>	<b>Total 37</b>			<b>97%</b>	<b>Total 79</b>			<b>97%</b>
<b>WOMEN'S AND CHILDREN'S</b>								
Women's	6	6	0	100%	172	165	7	96%
Children's					54	51	3	94%
<b>Divisional average:</b>	<b>Total 6</b>			<b>100%</b>	<b>Total 226</b>			<b>96%</b>
<b>Totals:</b>	<b>322</b>	<b>299</b>	<b>23</b>	<b>93%</b>	<b>1322</b>	<b>1231</b>	<b>91</b>	<b>93%</b>

## Freedom of information

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

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

In 2011/12 we received 291 Freedom of Information requests and/or requests for environmental information, compared to 264 in 2010/11. Many of these requests contained multiple individual questions, with information therefore needing to be obtained from more than one clinical or corporate area of our organisation – the table below shows the number of times that different areas had to provide information during the year to respond to all of the individual questions within those 291 FOI requests.

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

<b>Freedom of Information/Environmental Information Regulation requests received between 1 April 2011 and 31 March 2012, split by Division/Corporate Directorate</b>		
<b>Area</b>	<b>Number of times asked to provide FOI data in 2011/12</b>	<b>Approx % of overall 2011/12 activity</b>
<b>Finance and Procurement</b>	<b>65</b>	<b>14.7</b>
<b>Clinical Support Division</b>	<b>61</b>	<b>13.8</b>
<b>Operations</b>	<b>42</b>	<b>9.5</b>
<b>Human Resources</b>	<b>41</b>	<b>9.3</b>
<b>Women's and Children's Division</b>	<b>37</b>	<b>8.4</b>
<b>Information, management and technology</b>	<b>29</b>	<b>6.5</b>
<b>Corporate Medical</b>	<b>29</b>	<b>6.5</b>
<b>Acute Care Division</b>	<b>28</b>	<b>6.3</b>
<b>Facilities</b>	<b>27</b>	<b>6.1</b>
<b>Planned Care Division</b>	<b>26</b>	<b>5.9</b>
<b>Corporate Nursing</b>	<b>24</b>	<b>5.4</b>
<b>Corporate and Legal Affairs</b>	<b>16</b>	<b>3.6</b>
<b>Research and development</b>	<b>8</b>	<b>1.8</b>
<b>Communications</b>	<b>6</b>	<b>1.3</b>
<b>Strategy</b>	<b>4</b>	<b>0.9</b>

*Many of the requests involve multiple Divisions/Directorates, so the numbers shown below are higher than the total number of 291 FOI requests received in 2011/12.*

## **Managing risk**

During 2011/12 risk management continued to evolve with an increased emphasis on providing effective risk management that is compliant with national standards and embedded within day to day working practice. We achieved level one compliance of the NHS Litigation Authority Acute Risks Management Standards in December 2011 providing assurance that we have robust policies and guidelines in place to guide good practice. It is our aim to achieve compliance at level two during 2013/14.

Evidence of embedded risk management practice can be seen by more pro-active management of risks at Clinical Business Unit (CBU) level with regular reporting of risks to divisional boards. We've also enhanced our risk reporting process, making the process more streamlined in the escalation of risks, where necessary, from 'ward to Board'

A dynamic and integrated Strategic Risk Register and Board Assurance Framework (SRR/BAF) provides our Trust Board with a monthly update of risks that are likely to impact

upon the achievement of our objectives and assurances that these are being adequately controlled.

A challenging cost improvement programme (CIP) during 2011/12 was underpinned by comprehensive risk analysis to ensure that patient safety and quality of care was not adversely affected by reductions in expenditure. CIP risks were identified and analysed at divisional level, with further challenge around these provided by corporate teams with subsequent reports to both the Quality and Performance Management Group and the Governance and Risk Management Committee.

During the year we received a total of 126 patient safety related alerts via the Department of Health's Central Alerting System (CAS). CAS alerts recommend actions to be taken within specified timescales in order to reduce the risk of injuries to both staff and patients associated with medical devices, clinical practice, etc. We have a robust management process in place for these alerts, enabling the progress of actions to be monitored and followed up in those instances where deadlines are missed. We achieved 91 per cent compliance in terms of closing the alerts within the timescales required and it is our aim to increase the compliance rate year on year.

### **NHS Litigation Authority Clinical Negligence Scheme for maternity**

Our Maternity Service was successful in demonstrating compliance with the level one requirements of the *Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2011/12*, scoring 49 out of 50. We would again like to congratulate them on achieving such a high score.

They have previously been assessed against Level 2 of the pilot *CNST Maternity Clinical Risk Management Standards* in October 2008. Since that time, the organisation has undergone significant restructuring which meant that many of their policies were no longer in line with the current standards. Therefore the service made the decision to apply for a level one assessment in order to ensure that their risk management structures were robust and to allow for implementation of the revised systems and processes.

In preparing for this mandatory assessment the team invested a lot of time and energy into revising many of the documents and this should aid progression to assessment at higher levels. On the day of assessment, the team were congratulated on the fact that the evidence template was populated to a high standard and the policies were well written and easy to navigate, with a standardised format that utilised flow charts and tables well, enhancing the staff's ability to find relevant information at a glance. A particular example of a well written policy is the *High Dependency in Maternity Care Document, June 2011*, which clearly directs staff as to their responsibilities in caring for women.

At level one, the assessor reviews our approved documents which clearly describe how risks are to be managed. A score is only awarded if the approved documents meet each of the minimum requirements specified within the individual criteria.

The maternity service was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at level one the maternity service was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The maternity service scored as follows:

<b>Organisation</b>	10/10 Compliant
<b>Clinical Care</b>	10/10 Compliant
<b>High Risk Conditions</b>	10/10 Compliant
<b>Communication</b>	10/10 Compliant
<b>Postnatal &amp; Newborn Care</b>	9/10 Compliant
<b>OVERALL COMPLIANCE</b>	<b>49/50 Compliant</b>

## **Information governance**

Given the importance of protecting patient data, information governance remains an essential part of corporate management for hospital Trusts.

In this context, we have made great strides to meet all the demands of the information governance agenda. This includes promoting enhanced patient confidentiality, to building information skills of all staff across our three hospital sites. A corporate marketing campaign, 'Danny's Data Day', saw all staff receive updates on the requirements to protect personal information. This has been complemented by new induction and mandatory training to set standards and update information governance services. A new focus on information risk management has enabled us to improve compliance with the standards set in the annual information governance toolkit.

Finally a new approach to sponsoring information governance within the organisation has seen the establishment of the Information Risk Governance Programme Board that will monitor for risks, threats and issues within the organisation. The information governance programme board will promote new information services and standards to deliver continuous improvement in this area. The benefit of these new processes enhances governance and accountability for information governance performance issues, engaging all parts of the organisation in the revised programme to raise the value of business information. The overall aims include improving the security of all personal information including patient data and to raise the value of business information so that staff can access the right information at the right time to deliver better services on behalf of our hospitals.

Information governance is continuing to support key governance initiatives as patients and partners become more aware of duties arising from the management of personal information. Information governance provides a framework to bring together all of the requirements, standards and best practice that apply to the handling of information, allowing:

- implementation of central advice and guidance;
- compliance with the law;
- year on year improvement plans.

At its heart, information governance is about delivering the right information to the right people at the right time. Our information governance strategy 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 handling activities;
- patient and service user confidence in care providers;
- employee training and development.

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

<b>Serious Untoward Incidents 2011/2012</b>			
<b>Level 3 SUIs (reported directly to the SHA/PCT/Information Commissioner)</b>		<b>2010/2011</b>	<b>2011/12</b>
		0	0
<b>Summary of other personal data related incidents</b>			
<b>Category</b>	<b>Nature of the Incident</b>	<b>2010/2011</b>	<b>2011/12</b>
1	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	1	2
2	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1	1
3	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1	1
4	Unauthorised disclosure	3	2
5	Other	0	0

## **Health and safety**

Protecting the health, safety and welfare of our employees, patients and visitors is very important to us. Health and safety is a fundamental part of our business and forms an essential part of our risk management strategy, which is led by our Trust Board.

This year we continued to ensure our staff, from every level across the organisation, received health and safety training appropriate to their individual role. Following advice from the Health and Safety Executive we have increased our monitoring of work related skin problems.

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

We produce our own in house bulletin “Safety Matters” which is circulated to all wards and departments to promote safety awareness and learning.

We are pleased that we have maintained the reduction in the number of reportable accidents to staff following last year’s success.

## **Emergency planning**

This year there has been a keen interest in emergency planning with the appointment of the head of operations, who has the overall lead for our emergency planning. We’re also planning to support his role with a full time emergency planning officer later on in 2012 so we can get our business continuity and emergency plans in place and tested.

It has been a busy year with a particular emphasis on planning with our partner agencies, including the Local Resilience Forum (Multi-Agency Partnership) in preparation for the Olympic Games. We have attended several training exercises within the local NHS community testing our ‘command and control’ structures and ensuring that all staff are becoming aware of the importance of emergency planning and business continuity. An example of this was Exercise Greystoke in Loughborough, a ‘live exercise’ organised by the Health Protection Agency looking at the regions response to a mass casualty incident.

This year we have also had to respond to the English Defence League and Unite against Fascists demonstration’s in Leicester ensuring that all our staff, visitors and patients were able to continue their work and treatments in safety.

During the next year will see a particular focus on business continuity and a continuation of planning for the Olympic Games and Olympic torch relay.

## **Improving relationships with GPs: getting better at what do we do, working better together**

Throughout the whole of the year we have been committed to improving relationships with GPs, with the primary aim of getting better at what we do and working better together.

In May we carried out our first GP survey to highlight to help where and what we needed to concentrate our efforts on, as well as highlighting what we do well and where we can make improvements.

Following the survey feedback we developed a plan, which has been relatively successful. GPs told us they really wanted us to get better at communicating with them, so throughout the year we have significantly increased our communications to GPs. This has taken the shape of GP newsletters, GP consultant summit/ forums, a GP referrers guide, electronic transmission of patient discharge/ outpatient letters to GPs, GPs can now see details of test results performed on their patients in hospital, GP practice visits and GP education sessions (face to face and via video).

In November six months on, we repeated the survey and GPs told us we’d made significantly improvements in our relationships with them and in our communication to them.

This probably reflects a growing belief amongst GPs that we are serious about improving the way we manage these key relationships, as evidenced by the appointment of the 'Head of Service for GPs' and the account management structure between our key directors and clinical leaders and the Clinical Commissioning Group leads.

There is a growing recognition amongst local GPs that we are an organisation that is trying to progress, get better at what we do, through working better with them. Credibility and trust still appears high on our fix list. Clearly the later two points will increase as our relationship with primary care evolves.

## **Electronic transmission of discharge summaries to GPs**

The clinical correspondence project was set up to improve the process of getting electronic discharge summaries to GPs following their patients' care in one of our hospitals. By moving away from paper summaries to electronic ones, we have improved not only the quality and legibility of the letters, but also ensure the information is available to GPs within 24 hours of the patient leaving hospital.

There are a number of benefits to moving to this way of working. We can improve patient safety with better data which can help to reduce the risk of drug errors, there are reductions in the delays to treatment, patients are better informed about their treatment, discharge information is available quickly if patients are re-admitted and letters are available when and where they're needed.

We have a number of targets and standards to achieve, and this way of working can aid achievement of these targets. Electronic records also reduce the number of queries or complaints about illegible forms from GPs. By just being entered once, we've seen a reduction in errors during transcription and they can be managed electronically within GP practices with no need for scanning. This template has meant that information is easy to find in letters, there will be a reduction in the cost of paper, postage and transport when the electronic system is full implemented and paper is switched off.

## **Maternity and gynaecology reconfiguration project**

Following a review of maternity and children's services in 2010 and the early part of 2011, our commissioners asked us to develop a robust business case identifying a long term high quality, value for money, equitable safe and sustainable maternity service.

It was soon recognised that the local health system wouldn't be able to afford a new maternity unit at an estimated cost of over £80m, so we agreed to develop an interim solution until 2014 pending future availability of capital funding. This solution needed to mitigate risks in our current services highlighted on our risk register including capacity, obstetric theatre environment, scanning capacity, midwifery and obstetric staffing levels.

In January 2011 the primary care trusts agreed to an investment of £1.6m. There has also been a commitment to a £3.7m of capital investment which increases delivery rooms,

inpatient beds, assessment capacity and elective theatre sessions in maternity and more inpatient beds, elective theatre sessions and an increase in treatment and diagnostics capacity in gynaecology.

To allow the expansion of maternity services we've needed to move some gynaecology from their space on level one (ward 1 and 2), Kensington building at the Royal. This work will be completed by April 2012 with further maternity reconfiguration and expansion completed by April 2013.

## **Procurement and supplies**

We've had a very successful year improving our contract positions in a number of areas in cardiology, orthopaedics and a very large range of medical and surgical consumables items. We have also been able to consolidate some things we started in late 2010 to rationalise the range of inspection and operating room gloves with the potential to generate very worthwhile savings.

We have come under significant pressures with increasing patient numbers and levels of illness, nevertheless by working with the staffing agencies we have been able to make significant improvements to rationalise and improve the management of the agency medical staffing resulting in very large savings in both costs and overall expenditure of between 30 and 80 per cent, with our approaches being mirrored by many other Trusts in the region.

There were lots of projects identified this year and we've adopted a structured engagement process with the clinical staff to identify, prioritise and drive through these ideas to make savings. These procurements have focussed on strategic change but have involved staff via the establishment of a Clinical Procurement Group which identifies, evaluates and help drives through the improvements. In this way local staff can see actual cost saving benefits in the items they use daily.

The demand for savings continues and whilst the Procurement and Supplies Team measure actual cost savings they are also looking to leverage far greater savings by improving patient experience. Ease of use, better reliability and improved safety reduces the total cost of staff time and materials and leads to better patient outcomes.

Often such projects take much longer than a year to select, evaluate, finalise contracts and implement which means that projects carry over benefits to future years. In 2012/13 we have already identified a potential of between £5.2m and £6.5m.

We continue to work with our suppliers to ensure that the process of supply is as simple as possible, getting the right discounts for the large volumes we buy and that payment terms are both fair and that we are able to manage our income effectively. We spend on average £1m per day with over 80,000 invoices a year. Difficulties experienced last year after another very busy winter meant that by early summer, our cash position reached a critical position. The payments terms were simplified to improve cash management and our

suppliers were very supportive during the summer when we had to extend payment times to restore the balance to cash flow.

Some simple changes were made to generate savings rapidly in some areas:

- 1) Ensuring prices rebates were received and monitored
- 2) Substitution of cheaper non clinical materials
- 3) Rationalising the number of stationery items and negotiating better prices
- 4) Ensuring that lowest prices in multiple contracts are applied right across the Trust
- 5) Synchronise end dates of multiple contracts with one supplier to reduce prices
- 6) Negotiate out automatic uplifts in price
- 7) Simplify and extend payment terms. For example some service contracts had been paid annually in advance
- 8) Take advantage of special volume deals providing improved prices or free products.

As we move forward the opportunities to repeatedly reduce prices will lessen without actual change to the care pathway. Whilst patient needs are always the priority we have got to consider how we improve the cost effectiveness of the services we provide and what are our core skills.

We are already tendering the provision of the maintenance of our facilities and provision of catering and domestic services, along with how we might improve the service and information provided by our IT systems as it needs to provide much more support in the planning or work force the availability of beds, electronic patient information and better communication with patients and GPs. We are also piloting a partnership for the dispensing of drugs to Outpatients in the hospitals with a high street pharmacy to bring better retailing skills into the Trust, and partnering with Nottingham University Hospitals to create one better and cheaper Pathology service across the region.

## We treat people how we like to be treated

### **Listening to our patients and improving their experience**

During the year we have engaged patients, our members and the wider public in a variety of ways, both within our hospitals and outside.

To manage patient and public involvement (PPI) across our organisation, each Clinical Business Unit (CBU) has nominated a lead senior member of staff. These PPI leads, supported by the PPI manager, take responsibility for coordinating and monitoring patient involvement, acting as a local PPI resource. For example our lead cancer nurse recently ran a focus group with patients using our breast care service. As a result of this engagement we have made changes to our discharge arrangements which has improved patient satisfaction with the service.

We have continued to work with our Patient Advisors and meet regularly with them. Patient Advisors are members of the public who are attached to specific areas of the Trust. They sit on a number of boards and committees as well as gathering patient feedback and providing a patient's perspective to clinical and managerial staff. Patient Advisor activity is very varied and this year has included work on car parking, complaints, outpatients and clinics and our executive ward "walkabouts".

In addition to our Patient Advisors we have recently created a new volunteer role which is dedicated to patient engagement. These service improvement volunteers will support patients to give feedback on their experience and will work with our staff to make sure the issues raised will be acted upon. We are initially trialling the role in two areas of the Trust, with a view to rolling them out as the year progresses. We have already recruited our first six volunteers and look forward to working with them on this new project.

Sometimes carers can feel that they are not adequately involved or that their needs are not fully met. To address these concerns, in December 2011 our Patient Experience team worked with CLASP the carers' centre to hold a carers' engagement event. Over fifty carers came along to the event which aimed to explore the hospital experience of carers and look for ways in which we might improve our service. We used the event to establish a set of priorities which we are using as a basis for action. We will be surveying carers again later this year and plan to hold a follow up carers' engagement event later in the year to share our action plan and continue to work together to improve carer experience in our hospitals.

Externally, we have well established working relationships with our local involvement networks (LINKs) and a member of our staff attends monthly LINK board meetings. A dedicated LINK working group meet with our chief executive bi-monthly to discuss issues raised by LINK members. Managers also meet separately with representatives of both City and County LINKs to share information and maintain good lines of communication. We also work collaboratively with LINK, for example, staff from our children's' hospital worked with the

LINK to explore school children's experience of hospitals. With the City LINK we are planning a joint health event and we have been working alongside our County LINK to improve engagement with children and people living in remote rural areas. We have also recently supported an event which looked at hospital care run by the Rutland LINK.

## **Older people's champions**

Our older people's champions are members of staff and volunteers who have voluntarily completed additional training to highlight the specific needs of the older person. We currently have around 1,400 champions working across our hospitals to improve the experiences of older people. Information regarding the role of the champion is publicised locally in the bedside information booklet supplied to all patients who are admitted to hospital.

In 2011 our Patient Experience Team went into the city of Leicester and around hospitals to speak to older people about what worries them about coming into our hospitals and how a champion could help improve their experience. This information was captured on DVD and is now used for champions training. We also took the opportunity to speak to our current champions and capture them on film talking about some of the excellent work they have done to improve the experience of older people they care for.

Champions receive newsletters throughout the year and they also have the opportunity to attend the 'Older People's Champions Celebration Event', where staff and volunteers share with others initiatives they have implemented in our hospitals and the community. We present a nominated member of staff for their outstanding work and champions can attend workshops to extend their knowledge on current issues relating to older people (for example, continence, dementia and end of life care).

We are currently developing a new Older People's Champion structure to ensure we have the right staff from all areas across Leicester's Hospitals and to support champions in their role.

During 2012 we are planning three Older People's Champions Forums which will allow champions to be updated on current national and local initiatives for improving care for older people as well as having the opportunity to voice any concerns they may have regarding care for older people in our organisation. This year's Older People's Champions Celebration Event theme will be dementia and will take place on 21 September 2012 to support the World Alzheimer's Day.

## **Improving the care of frail older people**

In the last year we have redesigned our acute services to try and help improve the care of our frail older patients. The two main services are the Emergency Frailty Unit (EFU) and the Frail Older Peoples' Advice and Liaison Service (FOPAL).

The development of EFU and FOPAL services at the Royal Infirmary make up the strategy at our hospitals for creating a 'frail friendly front door'. The aim of these services is to try to

improve the care received by frail older people in hospital and reduce unnecessary hospital admissions, lengths of stay and readmissions. Each of the services works to deliver comprehensive geriatric assessment for each identified frail older person, joining together doctors, nurses, physiotherapists, occupational therapists, primary care co-ordinators, physician assistants and discharge specialists to provide an integrated response. The services provide an assessment covering not only medical aspects but psychological, social, environmental and functional assessment. This assessment therefore does not only identify, treat and manage the patient's initial reason for presenting to hospital but also works to reduce readmission rates by looking at the patient holistically.

**Emergency Frailty Unit (EFU)** Our EFU is a central area within our emergency decisions unit designed to improve the quality of care and decision making for frail older people in the emergency department. It delivers a multidisciplinary assessment from nurses, primary care coordinators, therapists and geriatricians at the front door enabling patients to have comprehensive geriatric assessment at presentation to facilitate an appropriate patient pathway. Appropriate patients are identified by emergency department staff, who use the 'identification of seniors at risk' tool which is a questionnaire used to identify older people at risk of functional decline, institutionalisation and death following discharge from emergency department. These patients are transferred to EFU rather than admitted to our acute medical unit for assessment.

Every morning the multidisciplinary team do a ward round focussing on understanding a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for their treatment and follow-up. The length of stay for patients over 85 on EFU is 0.4 days, and the overall discharge rate for patients over 85 has increased by 20 per cent compared to last year. Our geriatricians work closely with the emergency department to provide support in assessing older people throughout the day.

We are currently developing an EFU outreach service which would see a primary care coordinator from the EFU work jointly with community teams to manage recently discharged high risk frail older people to ensure they receive the right care, at the right time, in the right place.

**Frail Older Persons' Advice and Liaison (FOPAL)** Frail older patients are identified for FOPAL intervention every day on our acute medical unit by specialist nurses. These nurses help manage timely discharges for patients with complex medical and social needs. The majority of their work is with frail older adults, their carers and relatives, as well as social services, nursing and residential home staff. Once a patient has been identified and they have been seen by the acute medical team, the FOPAL team will start a comprehensive assessment. The FOPAL team is made up of a consultant geriatrician, physician assistant, physiotherapy and occupational therapy colleagues, but we hope in the future to expand the

team to include mental health colleagues specialising in older adults. A FOPAL review is not intended to repeat the work done in the emergency department or the acute medical unit team, but provides a comprehensive geriatric assessment for the patient. We have the time to look through past admissions, look for themes, and talk to patients, their relatives and carers, GPs, social workers. This investigative work can often be missed, not due to lack of wanting, but often lack of time. Once a FOPAL plan has been agreed for the patient a discussion with acute medical unit team leads to an agreed final management plan which can be put into place. This could be for the patient to be discharged home, with or without community interventions, or to go to a community hospital or a ward. Patients can be referred as necessary to falls prevention programmes, geriatrician clinic follow ups, district nurses, intermediate care teams and the myriad of community services available. Also issues such as advanced care planning can be instigated with patients, families and GPs to give patients a better quality of life out of hospital.

At the Royal Infirmary we are already seeing a substantial increase in older people attending our emergency department, with an increase of 8 per cent from 2010/2011 figures. EFU and FOPAL are helping to meet this challenge, and rising to the challenge of supporting healthcare provision for older adults across acute and community services in other ways and these include:

- Delivery of outpatient clinics, of which there are now 24 in place offering a variety of services across the City and County
- Support to City intermediate care services
- In August we began weekly ward rounds in ten community hospital wards, including working with community matrons on those at highest risk of adverse outcomes
- From July we began managing 5.5 acute wards across our hospitals
- Daily ward rounds and weekly multidisciplinary team meetings by orthogeriatricians to improve care to patients with fractured neck of femurs - our performance in this area has moved from bottom to top quartile.

## **Equality and diversity**

This year we became an early adopter of the Equality Delivery System (EDS), a new Department of Health framework which has been introduced as a means by which all NHS Trusts can deliver their Public Sector Equality Duty. We carried out our self assessment in September 2011 under the four headings of better health outcomes for all, improved access and experience, empowered, engaged and well supported staff and inclusive leadership at all levels. The assessment highlighted that we are achieving well in some areas with further work required in others.

**Representation in the workforce:** As part of last years equality programme our priority was to increase the representation of our workforce to better reflect our local community. Whilst this is a long term objective, we are pleased to report that we have seen a small increase

(one per cent) in the numbers of staff recruited from a BME background, particularly in the field of nursing

We also became a Project Search site, a national programme supported by the Department of Health providing work trials and potential employment for students aged 18-25 with learning disabilities. The project is managed in partnership with Leicester College, who provide the students and tutors and the supported employment provider Remploy, who provide an on site job coach to ease the students into their roles.

The purpose of the scheme is to improve the chances of employment for young people who have a learning disability. We've had a much better outcome than anticipated with 50 per cent of the first cohort of students securing permanent employment.

**Services:** We ran several events in 2011 inviting representatives from local black and minority ethnic (BME) communities, who were asked to identify their equality priorities for the 2012-2016 equality work programme. These were: better access to language support, improving our written information, and increasing the availability of equality training. By adding an additional computer based equality programme training to our menu, the number of people receiving training has increased.

In relation to improving services there have been several successes that we believe have enhanced the patient experience. These are: the Learning Disability Nurse Specialist team who have supported over 200 patients with complex needs this year; the introduction of a new care pathway for patients with a learning disability and who require a general anaesthetic for their feeding tube replacement; the increased use of our interpreting service, which on average provides 400 interpreting sessions for patients per month. We have also increased the number of patient information leaflets available in an easy read format and alternative languages and now hold a library of 140 easy read and translated patient information leaflets. Following patient feedback we have replaced and installed new hearing loops in over 30 locations on all three hospital sites.

## **Emergency triage service**

The teams in our Planned Care Division reviewed their surgery length of stay figures and discovered there were a high number of emergency surgical/ urology patients who were staying in hospital for 24 hours or less. It is believed that many of these patients do not need to be admitted but require different treatment pathways.

The team initially introduced a nurse led triage in surgery at the General Hospital. The merging of the surgery and urology emergency services and surgical triage has reduced emergency admissions by an average of 30 per cent. This initiative is now being extended to urology, led by senior nurses at the General. The process allows nurses to fast track blood samples and requests for scans enabling the medical teams to make decisions in a timelier manner and preventing unnecessary admissions.

Patients are initially assessed very quickly by the nurse, helping meet our internal professional standards, but it also means that patients receive treatment and are not admitted to hospital unnecessarily.

We're still in the early stages of implementing a similar triage service at the Royal Infirmary, but already have a dedicated area set up specifically for triaging patients and a medical champion to help embed the process.

## We're one team and we're best when we work together

### Our staff

We have a total of **10,029** substantive staff in post (as at 31 March 2012). They are broken down into the following groups:

	2011/12	2010/11	2009/10
Medical and Dental	1,496	1,477	1,496
Administration and Estates	1,953	2,054	2,104
Healthcare Assistants and other support staff	2,033	2,117	2,284
Registered Nursing and Midwifery	3,338	3,301	3,261
Scientific, Therapeutic and Technical	1,208	1,222	1,278

### NHS staff survey

Early on in the year we received our 2010 national staff survey results and we looked at them against were reviewed together with our internal staff polling results and went on to develop our 'Staff Experience – 8 Point Acton Plan' (2011). This plan will be reviewed through the Staff Engagement Steering Group with the 2011 results as highlighted below. This work will also be key to the revision of our Organisational Development Plan.

Staff Survey					
Response Rate	2010/11		2011/12		Organisational Improvement / Deterioration
	Organisational	National Average	Organisational	National Average	
	52%	55%	46%	52.50%	Decrease by 6%

Staff Survey - Top 4 ranking scores					
Top 4 ranking scores	2010/11		2011/12		Organisational Improvement / Deterioration
	Organisational	Acute Trust National Average	Organisational	Acute Trust National Average	
KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	99%	95%	96%	96%	Slight Deterioration
KF12. Percentage of staff appraised in the last 12 months	90%	78%	90%	81%	No change (In best 20% of Acute Trusts)
KF14. Percentage of staff with personal development plans in last 12 months	78%	65%	78%	68%	No change (In best 20% of Acute Trusts)
KF24. Percentage of staff experiencing physical violence from staff in last 12 months	0.1%	1%	1%	1%	Slight Deterioration

Staff Survey - Bottom 4 ranking scores					
Bottom 4 ranking scores	2010/11		2011/12		Organisational Improvement / Deterioration
	Organisational	Acute Trust National Average	Organisational	Acute Trust National Average	
KF29. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell	33%	26%	28%	26%	Improvement
KF36. Percentage of staff having equality and diversity training in the last 12 months	28%	41%	38%	48%	Improvement
KF10. Percentage of staff feeling there are good opportunities to develop their potential at work	37%	41%	36%	40%	Slight Deterioration
KF7. Trust commitment to work-life balance	3.33	3.38	3.28	3.36	Slight Deterioration

In terms of the four top/ bottom ranking scores in 2010/11, the scores from the 2011/12 survey mainly either plateaued or there was a slight deterioration in the result. There was a significant improvement in equality and diversity due to a programme which was delivered across the Trust during 2011. However, we remain below the acute Trust average in this area and the plan is to further develop e-learning to support training and development in equality and diversity.

Overall the 2012/13 National Survey results require a focus on key findings (KF) relating to staff satisfaction, communication between managers and staff, and staff recommendation of the Trust as a place to work or receive treatment. We are actively reviewing the results to ensure that appropriate actions are agreed, implemented and reviewed.

## **Reducing staff absence**

During the year we had an average sickness absence rate of 3.54 per cent, which means an average of 421 of our staff are off work at any one time. Our target is now 3 per cent which represents around 357 staff off at any time. However, during 2011 we again had the lowest sickness rates of all acute Trusts in the East Midlands

We recognise that there are many positive benefits from improving employee health and well-being including include increased staff productivity, better morale and improved communication between teams. This in turn leads to better quality services, improved patient satisfaction and a decrease in staff turnover.

Our Health and Well-Being Strategy has a comprehensive programme of actions which support improved attendance at work through an in-house occupational health service, staff counselling service, fast track physiotherapy and health awareness sessions for staff.

Our At Work for Patients project (@w4p) continues work to support staff attending work regularly. This is closely supported by the staff lottery funded Health and Well-Being Programme, which continues to provide a range of holistic activities for staff such as healthy eating cookery classes, a variety of exercise classes focusing on different abilities, a 5-a-side football league, a book club, a badminton club, alternative therapies such as reflexology and aromatherapy. Staff can also bid for funds to enhance their working life.

## **Consulting staff/ staff engagement**

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

We are committed to listening and talking to all staff and value their views about working in our organisation. It is important that we understand what matters most to our staff and work to continuously improve their working life.

In January 2011 we launched our local staff polling initiative and during the year we have surveyed the whole organisation (twice). In addition the eighth national annual staff attitude and opinion survey was carried out between October and December 2010 and 1,500 staff were selected to receive the survey.

Results of both the national and local survey have been analysed and an organisational wide '8 Point Staff Experience Action Plan' was introduced in April 2011. This action plan identified key priority areas, provided a brief overview of findings and clearly stated actions and expectations for people working in our organisation (managers and staff) to help effect change and bring improvements.

Our Staff Engagement Strategy and 8 Point Staff Experience Action Plan, encompass integrated elements, such as appraisal and leadership development, which shape and enable successful and measurable staff engagement. All elements impact on each other to produce a synergistic effect that is "greater than the sum of its parts". This work is led by our Staff Engagement Steering Group with staff side representation and the Workforce and Organisational Development Committee, which is a sub-committee of the Trust Board and chaired by a non-executive director.

As a result of the tremendous effort by staff over recent months, we noticed in January 2012 a significant improvement in our appraisal rate, reaching 96.1 per cent, our highest appraisal rate to date. To sustain and continue to improve on this performance a number of actions have been agreed to help us achieve our target of 100 per cent. We are also currently working on a 'Manager's Guide to Talent Management', to embed succession planning and talent management across our organisation, which we hope will promote co-operation and enthusiasm for the process. This will be based on delivering a culture which promotes identifying and managing talent within the appraisal system.

Our Engaging Leadership Excellence Strategy (2010-12) outlines a framework to develop excellent leadership capability and capacity across the Trust. The strategy sets out the development provision for existing leaders and also outlines the direction of travel in relation to the ways in which we will develop our leaders for the future. Key progress during the year with integrated elements set out in the strategy is summarised below:

- We have set up our Leadership Academy. The 'Clinical Leadership Programme' is the next phase of our Leadership Excellence Programme and intends to reach some 160 clinical leaders over two years. Our first two cohorts of leaders have successfully completed the programme. A key part of the programme is the successful implementation of an 'improvement project' and so far we've seen improvements and successes in the respective areas for staff, patients and the organisation;
- A board development programme is in place to strengthen relationships between the board, sub-committees and the divisions;
- A 'mentoring master-class' has been designed and implemented, initially targeting experienced consultants. A framework is now in place to assign mentors to new

clinicians. In addition, medical leaders are offered training in financial management and work is underway in developing other key leadership development interventions.

- Nominated senior clinicians and managers have accessed leadership development programmes offered by the East Midlands Leadership Academy (EMLA). The EMLA have commissioned a leadership development programme through ARUP Healthcare Consulting, market leaders in providing leadership development for middle managers, senior managers and executives in health care settings. EMLA and ARUP are leading a two stranded clinical leadership programme “*Leading Clinical Services - Collaboration at the Frontline*”. It was launched in January 2012 and the first two cohorts are be made up of medical consultants and other senior clinicians.

The new NHS Leadership Framework was launched in August 2011 and offers a single overarching framework for all NHS staff. This is currently being piloted across the organisation in nominated divisional and directorate areas.

## **Learning and development**

To deliver ‘Caring at its best’ it is crucial that all our staff have access to the right skills and knowledge and we are committed to providing learning and development opportunities to all staff.

Our Learning and Organisational Development Team co-ordinates a wide range of courses working together with local colleges and private training providers.

Our Chief Executive, Malcolm Lowe-Lauri, has signed the National Skills Pledge, confirming our commitment to enable staff to gain the skills and qualifications that will meet our organisations needs and support their future career progression.

During the year investment in learning and development to the value of £268,000 has been supported through the regional Joint Investment Framework initiative which aims to deliver skills, learning and qualifications to improve patient care and the delivery of services.

We are keen to support staff both personally and professionally with learning opportunities from the day they join us. In addition to comprehensive induction training and annual refresher updates, we offer a diverse range of learning opportunities.

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

Our Annual Training Awards Ceremony allows us to celebrate the achievements in learning and development of our staff. At our recent annual event, held in March 2012, 178 learners were presented with certificates for successfully completing vocational, skills for life, information technology or management qualifications. A number of special achievement awards were also presented by executive and non-executive directors.

**Apprenticeships:** Over the past 18 months we have employed 86 apprentices in a variety of roles including, administrators, porters, maternity care assistants, medical records assistants, ward clerks and plaster technicians. We have identified nine more posts for apprentices and our new young recruits will have joined us before the end of March 2012. During 2012/13 we anticipate a further 30 apprentice starts and we will be piloting a Health Care Assistant Apprenticeship Programme, following successful models in other regions.

**Work Experience:** We are reviewing how we enable those wishing to gain work experience in all areas of our organisation. A task group has been working for the past few months to improve our provision and centralise the application process to maximise opportunities across our organisation.

The task group has finalised the 2012/13 programme for work experience including provision for year 10 and 11 students, degree graduates on clinical programmes and those undertaking health and social care courses.

Did you know that only 7 per cent of people with learning disabilities nationally are being employed? We have a partnership with a local college and employment organisation developed and delivered a comprehensive 'ready for work' programme. So far we have helped four students find permanent employment.

## **Reward and recognition (including staff awards)**

We recognise that our staff are the most valuable resource we have and are key to the delivery of high quality services for the benefit of our patients.

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

Each day our staff and volunteers inspire others and deliver beyond expectations and make a difference to patients, their families and the communities we serve. It is important that we recognise and reward this excellence.

This year we set out to celebrate more staff more often and we launched our 'Caring at its best Awards' in September 2011. These new awards reward our inspirational staff who are living our values and deserve recognition for their outstanding success and commitment to providing 'Caring at its best'. The new scheme will see us rewarding more staff than ever before by moving to quarterly awards and an annual ceremony in September 2012. Our 'Caring at its best Awards' reflect six categories, one for each of our values (staff nominated) and the 'Caring at its best' category which allows members of the public to nominate someone who has touched their lives.



The nomination process opened in September 2011 and our first six outstanding staff and teams were awarded in December 2011. This will be followed by more worthy winners in March and then June. Every winner will then go on to the annual ceremony where the overall winner of winners for each of the categories will be awarded a trophy and prize. At our annual ceremony we will also take the opportunity to recognise our exceptional volunteers in a brand new category 'Volunteer of the Year Award'.

## **IM&T strategy for the future**

Information technology is indispensable in many hospital areas today and highly successful hospitals utilise their information systems to achieve integral support of their clinical and administrative services. We have developed a new IT strategy to optimise the quality of services we provide, drive economic efficiency and ensure the support of high quality innovative clinical services. The strategy was approved in September 2011.

Over the next five years, we will be focusing on ensuring we deliver what we need today, focusing on getting ready for tomorrow's challenges and delivering the components needed to propel us forward, ensuring we supporting patients, process, people, partnerships, performance and profitability.

To help us deliver the future model we are looking to create a partnership with a world class IT services provider to both help use our current technology better and to ensure we delivery what we've set out in our strategy. We will be looking for significant improvement in our IT services and utilising these to enable the transformation of our organisation. Part of our future plans is the creation of a fully Electronic Patient Record (EPR) of which our new partner will assist with the procurement and successful implement. With the EPR in mind as the final destination, our strategy will invest in steps needed along this road, starting with the easier deliverables and building a forward momentum, that will enable us to achieve this as fast and as safe as possible. Three early steps already identified, which help remove our reliance on paper and paper based processes; moving us to a paper light stage ready for an EPR implementation are:

- the deployment of the Electronic Prescribing and Medicines Administrative Software (EPMA)
- the development of a clinical portal, and
- he development of an Electronic Document and Records Management System (EDRM)

## We focus on what matters most

### Infection prevention

***Our aim is that no person is harmed by a preventable infection.***

This year the Department of Health again reduced targets for two infections that patients can acquire. They required that we had no more than nine cases of MRSA bacteraemia (blood stream infections) and no more than 165 patients newly identified with *Clostridium difficile* (C Diff) during the year.

Every year since 2005, hospitals have been required to demonstrate reductions in these figures, but we have no way of knowing when the lowest numbers achievable will have been reached, as not all patient infections can be prevented. However, we have been able to demonstrate a continued reduction in these infections in our hospitals up to now.

We continue to complete thorough investigations of any MRSA blood stream infections and C Diff cases, which are recorded on a patient's death certificate to make sure that we learn lessons and that these are fed back to ward teams for them to translate into actions.

Our C Diff liaison nurse continues to visit newly identified patients daily across our three hospitals and supports the clinical teams in managing these patients. Each patient's treatment is reviewed weekly by a multi-disciplinary team to ensure that there is specialist input into their care, and ward teams are also supported by our Infection Prevention Team.

We have also continued to screen both elective (planned) and non-elective (emergency) patients for MRSA in accordance with the Department of Health guidance.

Our infection prevention team continues to work with clinical colleagues to embed good infection prevention practice at ward level. All of our clinical staff are required to complete yearly mandatory infection prevention training.

During the year we launched a new infection prevention poster campaign to continue to highlight our priorities which are:

- effective hand hygiene
- ensure we provide a clean environment for our patients
- follow our infection prevention policies and guidelines
- prescribe antibiotics appropriately
- ensure our clinical staff practise Aseptic Non Touch Technique (ANTT). This is a technique that aims to prevent the contamination of wounds and other susceptible sites, by ensuring that only uncontaminated equipment, referred to as 'key parts' or sterile fluids come into contact with susceptible or sterile body sites during clinical procedures.

The cleanliness of our and your environment is very important to us. We monitor our environmental cleanliness against compliance cleaning standards and plan to complete a

deep/ steam cleaning programme across our hospitals, which can take up to two years to complete in an organisation of our size.

Decanting patients to another ward and having a completely empty environment has been possible in previous years but was increasingly challenging this year with our hospitals busier than ever. Our service provider, ISS, at the Glenfield Hospital in collaboration with our facilities colleagues, have opened a Patient Equipment Centre (PEC Centre) where equipment can be taken and thoroughly decontaminated before it is returned to the ward areas. This allows a bay by bay approach to deep cleaning and reduces service disruption. We are very proud of this innovation.

Minimum cleaning frequencies across our hospitals continues in line with national guidance and Patient Environment Action Team (PEAT) inspections are carried out on a quarterly basis.

Making sure we have clean equipment and instruments is of course a priority and we closely monitor the process through an audit programme that links to the national decontamination guidelines.

## **Clinical research in the Department of Infection and Tropical Medicine**

The Department of Infection and Tropical Medicine plays a very active role in clinical research and has extended its research portfolio over the past 12 months. The principal areas of research are in HIV infection, hepatitis C, tuberculosis (TB), and *Clostridium difficile*. The department participates in a number of portfolio studies including the MRC START and PIVOT studies which are investigating the optimum time to start antiretroviral therapy and whether it is possible for patients to maintain virological control on one class of drugs (the protease inhibitors) once they have achieved undetectable viral levels on combination treatment. The Department is part of the UK-CHIC database of infected patients, which has followed a cohort of several thousand patients over the past ten years generating numerous publications. They are also part the Trent Hepatitis Study Group which has investigated epidemiology and outcome of hepatitis C infection over the last 20 years and is soon to become part of a national hepatitis C group (HCV UK)

Professor Karl Nicholson and his research team have had a long-standing interest in influenza and other respiratory viruses and the advent of swine flu has boosted recruitment to vaccine and virus transmission studies. They have continued to investigate the effectiveness of a H5N1 (bird flu) vaccine study as the next pandemic could occur at any time. These novel vaccine studies require healthy volunteers and many of our staff participated in this research.

Studies involving basic science have involved collaboration with scientists at the University of Leicester, De Montfort University, Imperial College London and other centres. These studies include the IDEA study which is investigating the use of interferon-gamma release

assays in the diagnosis of active tuberculosis, improved bacterial culture for TB and changes in the gut bacterial flora during attacks of C.difficile infection.

## **Advances in the management of chronic hepatitis C infection**

Hepatitis C is one of the most important blood-borne virus infections with an estimated 216,000 infected patients in the UK, many of whom are unaware of their infection. The infection can cause chronic liver disease, resulting in cirrhosis, liver failure, liver cancer and death. In the majority of cases the infection can be cured with a combination of interferon and ribavirin for six to 12 months. Treatment is difficult and requires supervision and support from the hepatitis team. All patients referred with hepatitis C in Leicestershire are seen in a multidisciplinary hepatitis clinic involving Infectious Diseases and Hepatology specialists. Recent advances in the management of hepatitis C have focussed on increased testing and easier access to treatment.

This year we have been successful in a bid for a one-year trial for a community outreach specialist nurse to improve testing, assessment and treatment of patients in community settings including local prisons and drug treatment centres

We have also introduced new drug treatments, such as the directly acting antiviral agent's telaprevir and boceprevir which were licensed in 2012 and have been approved for us to use. These drugs have greatly improved the rate of cure in difficult to treat patients with genotype 1 virus

We commissioned a Fibroscanner for non-invasive assessment of liver fibrosis, which has great benefits for patients as it allows a more accurate assessment of chronic liver damage and treatment response. This avoids the need for the patient to have a liver biopsy, which can be a potentially painful and dangerous procedure.

Leicester is one of the centres which successfully bid for a Medical Research Foundation grant of £2m to set up a National Hepatitis C database (HCV UK). This has been adopted onto our research portfolio and will provide important information on the natural history and outcome of hepatitis C infection.

## **Improving the experience of women in our maternity service**

This year, our head of midwifery, lead nurse and senior midwife team were keen to increase the opportunities for their patients to provide feedback on our maternity services.

The service already had in place 'comments cards', called 'Message to Matron', for patients to write their feedback on and post in boxes around our three sites. Alongside these they also developed 'You help us learn' cards for patients and staff to help gather their views and suggestions.

Working with the Patient Experience Team, it was agreed that the maternity service would be phase two of a pilot to use electronic methods to gather feedback from women. The project went live in November 2011, promoting it with posters. We gather e-mail addresses

and consent so we can email the survey or a link to it on our website. This electronic feedback gives us immediate access to information to improve services, rather than waiting for paper responses to be analysed. The survey is split into three sections, antenatal care, labour and birth care and postnatal care. Women can choose to complete one section at a time or all together at the end of her maternity journey.

We are pleased with the feedback we've gathered during January and February. We send out 827 e-mails and received 84 completed responses back. Positive themes were around how women felt they were treated with the questions about 'were you treated with dignity and respect' and 'kindness and understanding' both scoring highly. There is a national recommended question that we ask and we're pleased with the positive response we've got:

How likely is it that you would recommend this service to friends and family?	<b>Extremely likely</b>	<b>Likely</b>	<b>Neither likely nor unlikely</b>	<b>Unlikely</b>	<b>Not at all</b>	<b>Don't know</b>	<b>NA</b>
	13	4	1	0	0	1	-

So far its highlighted some area where we need to make some improvements, which appear to be around understanding choices for place of delivery, feeling involved in decisions around care, length of stay being too short and advice not always feeling consistent around infant feeding.

**Some examples of the positive and less positive comments are shown as here:**

*Excellent! Best experiences of my life thanks to the great care from the midwives!*

*A wonderful experience from start to finish, professional, experienced and genuinely caring team. Felt safe, comfortable and confident throughout.*

*I have had numerous appointments at the LRI ante-natal clinic due to hypertension and gestational diabetes, so have come into contact with a range of midwives, consultants, support staff etc, and have been pleased with my dealings with everyone - staff have been polite, friendly and approachable so I have felt comfortable to ask questions and request advice. My only complaint has been the length of waiting time for clinic appointments*

*Staff on post natal ward were excellent, very supportive, kind and attentive. I felt well looked after and that nothing was too much trouble.*

*Sometimes I had to ring several departments before speaking to someone who could help me. It wasn't clear who was responsible to make decisions about my care because I was under several clinics.*

*I felt that the service was a little under staffed to offer an excellent service. Staff made me feel safe and I had every faith in them, however I felt at times that I couldn't ask more questions as I didn't want to take too much time from the other patients*

## **Would you like to tell us what you think?**

To give us your feedback either:

Visit our website: [www.leicestershospitals.nhs.uk/patientexperience](http://www.leicestershospitals.nhs.uk/patientexperience)

Provide your e-mail address below so that we can send you a survey:

*\* Your e-mail address will not be retained, shared or used for any other purpose*

## **Electronic clinical handover**

Handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient or a group of patients from one clinical professional to another person or professional group. It is one of the most important steps in the care of our patients and where this is not carried out to the required levels it can be a key contributing factor for subsequent error or potential harm.

We currently capture our handover information in varying forms, either orally, paper based or stored on a computerised spreadsheet. The quality and depth of information recorded and how it is shared between staff can vary from area to area.

An electronic system or “Electronic Handover” can help remove inefficiencies of the varying practices by standardising what information is recorded, the manner in which it is recorded and how it is shared.

Working with key clinicians, an in-house electronic handover system has been developed by IM&T’s integration and development team based at Glenfield. The key benefits of an electronic clinical handover system are that it standardises work processes across the organisation; information is legible and readily accessible on any site 24 hours a day, 7 days a week; we are able to have a full audit trail and it facilitates communication between healthcare professionals.

All of this helps us improve the way we deliver patient care safely, for example, by highlighting acutely unwell patients

The planned care division has led on the development this system by working on the specification with IM&T and initially using it for weekend handovers during the autumn on a small number of medical wards to allow refinements to be made. In February the division rolled out the system to all of its wards for nursing staff and the new system will be rapidly rolled out to all areas across the rest of the Trust.

## **Education and training**

We aim to be nationally recognised for teaching, for our high quality education and training, ability to support patient safety and clinical service delivery via excellence in education and training, and our aims to develop educational innovation and research.

Being a high-quality training organisation is important in maintaining the quality and safety of patient care; it helps keep our staff motivated and enthusiastic and enables us to attract new and high-quality staff to our organisation.

There are several national changes on the horizon which will have an impact upon education and training in our region. The introduction of the new Local Education and Training Board (LETB) who will commission and quality manage education in South East Midlands and we will need to work closely with this new organisation.

There have been numerous education and training developments within the year, including the appointment of a new director of medical education, Professor Sue Carr who took over from her predecessor Mr Tom Alun-Jones.

In August we were successful in securing funding from the East Midlands Health Education and Innovation Cluster (HIEC) [www.emhiec.co.uk](http://www.emhiec.co.uk) to launch two innovative education projects aimed at improving patient safety and outcomes.

Improving outcomes in acute kidney injury, which is common in hospitalised patients and can lead to significant morbidity and mortality, has been a priority for us. A recent report *National Confidential Enquiry into Patient Outcome and Death (NCEPOD)* highlighted that there was a need for improved education and training in this area. We're collaborating on this project with Derby Hospitals and it will improve the recognition, early assessment and treatment of acute kidney injury using ward teaching, an e-learning package and other educational materials. Preventing avoidable acute kidney injury will improve patient safety and quality of care and lead to reduced costs incurred from prolonged hospital stays in these patients.

We have also been focusing on raising standards for falls and fracture management in older people. Falls in older people are associated with significant mortality and morbidity and there are proven educational interventions that can reduce the risk of falls occurring. The project will provide training to all care home staff in appropriate and timely assessments of falls risk and provide actions required to minimise such risks. Providing effective education on falls management will reduce the numbers of falls and subsequent fractures of the hip. These reductions will have significant costs savings to health care providers and enhance the quality of life for older people within care communities.

In September a new specification describing medical educational activities was developed to improve the description of education roles in consultant job planning. This will ensure that our consultant trainers have identified and protected time for the education and training of medical students and doctors, thereby improving the quality of education and training as required by the General Medical Council in the document "The Trainee Doctor". Better medical training is the cornerstone of better care and patient safety.

In January we opened a new library in the Jarvis Building at the Royal Infirmary. Increasing familiarity and availability of technology has led to the recognition that libraries need to move away from being solely repositories of hardcopy books and journals towards being more

flexible environments integrating a range of media to promote learning. Access to information electronically is environmentally sound and provides up to date and easily accessible information for healthcare staff. As an organisation we are adopting the use of more digital technologies, including the use of e-prescribing and recording of information in eUHL, which enables us to better provide more cost-effective services across all three of our hospitals. During the year we also refurbished our library at the Glenfield.

In April we look forward to launching new clinical tutor roles which will enhance education governance and quality, and will work to engage more closely with doctors in training.

## **Clinical education**

In the last 20 years medical and nursing education curricula has changed significantly. Both are combined academic and experiential courses that have reduced the practical aspects of healthcare practice, this coupled with the changes in healthcare delivery, has reduced the opportunities of healthcare staff to experience rare events that potentially have catastrophic results. This is no more evident than with the implementation of the European Working Time Directive (EWTD) which has dictated that junior medical staff, students and healthcare staff are not allowed to work more than forty-eight hours each week without adequate compensation or rest periods. In the “Time for Training” review document (Prof Sir John Temple, May 2010), training issues across the medical discipline were identified as poor dependant on rota compliance (Prof Sir John Temple, 2010 p14). The healthcare professional’s role and exposure to the multitude of clinical scenarios is far more limited than their previous peers.

There is an increasing emphasis placed on patient safety led by clinical governance and litigation. International papers inclusive of the Department of Health publication “*An organisation with a memory*” (DH 2000) and the United States Paper by Kohn also in 2000 “*To err is human*” demonstrate that there is a commonality experienced globally with regard to the root causes of adverse events within the healthcare arena. These papers both support the concept that the healthcare practitioner can learn from the mistakes that have been made previously within the healthcare environment and can prevent the same problems occurring on national and international scales by altering working practices and educational programmes, but most of all sharing experiences and ways to address issues or systems that can currently fail.

Exposure to rare and unexpected events through simulation training provides deliverers of healthcare with experience and mechanisms to cope with the potential problems that may be encountered in real life situations. Gaba (2004) defined simulation training as a technique and not a technology that could enhance real experience through guided experience. The experience of simulation training is often immersive in nature and can evoke or replicate substantial aspects of the real world in a fully interactive nature.

Our Clinical Skills Unit is running Multi-Professional High Fidelity Simulation (simulation suite based or native i.e. in the workplace) to provide essential training to train teams that work in teams and improve skills, confidence, communication and ultimately patient safety. We are researching the effect of faculty training at MSc level and the assessment of candidates and teams at PhD level.

Over the last two years the foundation year 1 (FY) doctor group has been able to gain experience in low frequency high risk situations in conjunction with the Outreach Team and the consultant body. We've had some really good feedback about this project and it is now a mandatory aspect of FY1 training in Leicester. Following this we have invited the preceptor nurse group to work alongside this team and we have been able to further strengthen this work by including our core medical trainees in this programme. We continue to work with all of our divisions as well as a significant amount of the professions allied to the medicine population, including physiotherapists and pharmacists. We have split the day into two sessions with two lectures and two simulations in each. Each are evaluated and debriefed with the intention of measuring candidates improvement from simulation one to simulation two. The intention is to train in the teams that would naturally work together in teams and give them the opportunity to improve clinical competence, decision making and communication skills which in turn improve the quality of care delivered to our patients increasing levels of patient safety.

## **Safeguarding adults and children**

Safeguarding is a complex area of practice, which centres on the needs of people. The circumstances that people find themselves in can be difficult and it is important that staff recognise this and act accordingly. Over the past year the number of cases which have been brought to the attention of the service, illustrate an increasing complexity.

Our safeguarding service continues to support frontline staff in the management of these, to ensure a supportive approach is adopted when managing safeguarding cases. It is not unusual for these cases to take a considerable period of time to investigate and conclude, and so we should not underestimate the resource that is required. In the past year frontline staff have been involved in a number of investigations, which as an outcome of their involvement, has helped to ensure that people are safe whilst in our care and following discharge home.

In the past year, we have seen an increase in the number of adult safeguarding cases reported to the service and a continued high level of complex child protection cases that our organisation has been involved in.

As reported in previous years, scrutiny of the services we offer to safeguard people is done by external agencies in 2011 and early 2012.

We have received two positive reports from NHS East Midlands, regarding the services we provide to safeguard children and adults. These confirmed that we are compliant with all key

safety indicators. These have also been confirmed through the Primary Care Trust quality review process.

The Care Quality Commission has also carried out an unannounced visit and three short notice visits to our hospitals, where safeguarding services were reviewed. These confirmed compliance with the safeguarding standards developed.

In the past year we have continued to work with partner agencies to develop services, of particular note has been the work to implement a multi agency safeguarding referral form and approaches to deliver multi agency training.

## Providing spiritual and religious care

Our chaplaincy service is a valuable part of our commitment to deliver "caring at its best" to patients and their relative's right up to the end of life. Chaplains support those who face emotional distress arising from questions concerning life, death, meaning and purpose - questions that can be acutely highlighted by illness and suffering. We ensure that a chaplain is available 24 hours a day, 7 days a week to support patients and families, especially around the time of death.

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

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

## Sustainability

We take the challenge of providing modern healthcare from sustainable facilities very seriously at Leicester's Hospitals.

We have a Carbon Management Implementation Plan, which was produced in conjunction with the Carbon Trust, as part of a national programme. We are also carrying out significant investment in capital projects which will reduce our energy consumption and carbon emissions

Our strategy concentrates primarily on building (energy and water); waste management; transport and procurement. The table overleaf focuses on our utilities consumption and costs over the last two years.

Description	2010/11	2011/12	Variance	Percentage change
Total energy usage (KWh)	136,183,606	128,208,289	(7,975,317)	(5.86%)
CO2 emissions (tonnes)	39,236	38,881	(355)	(0.90%)
Total energy cost (£)	£5,282,765	£6,479,603	£1,196,638	22.65%

The above table highlights that whilst overall we have reduced our energy consumption by more than 6 per cent the cost of energy has risen by over 23 per cent.

## **Energy and carbon management**

**Electricity consumption:** We have invested significantly in local metering. Many of our buildings and departments are fitted with 'smart' meters which provide accurate data which can then be interrogated.

**Lighting Levels:** We have identified further opportunities to reduce electrical consumption by investing in low energy light fittings. This coupled with the use of local sensors ensures that our lighting systems operate at maximum efficiency.

**Building Management Systems:** We have invested in the upgrading of much of our energy management systems ensuring that the most economical heating and ventilation control systems are in place.

**Green Travel:** We are currently providing a variety of sustainable alternatives to the car for all site users. Our aim is to provide alternatives for those who can make use of them, and ensure that sufficient car park provision is made for those who cannot use alternatives.

Some of the measures used so far include support of the Bike 2 Work week and inclusion in the city wide car sharing scheme. We provide clear information for patients and visitors accessing our hospital, in patient letters, posters, leaflets and our website.

Partnerships with local business and members of the local authorities is also in place including being part of Smarter Travel Leicester, a group of key organisations within the city that work together to promote alternative sustainable travel.

One of our major achievements is the continued provision of our shuttle bus service, known as the Hopper. Over 12,000 passengers use the service every week! We continue to review the service on a regular basis and have recently added a link with the park and ride buses and an additional stop between the Royal Infirmary and the General.

## **Waste minimisation and management**

In the last 12 months we have disposed of 1,917 tonnes of clinical waste to our Nottingham waste contractor for incineration, 95 per cent of which is recycled in providing steam which is utilised to produce further hot water for the Nottingham District Heating Scheme. The energy produced services over 4,000 properties within Nottingham. We provided 34 per cent of Nottingham's annual tonnage therefore providing 4,462,976 kWh a year towards the heating scheme.

We have disposed of 1,283 tonnes of general waste in the last 12 months. Our local company have well organised processes for sorting waste prior to it going to landfill, so only 27 per cent of that general waste went to landfill. This method of segregation and recycling avoids the need for us to segregate at source both saving time, space and money as well as proving more efficient.

We do however have “primary segregation” for cardboard, confidential paper, glass, non confidential paper, WEEE, and other special wastes. These wastes are directly recycled through our other waste contractors who collect, free of charge in most cases, from our sites. Over the last 12 months 398 tonnes (inclusive of the above special waste types) have been taken from our sites for recycling.

## **Estate developments**

During the past 12 months, our Estates & Facilities Directorate has been actively engaged in a number of significant capital schemes to support our move to a two-site acute take at the Glenfield Hospital and Leicester Royal Infirmary.

This has involved the refurbishing and upgrading of several wards allowing us to transfer the care of elderly and stroke patients to the Royal Infirmary. In addition, two new theatres have been built and commissioned for planned orthopaedic work to be carried out at the General Hospital

Significant developments have also been completed to expand our academic and research base which has seen the establishment of the Diabetes Centre of Excellence at the General and the building of a new Biomedical Research Centre and the work that has started on the impressive Cardiovascular Research Centre (CVRC) at the Glenfield.

Notwithstanding the above, we have recognised the need to continually invest and upgrade our current estate and we have significantly invested in a number of improvements, replacement and refurbishment schemes. This has included a major lift replacement programme at the Royal Infirmary, the installation of new ventilation plant and several major electrical upgrades across all three sites.

In summary, we have allocated over £5m to the refurbishment of our buildings this financial year and we have committed a further £8m a year over the next five years to improving our estate and its infrastructure.

The quality of services our Facilities Directorate provide to patients is paramount and, as such amongst many quality reviews, we carry out four Patient Environment Action Team (PEAT) visits a year, where our services across all three hospitals have been recognised as being of a very high standard.

In regard to future services, we are currently embarking upon a large-scale and ambitious procurement process to outsource of all our services to a single private sector partner. This project is in collaboration with other NHS Trusts in Leicestershire. We are on track to award the contract to the successful bidder in Autumn 2012.

## **Our priorities for 2012/13**

We are clear that in response to our performance in 2011/12 we must refocus on our core purpose to provide Caring at its Best. This purpose will drive our organisation over the coming year, and this will be underpinned by the following priorities:

- Improve patient experience
- Enhance clinical quality
- Strengthen staff engagement
- Transform the emergency care system
- Build transformational capability
- Develop a sustainable site and service reconfiguration
- Deliver all operational targets
- Achieve financial sustainability
- Continue our journey towards foundation trust status.

As a result of significant work with partners across Leicester, Leicestershire and Rutland to develop a shared vision, 2012/13 will see us working with stakeholders to design and deliver a local health system which cares for people when and where they need it most. This means redressing the imbalance between care that is provided in hospital and care that is provided in the community. It means looking after people and especially older people in ways which prevent them having to go into hospital.

## Our Trust Board

NAME	POSITION	INTEREST(S) DECLARED
Mr M Hindle	Trust Chairman	Board member, Health Protection Agency, and Chair of its Finance Committee. Son is a partner in Beachcroft LLP, who provide legal advice to the Trust (not directly involved).
Mrs K Jenkins	Non-Executive Director	Employee of Egg Banking plc (which is a part of Citigroup).
Mr R Kilner	Non-Executive Director	Director of Deltex Consulting Ltd; Member of the Patient Group for Countesthorpe Health Centre.
Mr P Panchal	Non-Executive Director	Board member of the Akwaaba Ayeh Mental Health Project; Company Secretary of the Leicestershire Ethnic Minority Partnership Ltd (charity).
Mr I Reid	Non-Executive Director	Poppy Day Collector for the Royal British Legion; Trustee of Bitteswell United Charities.
Mr D Tracy	Non-Executive Director	Lay member and Chairman elect of the Insolvency Practices Council.
Ms J Wilson	Non-Executive Director	Board Chair, Leicestershire and Rutland Probation Trust.
Professor D Wynford-Thomas	Non-Executive Director	Trustee, Hope Against Cancer (cancer charity, Leicester); Dean of the University of Leicester Medical School and Pro-Vice Chancellor, Head of College for Medicine, Biosciences and Psychology, University of Leicester.
Mr M Lowe-Lauri	Chief Executive	Trustee, Thomas Cook Children's Charity; Member, NIHR Advisory Board; Member, Life Science Innovation Delivery Board; Member, HEFCE Health Education Advisory Committee; Member, Kings Fund Advisory Board Member, Strategic Advisory Board, Loughborough University; Chair, East Midlands Collaboration in Management Sciences; Chair, Kings College Hospital Scientific Advisory Board PSSQ; Chair, NIHR Industry Forum Chair, NIHR/Wellcom HICF
Ms K Bradley	Director of Human Resources	None to declare
Dr K Harris	Medical Director	None to declare
Mrs S Hinchliffe	Chief Operating Officer/Chief Nurse	None to declare
Mrs A Tierney	Director of Strategy (post acts as adviser to the Trust Board)	None to declare

<b>NAME</b>	<b>POSITION</b>	<b>INTEREST(S) DECLARED</b>
Mr A Seddon	Director of Finance and Procurement	Spouse is an Equity Partner in Morgan Cole Solicitors, who conduct work for the NHS.
Mr S Ward	Director of Corporate and Legal Affairs (post acts as adviser to the Board as of January 2007)	None to declare
Mr M Wightman	Director of Communications and External Relations (post acts as adviser to the Board as of January 2007)	None to declare

### **Trust Board meetings**

Our Trust Board meetings are held in public and details of dates are on our public website. The meetings move between our three hospital sites, and both staff and members of the public are welcome to attend the public session of each meeting. During the year we held our Annual Public Meeting on Saturday 17 September 2011 at the Royal Infirmary, presenting the Trust's 2010/11 annual report and accounts and answering questions from the public. As part of the event on 17 September 2011, members of the public could also attend a health and wellbeing fair and take a guided tour of some of the hospital areas including neonatology and surgery units.

### **Openness and accountability**

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

## Operating and Financial Review

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

We provide hospital and community based healthcare services to patients across Leicester, Leicestershire and Rutland and specialist services to patients throughout the UK. As such, our main sources of income are derived from Primary Care Trusts, the National Specialised Commissioning Group and education and training levies. We are actively engaged with key stakeholders to implement NHS policy to improve health services in the local area through a range of formal and informal partnerships. These include the primary care interface group, networks with other providers, academic partners and with patients, members and public groups.

### Financial review for the year ending 31 March 2012

We met our financial and performance duties for 2011/12 by doing the following:

- **Balancing the books** - delivery of an income and expenditure surplus of £88k prior to a technical impairment charge of £28.1m following the revaluation of our property, plant and equipment.
- **Managing cash** - undershot the External Financing Limit by £0.4m which is permissible.
- **Investment in buildings, equipment and technology** - invested £17.8m in capital developments.
- **Invoice payment performance** – 89 per cent of our invoices in value terms were paid within 30 days.

### Performance against our financial plan

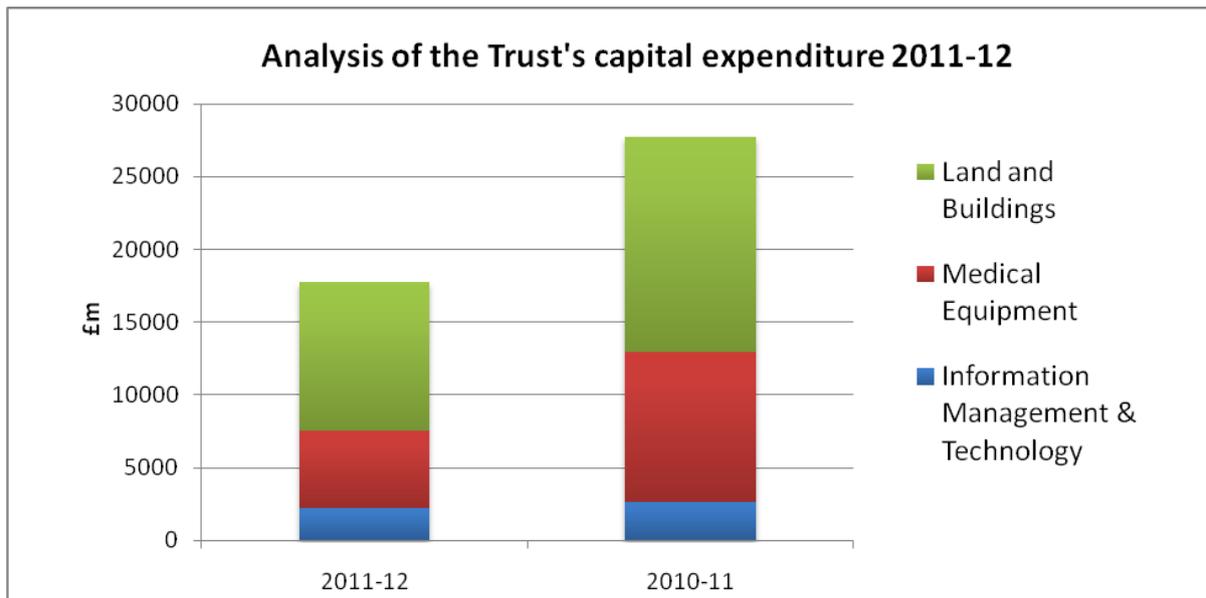
We delivered an £88,000 surplus result against a planned outturn of £1.3m. The plan included income of £680.4m and expenditure of £679.1m (excluding impairment).

The final year end position showed the following:

Total income:	£719.2m actual, £38.8m over plan of £680.4m
Total expenditure:	£719.1m actual, £40m over plan of £679.1m

### Capital expenditure

We spent £17.8m against a capital plan of £18.5m, detailed in the chart overleaf.



We also entered into a land swap in 2011/12 with a local NHS Trust for land and buildings valued at £19.8m. This was cash neutral for both parties therefore both the total fixed asset additions and disposals shown in the Financial Statements for 2011/12 include the £19.8m.

### Balance sheet

We revalued our land and buildings in 2011/12 resulting in a total downward valuation of £58.9m. In line with accounting guidance we have charged a £28m technical impairment to expenditure with £30.9m being charged to the revaluation reserve.

We planned to increase our cash holdings by £7.9m by the end of March 2012, which we have achieved with an actual cash balance of £18.4m at the year end.

Our debtors' position increased by £6.7m in 2011/12. Whilst 2011/12 has seen further improvement in our performance on debt recovery, there were several large debts outstanding with the local PCTs at the year end which have been received in April 2012.

Our underlying creditor position has been maintained with a small increase of £2.7m from the prior year.

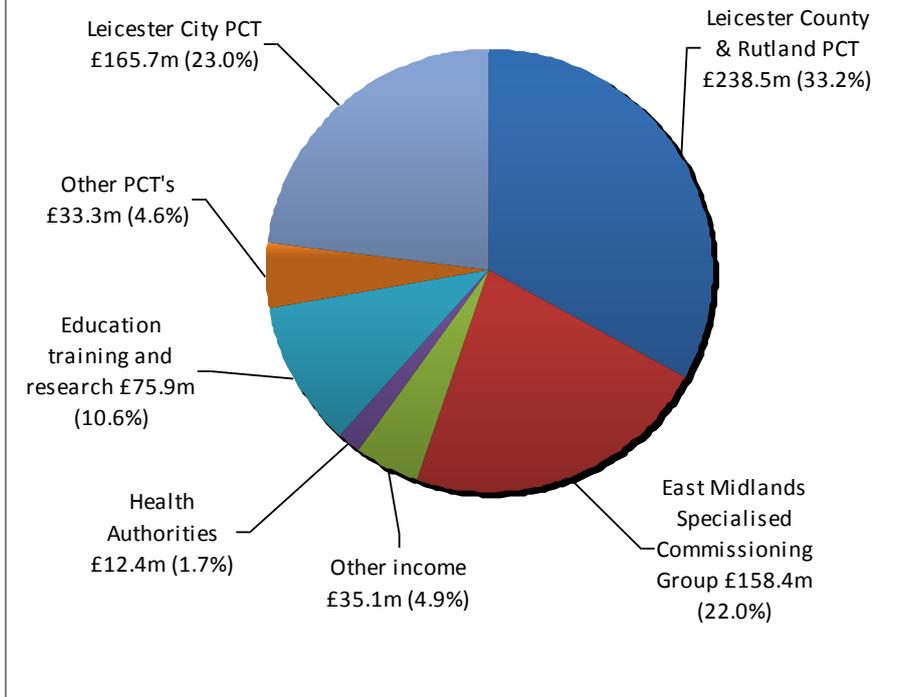
### Key Financial Indicators

#### Trust income 2011/12

The chart below details the £719.2m of income we received. This is a £9.4m (1.3 per cent) increase from the £709.8m received in 2010/11, reflecting:

- increased PCT income of £8.5m; and
- increased income from overseas patients of £0.6m due primarily to increased ECMO activity.

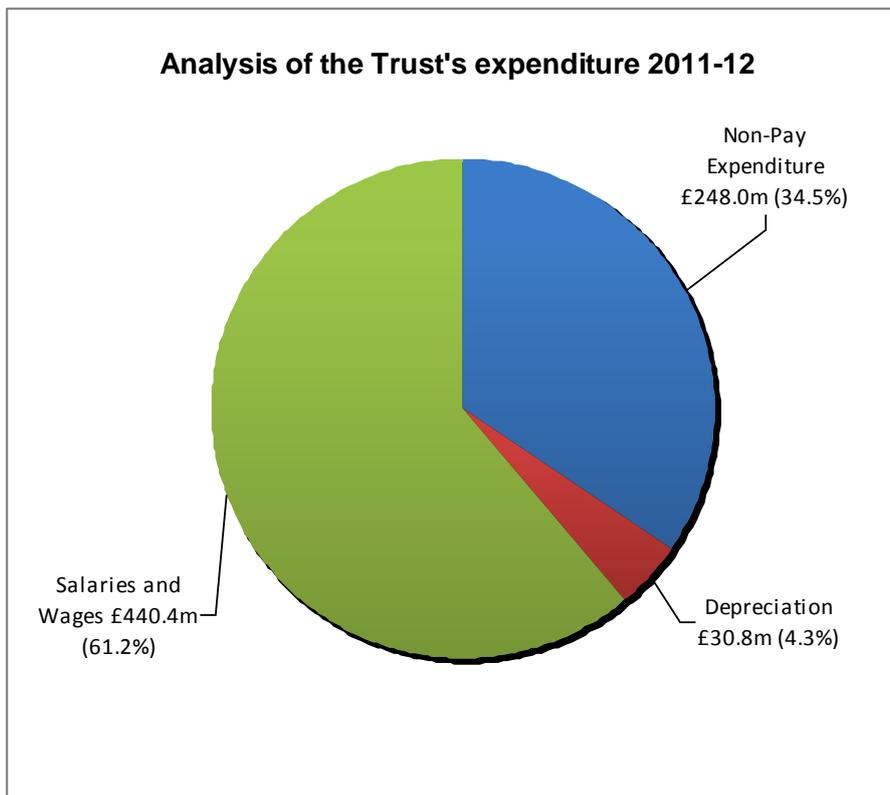
### Analysis of the Trust's income 2011-12



### Trust expenditure 2011/12

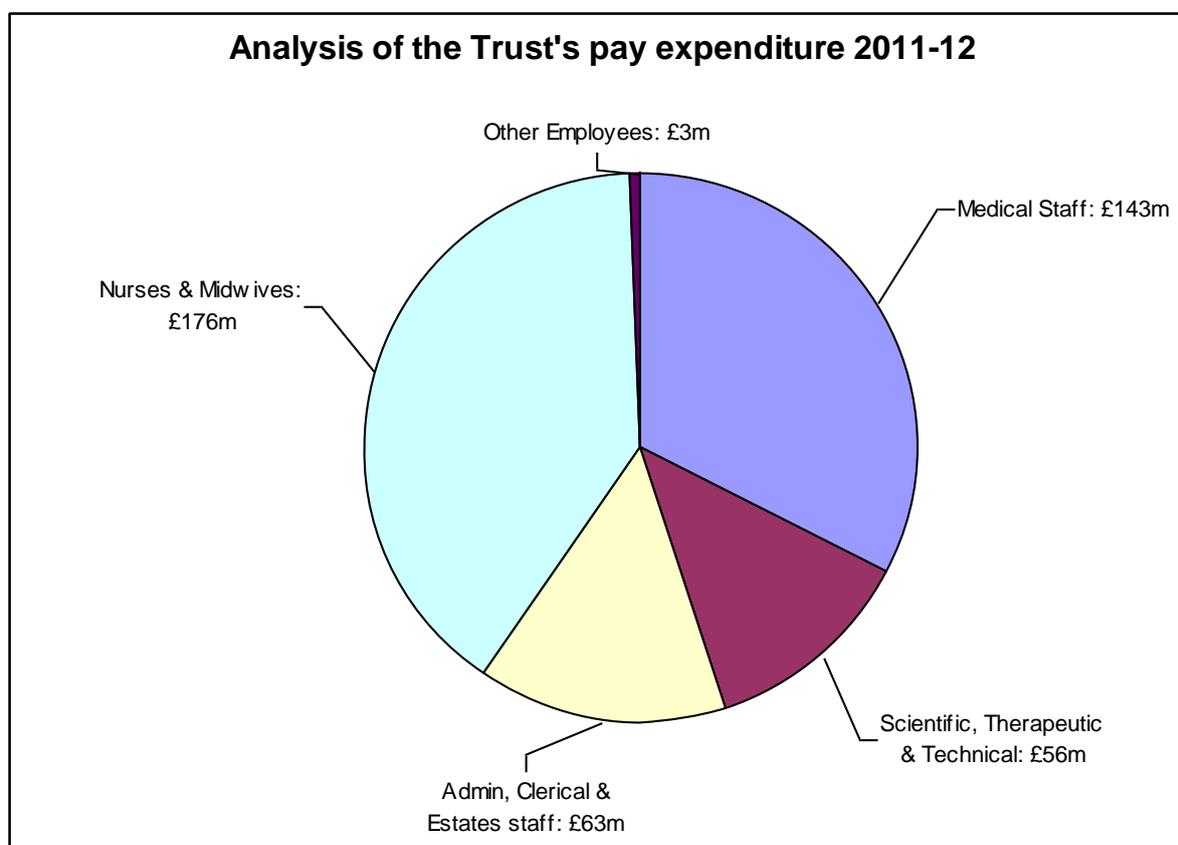
The chart overleaf details the £719.1m of total expenditure (excluding impairment) we incurred. This is a £10m (1.4 per cent) increase from the £709.1m received in 2010/11, reflecting:

### Analysis of the Trust's expenditure 2011-12



## Spend on pay by staff group 2011/12

The chart below shows our spend of £440.4m on pay for the year, which is a £0.9m decrease over the 2010/11 total of £441.3m.

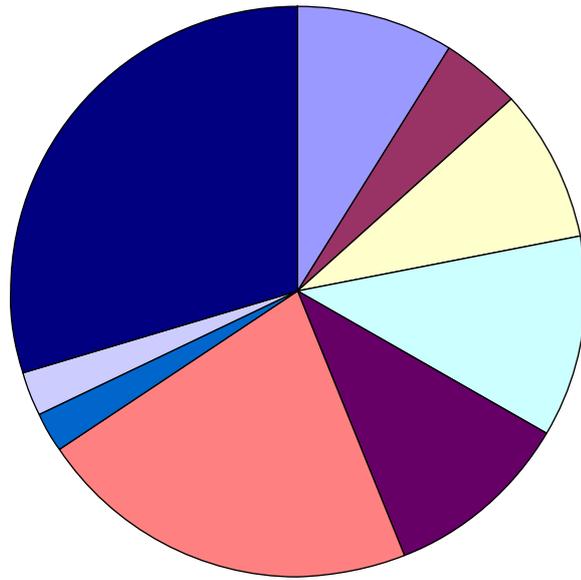


## Non-pay expenditure 2011/12

The chart overleaf shows our spend on non-pay (excluding impairment) for 2011/12 which was £279.4m, an £11.6m (7 per cent) increase over the 2010/11 total of £267.8m. This increase is due to a number of factors including:

- an increase of £8.4m on clinical supplies and services costs including additional investment in high cost therapies and drugs of £3.7m;
- an increase of almost £1.8m on premises and fixed plant costs as a consequence of the in year price increases in utilities predominately electric, gas and water and sewerage (£1.3m), and business rates of £0.3m; and
- an increase of £2m on clinical negligence insurance costs 2010/11 levels due to the inflationary increase on the contract and the Trust falling a level in the financial year thus increasing contribution costs.

### Analysis of the Trust's non-pay expenditure 2011-12

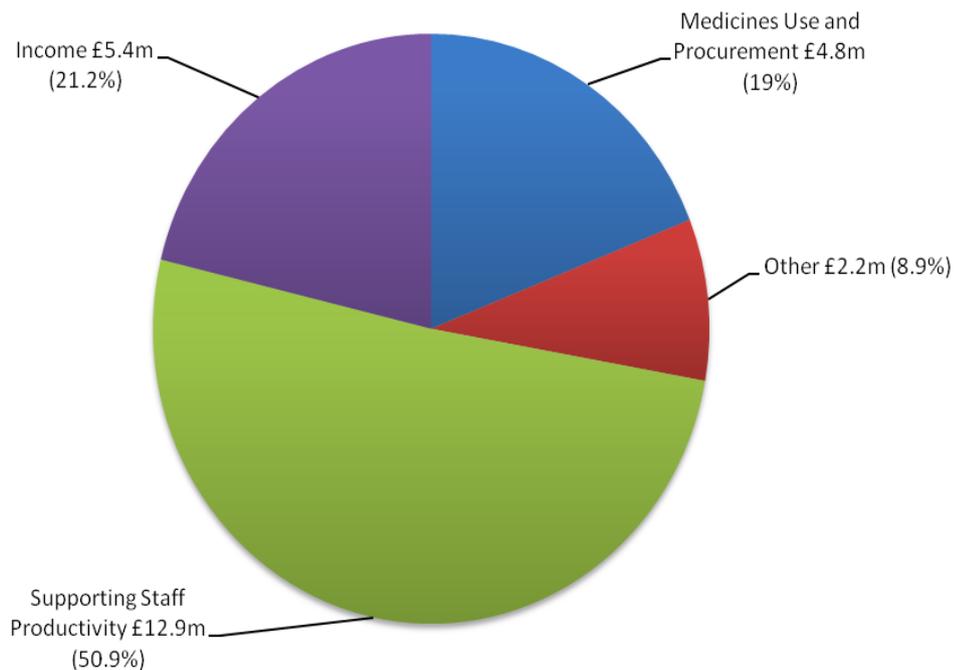


- Utilities, building and office equipment: £23.7m
- PDC dividends: £12.1m
- Hotel services, catering etc: £23.1m
- Depreciation: £30.7m
- Other: £29m
- Drugs: £58m
- Purchases from non-NHS bodies: £5.9m
- Transport, Telephones, stationery etc: £7.2m
- Medical and surgical consumables: £79.7m

### Our efficiency programme 2011/12

We delivered £25.3m of our £38m cost improvement programme in 2011/12. The major components of the delivery of the programme are outlined in the chart below. These were delivered as part of our focus on productivity whilst maintaining high quality patient services.

### Analysis of the Trust's efficiency programme 2011-12



## **Managing risk**

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

As in 2011/12, we will continue to manage key risks linked to management and control of infection, the patient experience, delivery of national waiting time targets, and delivery of financial balance.

## **Future challenges**

In 2012/13, we have set a challenging efficiency target of £32m (representing 4.4 per cent of total turnover) which includes schemes in the following key areas:

- buying goods and services;
- length of stay reduction; and
- clinical coding.

We are making a significant investment in new assets. The capital programme for 2012/13 involves £32.1m of investment. Major schemes starting in 2012/13 include:

- £3.6m to develop two NIHR Biomedical Research Centres in Respiratory and Nutrition, Diet and Lifestyle;
- £1.3m to develop a Theatre Assessment Area at the Royal Infirmary;
- £3.1m to reconfigure maternity and gynaecology services;
- £1m to reconfigure Ward 29 at Glenfield as part of the review of Childrens' Heart Services; and
- Major redesign of the Emergency Department.

In addition we are investing £22.4m on replacing medical equipment, improving buildings and developing IT systems.

## Foreword to the accounts

### University Hospitals of Leicester NHS Trust

These accounts for the year ending 31 March 2012 have been prepared by the University Hospitals of Leicester NHS Trust under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

The accounts for 2011/12 have been prepared under International Financial Reporting Standards (IFRS), which have been effective for the NHS from 1 April 2009.

These accounts comprise a summarised version of our annual accounts. A copy of our full financial statements and our Charitable Funds can be obtained on request from:

Assistant Director of Finance (Financial Accounting)

Trust Headquarters

Level 3, Balmoral Building

Leicester Royal Infirmary

Infirmary Square

Leicester, LE1 5WW

0116 258 8557

## Summary financial statements

### Statement of comprehensive income for year ending 31 March 2012

	2011/12	2010/11
	£000	£000
		(restated)
Employee benefits	(440,415)	(441,265)
Other costs	(294,234)	(257,572)
Revenue from patient care activities	615,066	606,135
Other Operating revenue	<u>104,088</u>	<u>103,579</u>
<b>Operating surplus/(deficit)</b>	<b>(15,495)</b>	<b>10,877</b>
Investment revenue	66	70
Finance costs	<u>(459)</u>	<u>(459)</u>
<b>Surplus/(deficit) for the financial year</b>	<b>(15,888)</b>	<b>10,488</b>
Public dividend capital dividends payable	<u>(12,097)</u>	<u>(13,325)</u>
<b>Retained (deficit) for the year</b>	<b><u>(27,985)</u></b>	<b><u>(2,837)</u></b>
<b>Other Comprehensive Income</b>		
Impairments and reversals	(30,852)	(194)
Net gain on revaluation of property, plant & equipment	1,472	0
Net (loss) on other reserves	<u>0</u>	<u>(272)</u>
<b>Total comprehensive income for the year</b>	<b><u>(57,365)</u></b>	<b><u>(3,303)</u></b>
<b>Financial performance for the year</b>		
Retained surplus/(deficit) for the year	(27,985)	(2,837)
Impairments	<u>28,073</u>	<u>3,555</u>
<b>Adjusted retained surplus/(deficit)</b>	<b><u>88</u></b>	<b><u>718</u></b>

## Statement of financial position as at 31 March 2012

	31 March 2012	31 March 2011 (restated)
	£000	£000
<b>Non-current assets:</b>		
Property, plant and equipment	349,363	417,069
Intangible assets	5,242	5,119
Trade and other receivables	2,188	1,878
<b>Total non-current assets</b>	<b>356,793</b>	424,066
<b>Current assets:</b>		
Inventories	12,262	11,923
Trade and other receivables	29,126	22,722
Cash and cash equivalents	18,369	10,306
<b>Total current assets</b>	<b>59,757</b>	44,951
<b>Total assets</b>	<b>416,550</b>	469,017
 <b>Current liabilities</b>		
Trade and other payables	(62,277)	(59,556)
Provisions	(789)	(667)
Borrowings	(4,038)	(3,649)
<b>Total current liabilities</b>	<b>(67,104)</b>	(63,872)
<b>Net current assets</b>	<b>349,446</b>	405,145
 <b>Non-current liabilities</b>		
Provisions	(2,121)	(2,232)
Borrowings	(1,427)	(3,237)
<b>Total non-current liabilities</b>	<b>(3,548)</b>	(5,469)
<b>Total Assets Employed:</b>	<b>345,898</b>	399,676
 <b>FINANCED BY:</b>		
<b>TAXPAYERS' EQUITY</b>		
Public Dividend Capital	277,487	273,903
Retained earnings	3,705	17,093
Revaluation reserve	64,706	108,680
<b>Total Taxpayers' Equity:</b>	<b>345,898</b>	399,676

## Statement of cash flows for the year ending 31 March 2012

	2011/12	2010/11
	£000	£000
<b>Cash Flows from Operating Activities</b>		
Operating Surplus/Deficit	(15,495)	10,877
Depreciation and Amortisation	30,764	29,383
Impairments and Reversals	28,072	3,555
Donated Assets received credited to revenue but non-cash	(763)	(486)
Interest Paid	(361)	(385)
Dividend paid	(13,356)	(13,325)
(Increase)/Decrease in Inventories	(378)	290
(Increase)/Decrease in Trade and Other Receivables	(6,058)	13,882
Increase/(Decrease) in Trade and Other Payables	3,252	(12,666)
Provisions Utilised	(498)	(465)
Increase/(Decrease) in Provisions	509	(615)
<b>Net Cash Inflow from Operating Activities</b>	<b>25,688</b>	<b>30,045</b>
 <b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Interest Received	65	67
(Payments) for Property, Plant and Equipment	(15,790)	(27,496)
(Payments) for Intangible Assets	(1,254)	(1,357)
<b>Net Cash Outflow from Investing Activities</b>	<b>(16,979)</b>	<b>(28,786)</b>
 <b>NET CASH INFLOW BEFORE FINANCING</b>	<b>8,709</b>	<b>1,259</b>
 <b>CASH FLOWS FROM FINANCING ACTIVITIES</b>		
Public Dividend Capital Received	3,584	0
Capital Element of Payments in Respect of Finance Leases	(4,230)	(3,449)
Capital grants and other capital receipts	0	1
<b>Net Cash Outflow from Financing Activities</b>	<b>(646)</b>	<b>(3,448)</b>
 <b>NET INCREASE/(DECREASE) IN CASH &amp; CASH EQUIVALENTS</b>	<b>8,063</b>	<b>(2,189)</b>
 <b>Cash and Cash Equivalents at Beginning of the Period</b>	<b>10,306</b>	<b>12,495</b>
<b>Cash and Cash Equivalents at year end</b>	<b>18,369</b>	<b>10,306</b>

### **Better payment practice code - measure of compliance**

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

	<u>£000s</u>	<u>Number</u>
<b>Non-NHS payables</b>		
Total non-NHS trade invoices paid in the year	117,656	375,991
Total non-NHS trade invoices paid within target	99,823	333,197
Percentage of non-NHS trade invoices paid within target	<b>85%</b>	<b>89%</b>
<b>NHS payables</b>		
Total NHS trade invoices paid in the year	13,796	117,111
Total NHS trade invoices paid within target	11,254	105,194
Percentage of NHS trade invoices paid within target	<b>82%</b>	<b>90%</b>

### **Audit fees**

Our external auditor for statutory audit and services during 2010-11 was KPMG LLP. The Audit Commission appointed KPMG LLP as our external auditors in 2000. The total value of payments to KPMG for statutory audit services in 2011/12 was £327k.

### **Pension liabilities**

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

### **Statement of directors**

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

<b>Salary and pension entitlements of senior managers</b>						
<b>Name and Title</b>	<b>2011/12</b>			<b>2010/11</b>		
	<b>Salary</b>	<b>Other remuneration</b>	<b>Benefits in kind</b>	<b>Salary</b>	<b>Other remuneration</b>	<b>Benefits in kind</b>
	<b>(bands of £5000) £000</b>	<b>(bands of £5000) £000</b>	<b>rounded to the nearest £100</b>	<b>(bands of £5000) £000</b>	<b>(bands of £5000) £000</b>	<b>rounded to the nearest £100</b>
M Hindle, Chairman	20-25	0	0	20-25	0	0
M Lowe-Lauri, Chief Executive	200-205	0	0	210-215	0	0
S Hinchliffe, Chief Operating Officer	160-165	0	0	160-165	0	0
K Bradley, Director of Human Resources	120-125	0	0	120-125	0	0
Professor D Rowbotham, Director of Research & Development	20-25	200-205	0	20-25	200-205	0
S Ward, Director of Corporate & Legal Affairs	100-105	0	0	100-105	0	0
M Wightman, Director of Communications	95-100	0	0	95-100	0	0
K Harris, Medical Director	40-45	165-170	0	35-40	170-175	0
A Seddon, Director of Finance and Procurement	140-145	0	0	140-145	0	0
A Tierney, Director of Strategy	135-140	0	0	135-140	0	0
D Wynford-Thomas, Non Executive Director	5-10	0	0	5-10	0	0
I Reid Non Executive Director	5-10	0	0	5-10	0	0
D Tracy, Non Executive Director	5-10	0	0	5-10	0	0
R Kilner, Non Executive Director	5-10	0	0	5-10	0	0
J E Wilson, Non Executive Director	5-10	0	0	5-10	0	0
P Panchal, Non Executive Director (from 01.07.10)	5-10	0	0	0-5	0	0
K Jenkins, Non Executive Director (from 01.07.10)	5-10	0	0	0-5	0	0

## Salary and pension entitlements of senior managers - pension benefits

Name and title	Real increase in pension at age 60  (bands of £2500) £000	Real increases in lump sum at age 60 at 31 March 2012  (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2012  (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012  (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2012  £000	Cash Equivalent Transfer Value at 31 March 2011  £000	Real Increase in Cash Equivalent Transfer Value  £000	Employers Contribution to Stakeholder Pension  To nearest £100
M Lowe-Lauri, Chief Executive	(2.5-5.0)	(12.5-15.0)	80-85	250-255	1,693	1,618	25	0
A Seddon, Director of Finance and Procurement	0.0-2.5	5.0-7.5	15-20	45-50	304	244	52	0
S Hinchliffe, Chief Operating Officer	0-2.5	0-2.5	55-60	170-175	1,067	941	97	0
K Harris, Medical Director	0	0	0	0	0	0	0	0
K Bradley, Director of Human Resources	0-2.5	5.0-7.5	30-35	100-105	608	490	102	0
A Tierney, Director of Strategy	0-2.5	0	15-20	0	156	97	56	0
Professor D Rowbotham, Director of Research & Development	0	0	0	0	0	0	0	0
M Wightman, Director of Communications	0-2.5	0-2.5	15-20	55-60	285	221	57	0
S Ward, Director of Corporate & Legal Affairs	0-2.5	0-2.5	35-40	105-110	660	579	64	0

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

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

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

## Exit packages

Exit package cost band (including any special payment element)	2011/12			2010/11		
	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	7	0	7	30	0	30
£10,001-£25,000	1	0	1	10	0	10
£25,001-£50,000	2	0	2	1	0	1
£50,001-£100,000	1	0	1	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
<b>Total number of exit packages by type (total cost)</b>	<b>11</b>	<b>0</b>	<b>11</b>	<b>41</b>	<b>0</b>	<b>41</b>
<b>Total resource cost (£000s)</b>	181	0	181	291	0	291

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs are accounted for in full in the year of departure. Where the NHS Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

## **Pay multiples**

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

The banded remuneration of the highest paid director in the Trust in the financial year 2011/12 was £200,000 - £205,000 (2010/11 £210,000 - £215,000). This was 7.9 times (2010/11, 8.3 times) the median remuneration of the workforce, which was in the banding £25,000 - £30,000 (2010/11, £25,000 - £30,000).

We have implemented a pay freeze across all staff groups in 2010/11 and 2011/12 in accordance with the national guidance. In 2011/12 and 2010/11, no employees received remuneration in excess of the highest-paid director. Remuneration across the Trust ranged from £5,000 - £205,000 (2010-11 £4,000 - £215,000).

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

## Annual Governance Statement 2011-12

### Scope of Responsibility

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

### The Governance Framework of the Organisation

#### *Trust Board Composition and Membership*

The Trust Board comprises 13 members: a Chairman, seven Non-Executive Directors and five Executive Directors, one of whom is the Chief Executive. The Board is supported in its work by the Director of Communications and External Relations, Director of Corporate and Legal Affairs and Director of Strategy, respectively.

There have been no changes to Board membership during 2011/12.

#### *Performance Management Reporting Framework*

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

The monthly report:

- is structured across five domains: patient safety; patient experience; clinical outcomes; staff experience/workforce; and value for money;
- includes a summary section, 'UHL at a Glance', which provides an overview of both in-month and year to date performance, and trends;
- includes performance indicators rated red, amber or green;
- includes data quality indicators, measured against five key data quality components to assist the Board in gaining assurance;
- is complemented by commentaries from the Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

A Clinical Divisional heat map, identifying individual Divisional and Clinical Business Unit performance across all of the domains is also available to the Board.

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

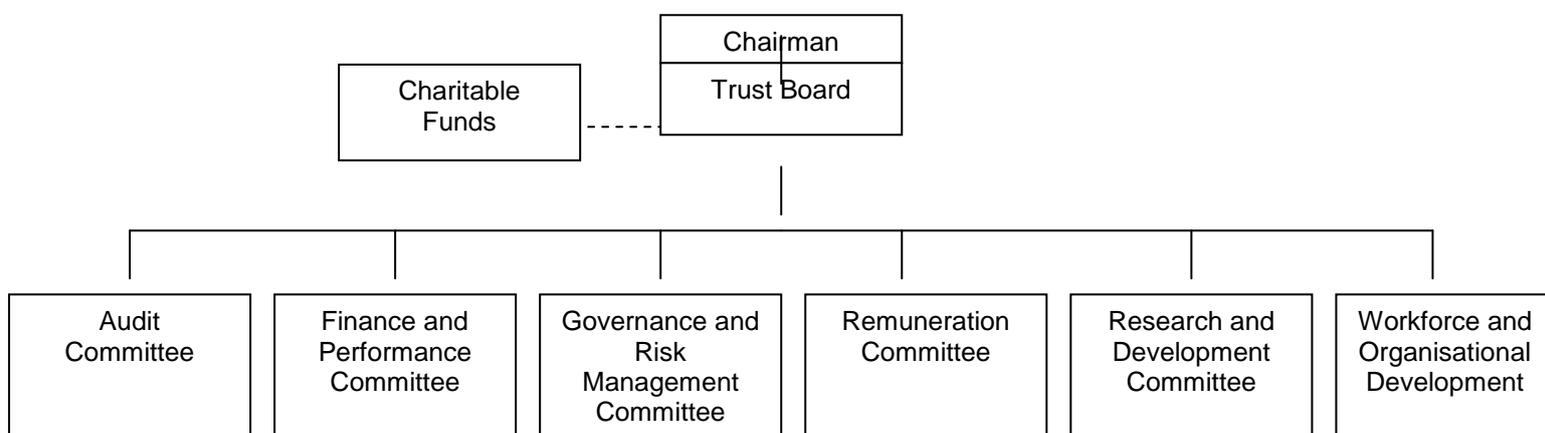
- patient stories, which are presented in public at Board meetings every quarter. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement;

- Board members undertake patient safety walkabouts regularly; and four of the Non-Executive Directors are linked to the Clinical Divisions and attend Divisional board meetings.

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

### *Committee Structure*

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



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

The Audit Committee is established under powers delegated by the Trust Board with approved terms of reference that are aligned with the NHS Audit Committee Handbook. The Committee consists of four Non-Executive Directors, has met on five occasions throughout the 2011/12 financial year and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

### *Attendance at Board and committee Meetings*

The attendance of the Chairman, individual Non-Executive Directors, Executive Directors and Corporate Directors at Board and committee meetings during 2011/12 is set out overleaf. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attendees as detailed in the terms of reference for each committee.

<b>NAME</b>	<b>TRUST BOARD MAXIMUM - 13</b>	<b>AUDIT COMMITTEE MAXIMUM - 5</b>	<b>FINANCE AND PERFORMANCE COMMITTEE MAXIMUM - 12</b>	<b>GOVERNANCE AND RISK MANAGEMENT COMMITTEE MAXIMUM – 12</b>	<b>RESEARCH AND DEVELOPMENT COMMITTEE MAXIMUM – 10</b>	<b>REMUNERATION COMMITTEE MAXIMUM – 4</b>	<b>WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE MAXIMUM - 4</b>
Martin Hindle	13	N/A	N/A	N/A	10	4	N/A
Kiran Jenkins	12	5	N/A	N/A	N/A	4	N/A
Richard Kilner	13	5	12	N/A	N/A	4	4
Prakash Panchal	12	N/A	N/A	10	8	3	4
Ian Reid	12	3	12	N/A	N/A	4	N/A
David Tracy	13	4	N/A	12	N/A	4	3
Jane Wilson	12	N/A	10	9	N/A	4	4
David Wynford-Thomas	10	N/A	N/A	7	7	3	N/A
Kate Bradley	13	N/A	N/A	N/A	N/A	4	4
Kevin Harris	11	N/A	7	7	8	N/A	3
Suzanne Hinchliffe	13	N/A	10	8	N/A	N/A	3
Malcolm Lowe-Lauri	12	2*	11	11	7	4	3
Andrew Seddon	13	4	12	N/A	N/A	N/A	N/A
Abigail Tierney	13	N/A	9	N/A	6	N/A	N/A
Stephen Ward	12	4	N/A	9	N/A	4	N/A
Mark Wightman	13	N/A	N/A	9	4	N/A	2

\*NB – Audit Committee Terms of Reference refer to the Chief Executive being invited to attend a meeting annually.

### *Board Effectiveness*

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

Board performance depends both upon leadership and the interaction of particular people and personalities. Recognising the importance of getting the right dynamics between Executive and Non-Executive Directors, and to strike the right balance between challenge and support to the Executive Team,

each member of the Board has undertaken a 'Myers Briggs' assessment of their personality preferences. This has helped each Board member to become aware of their particular style and to better understand and appreciate the helpful ways that people differ from one another. It has also formed the basis of the development and Board agreement of the Code of Conduct for Directors.

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

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

Outside of its formal meetings, the Board has held development sessions throughout 2011/12. Amongst the topics considered were risk management; winter planning; market assessment and the forthcoming establishment of Health Watch.

The Chairman of the East Midlands Strategic Health Authority set objectives for the Trust Chairman for 2011/12.

Our Chairman set objectives for the Chief Executive and Non-Executive Directors for 2011/12. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2011/12.

### *Corporate Governance*

In managing the affairs of the Trust, the Trust Board is committed to achieving high standards of integrity, ethics and professionalism across all areas of activity. As a fundamental part of this commitment, the Board supports the highest standards of corporate governance within the statutory framework.

We have in place a suite of corporate governance policies which are reviewed and updated annually. These include standing orders, standing financial instructions, a scheme of delegation, policy on fraud and code of business conduct.

The Trust Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'.

During 2012/13, the Trust Board is to undertake a self-assessment against the Department of Health's Assurance Framework for Aspirant Foundation Trusts. This work is timetabled to be completed by November 2012.

### **Risk Assessment**

We operate a risk management process which enables the identification and control of risks at both a strategic and operational level. Central to this is our Risk Assessment Policy which sets out details of the risk assessment methodology used across the Trust. This methodology enables a suitable, trained and competent member of staff to identify and quantify risks in their respective area and to decide what action, if any, needs to be taken to reduce or eliminate risks. All risk assessments must be scored and recorded in line with the procedure set out in the Risk Assessment Policy. Completed risk assessments are held at Clinical Division and Corporate Directorate level and when they give rise to a significant residual risk must be linked to the Trust's operational and, if appropriate, strategic risk register.

A common risk-scoring matrix is used by the Trust to quantify and prioritise risks identified through the risk assessment procedure. It is based on the frequency or likelihood of the harm combined with the possible severity or impact of that harm. The arrangement determines at what level in the organisation a risk should be managed and who needs to be assured management arrangements are in place.

We recognise the importance of robust information governance. During 2011/12, the Director of Strategy led on information governance issues as the Trust's Senior Information Risk Owner, supported by an Information Governance Manager. The Medical Director was our Caldicott Guardian during 2011/12.

We took further actions during 2011/12 to secure improvement in its information governance arrangements. An Information Governance Steering Group monitors and oversees compliance with information governance requirements. We fully supported NHS East Midlands' information governance awareness campaign to promote secure handling of personal data ('NHS Confidential').

All NHS Trusts are required annually to undertake an information governance self-assessment using the NHS Information Governance Toolkit. This contains 45 standards of good practice. Our overall percentage score for 2011/12 was 84%, compared to 75% in

2010/11. This is deemed to be a 'satisfactory – minimum level 2' standard across all of the information governance standards.

There were no serious untoward incidents involving lapses of data security which were required to be reported to the Information Commissioner's Office in 2011/12. In respect of other personal data related incidents experienced during 2011/12, the Trust has undertaken investigations to ensure that the root causes are properly understood and addressed; in addition, patients have been contacted to inform them of the lapses and to provide them with assurance about the actions taken by the Trust to prevent recurrence.

### **The Risk and Control Framework**

Our Risk Management Strategy describes an organisation-wide approach to risk management supported by effective and efficient systems and processes. The Strategy clearly describes the Trust's approach to risk management and the roles and responsibilities of the Trust Board, management and all staff. The Strategy was approved by the Trust Board in May 2011.

Key strategic risks are documented in the Trust's Strategic Risk Register and Board Assurance Framework. Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team and Trust Board review the Register/Framework on a monthly basis to identify and review the Trust's principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed.

Our Annual Plan 2012/13 responds to and, where possible, addresses the strategic risks facing the Trust. The Trust Board will review the current Register and update it to reflect any additional risks in the 2012/13 Plan.

### **Annual Quality Report**

Our Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to NHS Trusts on the form and content of annual Quality reports which incorporates the above-mentioned legal guidance.

The Director of Clinical Quality, on behalf of the Medical Director co-ordinates the preparation of the Trust's Annual Quality Report. This is reviewed in draft form by the Trust's Governance and Risk Management Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2011/12, the Governance and Risk Management Committee has noted the Trust's internal controls and standards which underpin the Statement of Directors' responsibilities in respect

of the Quality Account – which Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 28 June 2012.

### **Review of the Effectiveness of Risk Management and Internal Control**

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Managers and Clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft Quality Account 2011/12 and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance and Performance Committee, Governance and Risk Management Committee and Workforce and Organisational Development Committee. During 2011/12, each of these bodies has been involved in a series of processes that, individually and collectively, has contributed to the review of the effectiveness of the system of internal control.

In the Head of Internal Audit Opinion 2011/12, the Head of Internal Audit notes that, based on the results of the Internal Audit work performed as set out in the 2011/12 Internal Audit Plan (and subsequent amendments) approved by the Audit Committee, at UHL there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. Where individual audits identified high risk issues, action plans have been agreed by management to meet Internal Audit's recommendations and to strengthen internal control.

The Head of Internal Audit's Opinion 2011/12 (which, using the terminology set out in the Department of Health guidance to Head of Internal Audit, equates to "significant assurance") has taken into account the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

2011/12 proved to be a very challenging year for the Trust, particularly in terms of financial delivery, performance of the emergency care system and staff engagement and morale. Given the challenges, the Trust is very aware of the potential impact on clinical quality. Accordingly, in March 2012 the Trust undertook a review of clinical quality indicators over the period winter 2011/12. This demonstrated that, while winter pressures had resulted in a negative impact on patient experience, no measurable effect on patient mortality or clinical outcomes was discernable. Nevertheless, in March 2012 the Care Quality Commission undertook an unannounced inspection at the Acute Medical Unit at the Leicester Royal

Infirmity and found, in its judgement, that there were major concerns in relation to the care and welfare of people using the service.

The Care Quality Commission issued a warning notice setting out its findings, to which the Trust responded formally. The Commission subsequently carried out a further inspection and issued a report confirming that the Trust had addressed its concerns and discharged the warning notice.

The Trust Board is not satisfied that the plan in place at present is sufficient to meet the A&E/4 hour standard on a sustainable basis and so it has commissioned two external reviews to examine the Emergency Department and the entire emergency care pathway, respectively. The Board is to receive a revised plan in July 2012 to ensure that the standard is achieved on a sustainable basis. During 2012/13, Internal Audit is to carry out a review of the sustainability and deliverability of the revised plan.

For 2011/12, we set ourselves the target to be in the top 20% of Trust's nationally for positive patient feedback, according to local patient experience survey results and the national patient survey.

Based on the most recent national survey results, although we have not achieved the target we set ourselves, we are in the middle 60% of Trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent.

For 2012/13, we have again identified improving patient experience as one of our top priorities. We want to increase the opportunity for patients, carers and the public to provide feedback on services and care provided through a range of media including establishing the question and baseline 'Net Promoter Score' for 10% of inpatient discharges for any given week at or within 48 hours of discharge.

The first month of reporting will be in April 2012, following which a trajectory for improvement will be agreed to ensure either a 10 point improvement in Net Promoter Score or achievement or maintenance of top quartile performance throughout 2012/13.

We have accepted the need to improve its risk management arrangements and, in response to recommendations made by its Internal Auditor, have agreed a series of actions to improve the effectiveness of risk management at the Trust during 2012/13.

The Trust Board has identified the need to strengthen the capability and experience of the Trust's management team in order to deliver the Annual Plan: this is a key priority for 2012/13 and the Chief Executive, supported by the Chief Operating Officer/Chief Nurse is to report to the Board during quarter 1 2012/13 setting out plans in this regard.

The Trust Board has also identified actions to mitigate other significant risks in 2012/13 in relation to:

- (a) the ability to identify sufficient levels of cost reduction and secure the clinical engagement necessary to deliver long-term transformation;

- (b) achieving an affordable and sustainable clinical service and site configuration across UHL and the Leicester, Leicestershire and Rutland health economy; and
- (c) maintaining the trajectory relating to the Trust's application for NHS Foundation Trust status.

In addition to the issues identified above, further work will be undertaken in 2012/13 to review and strengthen the Trust's governance, risk management and internal control systems, policies and procedures. This work will contribute to the Trust's aim of submitting its application for authorisation as an NHS Foundation Trust.

I am of the opinion that the implementation of the actions described above will strengthen the Trust's system of internal control in 2012/13 and beyond.

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



Signed:

Chief Executive

(on behalf of the Trust Board)

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



## INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2012.

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

### Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

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

### Basis of opinion

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

### Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of University Hospitals of Leicester NHS Trust for the year ended 31 March 2012 on which we have issued an unqualified opinion. We have not considered the effects of any events between the date on which we signed our report on the statutory financial statements, 8 June 2012, and the date of this statement.

A handwritten signature in blue ink, appearing to read 'Andrew Bostock'.

### Andrew Bostock

For and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants  
One Snowhill  
Snow Hill Queensway  
Birmingham  
B4 6GH

19 September 2012

**Please help us to improve the way we give people information**

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

We would be very grateful if you could answer the questions below and send your response to us by 31 December 2012.

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

**1 The information we give:**

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

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

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**2 Were there any areas of the annual report which you found most useful, please feel free to list and explain why**

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

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

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

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If you would like to be notified when the 2013/14 annual report is available? If so, please give your email address

.....

Completed questionnaires can be sent to:  
**Communications Team**, University Hospitals of Leicester NHS Trust, Medical Illustration,  
Level 2 Windsor Building, Leicester, LE1 5WW

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

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

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

ਜੇ ਤੁਸੀਂ ਆ ਪਤ੍ਰਿਕਾ ਨੂੰ ਲਿਖਿਤ ਅਥਵਾ ਟੇਪ ਉੱਪਰ ਆਖ਼ਾਨਰ ਜ਼ੈਰੰਨੂੰ ਡੇਵ ਨੋ ਮਠੇਰਆਨੀ  
ਡੇਵ ਬੇਕਰ, ਸਰਵਿਸ ਈਕੁਅਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116 258 8295 ਉੱਪਰ ਸੰਪਰਕ ਕਰੋ।

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

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

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

Published by the University Hospitals of Leicester NHS Trust  
June 2012

# Annual Report

& Accounts 2011/2012