University Hospitals of Leicester NHS

NHS Trust

Caring at its best

Transforming technology & healthcare

Annual Report

& Accounts 2012-2013

Equality

Action

Focus

Teamwork

Innovation

Our Values

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

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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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 more than 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 aneurism 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.

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.

Welcome from the chairman

Hello and welcome to our Annual Report and Accounts for 2012/13.

It has been a fascinating and challenging 12 months for Leicester's Hospitals and indeed for the whole NHS.

Nationally the NHS agenda has been dominated by the Francis report into the fundamental failings of care in Mid Staffordshire NHS Foundation Trust. The report contained 290 separate actions but essentially the message was that in case anyone was in any doubt 'quality and safety' are the subjects which NHS Boards ought to obsess about.

Of course this is right. In November, we published our 'Strategic Direction' which sought to clarify for staff, patients and stakeholders the vision for the Trust over the next five years. At the heart of that vision is our commitment to provide 'safe, high quality, patient centred healthcare.'

No one could argue with that being the centrepiece of the strategy but to make this clearer and measurable our Quality Commitment says that we will save 1,000 more lives, reduce the numbers of 'avoidable harms' by 5,000 and improve the patient experience over the next five years.

In performance terms the last 12 months have been somewhat of a mixed bag. We have continued to reduce hospital acquired infections and in the case of MRSA, in a real sense, it can be said that we have reduced the incidence to zero over the last year. Referral to Treatment performance has also been good, despite on-going emergency pressures and as a consequence we have hit the three headline targets of 90% of admitted patients treated within 18 weeks; 95% of non-admitted and overall 92% of all patients within 18 weeks.

However, in terms of the A&E standard, which states that patient must be seen, treated, admitted or discharged within 4 hours of attending, we have struggled throughout the year, resulting in an overall performance for the year of 91.9%. This is something our new Chief Executive, John Adler is determined to crack as he describes on the next page.

Our staff are exceptional. The very hard winter resulted in emergency pressures which only just seem to be abating at the time of writing this introduction, (August). In recognition that this pressure and the relative illness of our 'average' patient had increased the Trust Board decided that we needed more nurses and Health Care Assistants on our wards and especially on our medical wards. And so we have invested an extra £2m recurrently into the nurse staffing budgets.

Still on the subject of staff, the Annual Staff Survey showed that there had been an improvement in the results, with more staff saying they were satisfied with their jobs and with the levels of care they give to patients. We think that this is in part as a result of the increased ward staffing and in response to greater clarity about our future through the Strategic Direction. There is however far more to do in terms of staff engagement and again John has already started to make a real difference in this area.

In regard to the wider engagement with partners and our communities and stakeholders we have been grateful for their continued and passionate support. Nowhere was this more apparent than in the 3 year (and counting) campaign to save children's heart surgery at the Glenfield. The Secretary of State announced in June that the Safe and Sustainable review recommendation, which included the closure of surgery in Leicester, was based on a 'flawed interpretation of inadequate data', and as such the decision was quashed… I recognise that this is not strictly speaking within the time period covered by this Annual Report but it would be remiss of me not to mention it and recognise the amount of work which has gone into the campaign and clinical case by our team and our stakeholders.

Finally, I want to say 'good bye' and 'thank you.' This is my last report to you the staff, patients and stakeholders of Leicester's hospitals. At the end of September I will be taking up the Chairmanship of the new Academic Health Science Network for the East Midlands. In the seven years I have had the privilege to Chair Leicester's Hospitals, I have been in daily contact with people who have consistently exemplified all that is great about the NHS and I will greatly miss the many people who I have counted as colleagues from across the Trust. When I leave, shortly after this year's Annual General Meeting, I know I will be leaving the Trust in safe and very capable hands. John Adler, our new Chief Executive joined in January and I have to say that he has wasted no time in getting to grips with the 'big ticket' issues which we need to address. John is supported by a talented team of Executives and Non-Executives and I have no doubt that over the next year, under John's leadership, Leicester's hospitals will flourish.

Thank you to all those people who have supported the Trust during my Chairmanship and especially to our staff, it has been an honour and a pleasure to work with you.

Martin Hindle, Chairman

Welcome from the chief executive

Hello,

I'd like to start my introduction by recognising and thanking Martin, our outgoing Chairman. University Hospitals of Leicester is an enormous and complex organisation and as a consequence leading such an organisation requires great skill, stamina and diplomacy. Add to that the fact that during Martin's tenure the NHS itself has undergone a once in a generation upheaval and the job Martin has done seems all the more remarkable. On behalf of the Trust Board and our staff, I'd like to say thank you, you will be a hard act to follow!

I joined the Trust in January having spent 10 years as Chief Executive of an acute Trust in the West Midlands. I know this area well; I was at University in Loughborough… a tradition which my children have seen fit to continue. I must say that the welcome I have received from staff, stakeholders and partners has been overwhelmingly supportive and indicates just how important Leicester's Hospitals are to the life and community of the City and Counties we serve.

One of the first documents I read before joining the Trust was the Strategic Direction and I have to say it did and still does, make complete sense to me. Yes, quality and safety have to drive everything we do. Yes, these hospitals will become smaller and more specialised as we move some of our work out into the community and other settings and yes, we have to create a sustainable Trust which is capable of delivering excellent healthcare within an increasingly tight budget.

So, when I first arrived I was pleased to see that there is clear support for the strategy… but the other thing which struck me was that staff and stake holders were very keen to see the Trust get cracking on the delivery of our Strategic Direction.

In the last few months we have been doing just that. One of the key elements of the strategy is to create a joined up emergency care system. Our current Emergency Department (ED) performance is poor in terms of the 4 hour target and given that this is a crucial indicator of how the whole process of emergency and urgent care works both within and outside hospital we have to improve it in a lasting and sustainable way. I am acutely aware that ED is both our biggest quality issue and the biggest drain on our finances and clinical resources. In short ED performance currently dominates our agenda.

This is why one of the first major improvements we have made is to create a 'single front door' into the hospital for all the non-ambulance patients who come into the trust. Though it is early days it already appears to have made a difference in the ability of the ED team to focus on those patients who really need our help.

We are also planning to invest somewhere in the region of £40m into building a new fit for purpose ED. The current ED was built for 115,000 patients a year but we are seeing 165,000. Our plan is to create space at the Royal Infirmary for a larger ED by moving some outpatient clinics to the General Hospital. Not only will this give us the space to expand our emergency care footprint it ought to also alleviate some of the parking issues at the Royal.

Leaving emergency care aside for a moment, I also wanted to talk about our staff. Like Martin, I believe that the staff in Leicester do a great job in sometimes difficult circumstances. The Trust is investing in staffing numbers on wards in recognition of the fact that the acuity of our patients has increased over the last few years and we need to staff up accordingly. But our investment in staff does not end there. As well as having the right numbers of staff we also need to make sure that our staff feel engaged, valued and listened to. And so one of my first actions has been to launch a Trust wide programme called 'Listening into Action', (LiA). The clue is in the name; Listening into Action is concerned with making sure that we listen to staff, identify those issues which get in the way of them doing the best job for their patients and then take timely action to sort the issues out. It is early days but LiA seems to be going well and eventually as more and more staff and departments take part in LiA it will simply be seen as 'the way we do things around here'.

It would be remiss of me to introduce the Annual Report and Accounts and not to mention finance. My approach to finance is straightforward; I do not want money to monopolise our agenda. Financial stability is an enabler; having a decent grip on finance and hence creating a sustainable financial strategy is the way to get other things done and not an end in itself. However, it has to be said that the history of the Trust is partly defined by financial volatility. In fact we need to recognise that for this year we were able to meet our financial responsibilities only as a result of a generous settlement from our commissioners and I would like to thank them for that.

Looking to the future the only certainty in terms of finance is that it is going to be increasingly more difficult to balance the books whilst pursuing any kind of 'business as usual' strategy. We recognise that, our partners in the Clinical Commissioning Groups recognise that and I think that our patients and the wider public do too.

These hospitals, working in partnership with primary care, social care and our colleagues in the Leicester Partnership Trust have a great future. My job, along with my fellow Executives is to build on the existing strengths of these hospitals, of which there are many and repair the weaknesses, of which there are fewer and I am looking forward to reporting back in due course on the progress we are making!

John Adler, Chief Executive

Our values and the NHS Constitution

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

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

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

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

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.

Excellent care on Ward 21

My Dad was admitted to Ward 21 at the Royal Infirmary for elective surgery on his aortic aneurysm. He was very anxious because of the seriousness of his condition, as was the rest of the family. The multi-disciplinary team on ward 21 put him at ease and he was really happy with the care he received. He commented that the staff couldn't do enough for him and he enjoyed the food.

I was particularly happy to see the interaction between my Dad and the staff nurse he had met the week before in the pre-op assessment clinic. It was clear that she remembered the conversation they had at the clinic as she referred to things like his holiday plans and the fact that she was too short to measure his height. It makes patients feel special when staff remember them. As an employee of the Trust I was proud to see quality care in action.

Anonymous

Our priorities in 2012/13

Our priorities for 2012/13 were:

- deliver all operational targets
- achieve financial sustainability
- transform the emergency care system
- enhance clinical quality
- improve patient experience
- strengthen staff engagement
- build transformational capability
- develop a sustainable site and service reconfiguration
- deliver a successful FT application.

Throughout this report we will show how we have achieved these priorities.

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 2012/13 Operating Framework. Our performance is shown for a selection of key indicators covering Accident & Emergency wait times, infection control, access waiting times and Cancer waiting time.

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

We all recognise that the pressures faced in our Emergency Department (ED) have been challenging this year, and are unsustainable. Whilst some of the issues are about the effectiveness of our processes, there is a fundamental problem that the current ED is simply too small. It was designed for 115,000 patients, not 150,000! We are dealing with increasing numbers of patients, many of whom are older and sicker than in previous years. Despite the sustained hard work of our team in ED and across the wider-Trust in implementing improved processes we have continued to fall well short of the standards we expect in terms of waiting times. This has meant that our **Accident & Emergency performance** for the year stands at 91.9 per cent of patients being seen, treated or discharged within four hours. This figure includes the patients seen within the urgent care centre, co-located to the ED at the Royal Infirmary.

For 2013/14 achieving the 95 per cent target on a sustainable basis continues to remain the top priority for both us and the local health economy.

Despite the pressures on emergency services we've had a good year in managing and reducing our waiting times. In 2012/13 we said we would deliver both **Referral to treatment (RTT) – 18 weeks –** standards on a monthly basis.

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

We achieved all three of these standards every month during 2012/13.

In 2013/14 we are required to achieve the admitted and non-admitted RTT targets across the organisation and at an individual specialty level. We have been unable to deliver sustainable performance against this target across all specialties during 2012/13, but in 2013/14 we are implementing plans to deliver these improvements.

Cancer waits: During the year we achieved seven of the eight cancer targets. Unfortunately we have been unable to deliver sustainable performance against the 62-day wait from urgent GP referral to first definitive treatment for cancer during the year.

We have identified delays in the diagnostic/imaging stage of the pathway and in 2013/14 we are implementing plans to deliver improvements that will focus on reducing unnecessary delays in early diagnosis.

We aim to ensure our waiting time performance is at least as good as the national average at tumour site level and we expect to be able to deliver this on a monthly basis from July 2013.

Our continued success story is in our work around **reducing 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).

All hospitals are given a target number beyond which they are not expected to exceed. For MRSA bacteraemia this was six cases and for CDiff this was 113 cases. Again we exceeded both of these targets with only two hospital associated MRSA bloodstream isolates. One was probably a contaminant and the other was a late presentation of a community-acquired MRSA soft tissue infection and therefore not preventable. We had 94 cases of CDiff.

In a very real sense, it can be claimed that MRSA bacteraemias have been reduced to zero. This contrasts with 161 cases in 2001.

We now screen every one of our elective and non-elective patients (100 per cent) for MRSA.

Thank you for your compassionate care

Excellent service! Ward 11 staff nurse was lovely; anaesthetist and surgical team explained everything perfectly. Anaesthetic team were very competent and friendly, SpR drew the 'required' snow leopard to indicate where surgery should take place. Post-op care was very caring and compassionate.
My daughter's first hospital experience was made better by the staff supporting us.
Big thanks to all involved.

Salsa

Performance Against 2012/13 National Targets

	Performance Indicator		Target 2012/13	2012/13	2011/12	2010/11
Access to A&E	**A&E**	Total time in A&E	95%	91.9%	93.9%	96.1%
Infection Control	**MRSA**		6	2	8	12
	Clostridium Difficile		113	94	108	200
Access 18 week wait	**RTT waiting times**	Admitted	90%	91%	84%	92.3%
	RTT waiting times	Non-admitted	95%	96.8%	96%	97.2%
	RTT incomplete	92% in 18 weeks	92%	92.4%	Not applicable	Not applicable
	RTT delivery	In all specialties	0	1	Not applicable	Not applicable
	Diagnostic Test	Waiting times	<1%	0.5%	Not applicable	Not applicable
Access Cancer	**All cancers:**	2 week wait from referral to date first seen	93%	93.3%	94%	93.4%
	Cancer:	2 week wait from referral to date first seen for symptomatic breast patients	93%	94.4%	95.9%	95.9%
	All cancers:	31 day wait from diagnosis to first treatment	96%	97.3%	97.4%	97%
	All cancers:	31 day wait for second or subsequent treatment - surgery	94%	95.9%	94.5%	95.2%
	All cancers:	31 day wait for second or subsequent treatment - anti cancer drug treatments	98%	100%	99.9%	100%
	All cancers:	31 day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	98.4%	99%	99.5%
	All cancers:	62 day wait for first treatment from urgent GP referral	85%	83.7%	83.8%	86.4%
	All cancers:	62 day wait for first treatment from consultant screening service referral	90%	94.4%	93.8%	91.6%

Our strategic direction

Our strategic direction outlines our thinking about the future shape of our clinical services. It reflects the ambitions of our staff to provide quality acute care and contribute to the wider healthcare system for the people of Leicester, Leicestershire and Rutland.

Our strategic objectives

Underpinning our vision, purpose and values are our strategic objectives. By delivering these we will fulfil our purpose to provide 'Caring at its best'.

They place quality and safety at the heart of our hospitals; they show that timely, effective emergency care is crucial; they recognise that we want people to choose to come to us when they require planned care and they underline the importance of research and teaching in the development of our specialist services.

Provide safe, high quality, patient-centred healthcare

Quality is both cultural and operational; it has to be ingrained as well as applied. We will focus on relentlessly on specific quality themes to create a Trust where pressure ulcers, infections and patient falls are rare.

Cancellations, delays and readmissions will be negligible and mortality will be amongst the lowest in the country. In honouring our values and behaviours we will improve the patient experience to make 'Caring at its best' a daily reality for every patient in every part of the Trust.

Overall we will save more lives, reduce avoidable harm and improve patient experience.

Our commitment to quality

This year our clinical teams agreed a commitment to quality and safety. Our Quality Commitment focuses on saving lives, reducing harm and patient-centred care.

Saving lives means we will save 1,000 extra lives in next three years. Reducing avoidable harm means we will avoid 5,000 patient harm incidents in next three years. Patient-centred care means that we will treat all patients with dignity and respect so that 75 per cent would recommend us.

Save lives

Our aim is to reduce mortality (the number of people who die) in our hospitals and save 1,000 extra lives in next three years and avoid 5,000 patient harm incidents over that same period.

To do this we are focusing on specific areas over the coming years. In 2013 the focus is on three areas. The first area is out-of-hours (weekends and nights). During this time we will reinforce the Hospital 24/7 programme, recruiting additional staff where required. Beginning at the Royal Infirmary, we will use coordinators, clinical aides and additional support during its introduction. The aim is to have the system up and running across all of our hospitals by July 2013.

A detailed audit analysing notes will look to identify the causes of higher mortality for out-of-hours admissions. This will be linked with an ongoing audit into pneumonia. A 'process map' will chart the experience of patients to help identify possible areas and reasons for any delays. Once the problems are identified work will be carried out to tackle them, for example delays on support services, such as portering, physiotherapy or pharmacy.

To make lasting improvement we will need to facilitate cultural changes. To ensure maximum success we are conducting a survey to assess the willingness of junior doctors to call consultants out-of-hours. This will help to identify key interventions to improve communications, specifically mortality and morbidity meetings, and mandate attendance to these meetings. It will also look at consultants calling junior doctors, for example through a routine 11pm call and create training case examples to encourage junior doctors to contact the consultants. Once rolled out, it will be tracked at a consultant level and a survey repeated to measure its success.

Finally, we will be carrying out a review of the respiratory pathway with the ambulance service, emergency department and other acute services. This will identify any potential blocks or mitigating factors that affect the pathway for patients with respiratory disease away from specialist care at Glenfield.

In 2014, the focus will move to peri-natal mortality (number of stillbirths and deaths in the first week of life per 1,000 live births, after 24 weeks gestation), the impact of locum and agency staff and escalation processes.

Hospital 24/7

We are creating safer clinical care out of hours with a new mobile healthcare system to support our Hospital at Night programme.

Nervecentre has replaced our traditional 'bleep' paper-based system of communication out-of-hours with clinical staff. Instead live patient-related information can be shared between a senior nurse coordinator and clinicians' smart phones over our wireless network.

This new system, launched in March 2013, will help us to prioritise patient-related tasks based on clinical need and ensure that the right healthcare professional is guided to the right place at the right time. Nervecentre will also provide us with data on out-of-hours activity and help us plan services and staffing.

For all non-core hours – which makes up 75 per cent of the week – the staff use Nervecentre to request and coordinate the allocation of all clinical requests from wards through to the multidisciplinary clinical team. Compared to the use of a 'bleep' this reduces internal delays and improves accuracy and visibility of information, improving patient safety and staff experience, as well as providing a governance record of every activity performed in the hospital allowing for continuous process improvement.

Out-of-hours care is provided by teams of junior doctors, nurses and clinical aides, with all patient-related tasks managed by a senior nurse who triages and assigns tasks to a member of the team. The task is accepted by the team member, and is added to their task list held on their smartphone. It stays active until the team member has completed the task.

Emergency eye clinic

Excellent support by phone when checking whether or not I should attend the clinic. Treated with respect and there was no sense of wasting anyone's time. Recommended to go into the clinic where I was seen by a very helpful nurse and a doctor within an hour. Clear explanation of follow up treatment and easy booking the next appointment.

Chris Swan

Reducing avoidable harm

Critical Safety Actions

This year the 5 Critical Safety Action CQUIN (Commissioning for Quality and Innovation) programme has seen a reduction of 21 per cent in SUIs (serious untoward incidents) related to the 5 Critical Safety Actions and more specifically a reduction in SUIs associated with non-escalation of EWS (early warning score) by 25 per cent (to end of December 2012).

We have implemented the use of electronic handover by nursing staff in in-patient areas and all of our healthcare assistants have been assessed as competent for carrying out EWS observations on our patients.

We have developed and started to implement robust guidance for screening and diagnostic testing and all of our specialities are now doing mortality and morbidity review meetings. Overall we have seen a reduction in avoidable mortality and morbidity.

End of life care

In March 2012 we became part of a national programme 'Transforming End of Life Care in Acute Hospitals' which aims to improve end of life care in hospitals across England.

By taking part in this programme we are driving improvements and raising the standards of end of life care. We are working in partnership with other hospitals and local health organisations to ensure we are providing integrated care for people who are dying, their relatives and their carers.

Through training and education we are committed to ensuring our staff has the skills, knowledge and experience to provide outstanding end of life care.

The key elements are:

- introduction of Advance Care Plans across Leicester, Leicestershire and Rutland
- introduction of a care bundle for those patients who have recovery uncertain
- to maintain the use of the Liverpool Care Pathway. The Liverpool Care Pathway for the Dying Patient is a care pathway used in the UK covering palliative care options for patients in the final days or hours of life. It has been developed to help doctors and nurses provide quality end-of-life care
- to continue to facilitate Rapid Discharge for dying patients to their preferred place of care.

We also recognise the value of involving people who have had experience of end of life care services in the design of future service developments.

In October our staff embraced **Butterflies**, a new scheme to show extra respect to the families of those who are dying or have died in the emergency department.

The new initiative involves placing an image of a butterfly on the door to identify that the patient needs peace and quiet. The butterflies act as a visual prompt to Emergency Department staff and ambulance crew bringing patients in and have been embraced by all in the department.

Reducing patient falls

Many of our wards have made significant improvements in preventing the numbers of patients who fall during their stay with us. Despite this we have not seen an overall reduction in the numbers of in-patient falls across the Trust. Given this, falls is a key element of the reducing harms strand of the Quality Commitment for 2013/14.

Some of the key achievements in relation to falls are embedding in the Patient Safety Thermometer monthly prevalence audit where the data indicates the number of harms acquired in hospital in relation to falls has reduced over the year. There has been an education programme, bespoke to wards, as well as being included in mandatory training, which has given the clinical staff the knowledge on how to reduce the risk of their patients falling. Our frail older people's service also provide the input of a geriatrician to patients who are under the care of a non-geriatrician and are frail and at a risk of falling. Increasing the nurse to bed ratio and hourly matron rounds has also had an impact. The nursing metrics, which includes reviewing documentation of patients falls risks and associated plans, continue to show improvement.

In fact 12 wards have seen significant reductions in falls due to the work they have carried out, and that success indicates that it is absolutely possible to reduce patient falls in a range of clinical settings. Therefore the approach these areas have used will be shared across the organisation to increase the pace and breadth of this work and will bring about significant reductions in falls in the first part of the 2013/14 financial year.

Making Every Contact Count (MECC)

As a health organisation we have a responsibility to protect and improve the overall health and wellbeing of our patients and staff. MECC is about addressing four lifestyle issues which have an impact on our overall health and wellbeing.

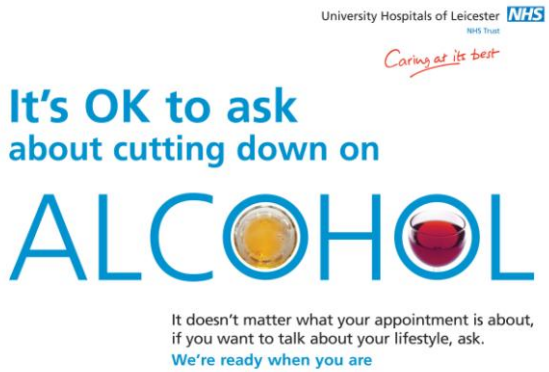
Evidence from a study carried out in Norfolk (1993-2006) showed a 14-year difference in life expectancy between those implementing all four health lifestyle behaviours.

1. Not smoking
2. Drinking alcohol within recommendations
3. Eating a healthy diet
4. Undertaking the recommended amount of activity.

We are actively focusing on the first two lifestyle issues – smoking and alcohol. Every healthcare practitioner should:

- Ask about the lifestyle issue
- Advise
- Act.

MECC is not about adding on another job, staff becoming specialists or counsellors or preaching to patients. It is about a brief conversation that leads to a patient being signposted to the appropriate service.



Alcohol liaison team

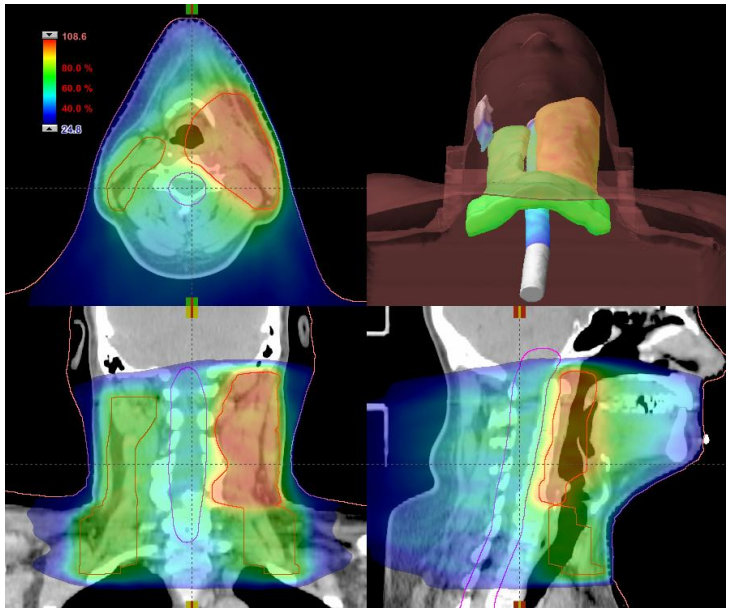
Since April 2012 our alcohol liaison team has expanded from one to four members of staff. The team is based at the Royal Infirmary but responds to referrals from all the sites. Patients are usually seen within 24 hours (Monday - Friday), with the aim of seeing most patients whilst they are still in hospital. For those that cannot be seen during their in-patient admission, outpatient clinics are arranged.

Under 'Making Every Contact Count' (MECC), the service has expanded to include self-referrals from members of the public that are not necessarily our patients. Through our alcohol awareness and MECC training we have actively sought to promote the service and referrals to it.

Intensity modulated radiotherapy

Intensity modulated radiotherapy (IMRT) is an essential part of modern radiotherapy, allowing complex patterns of radiation to be delivered which ensure the cancer is targeted but nearby sensitive areas are avoided. In October 2012 David Cameron challenged the NHS to ensure innovative radiotherapy treatments, like IMRT, were available to all patients who would benefit from them – nearly a quarter of all new radiotherapy patients.

By March 2013 we answered the challenge and met the standard. And because most of our IMRT treatments are delivered using a special form of rotational IMRT called VMAT (volumetric modulated arc therapy) the treatments are quicker and simpler. We will continue to advance radiotherapy in the coming year, continuing to increase the number of patients who receive IMRT, VMAT and other forms of innovative radiotherapy, to ensure we are at the forefront of the Department of Health's aim to deliver world class radiotherapy.



IMRT allows complex patterns of radiation to be delivered to ensure the cancer is treated whilst avoiding nearby sensitive areas

COPD Care Bundle CQUIN

In the past year the Respiratory Discharge Service (REDS) has been working to ensure that patients with COPD (chronic obstructive pulmonary disease) receive the COPD care bundle before their discharge. This is a suite of evidence-based interventions that includes smoking cessation advice, supported self-management, inhaler technique assessment and referral to pulmonary rehabilitation. So far the REDS team has delivered the care bundle to more than 1,100 patients – around 70 per cent of all COPD patients discharged from Glenfield Hospital.

As a result more patients are now receiving the correct self-management advice, referral to smoking cessation services and there has been more than a 50 per cent increase in referrals to our pulmonary rehabilitation team.

Fibroscanner for assessment of chronic liver disease

A liver fibroscanner was purchased in 2012 and is currently being used by the departments of infectious diseases and Hepatology to assess patients with chronic liver disease, including those with chronic viral hepatitis, auto-immune disease and alcohol-related liver disease.

The fibroscanner gives a painless, non-invasive rapid assessment of liver fibrosis and steatosis (fat accumulation) and can be used to assess the severity of liver disease and the need to start treatment. Serial readings over time can be used to chart progression of the disease or improvement on treatment.

The fibroscan is a portable machine which is now routinely used in the clinic setting and has replaced the need for liver biopsy in many patients. This saves patients the pain and discomfort of the liver biopsy, avoids the risk of serious complications from the biopsy (bleeding and death) and the expense of day case admission required for a biopsy. Patient satisfaction with the procedure has been very high.

Fibroscanning is now established nationally as a reliable non-invasive assessment of severity of liver disease.

Patient experience

We continue to offer patient experience surveys in adult inpatient, adult day case, children's in-patient and intensive care unit areas. Approximately 1,675 surveys are returned on a monthly basis, an increase from 2011/12. From April 2012 we have used the local Friends and Family Test (also known as the net promoter score) as part of the survey, this has been changed to reflect the revised national question: *'How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?*'

Each month we look at the Friends and Family Test result for each ward, department and as an organisation. We can then benchmark our feedback from patients with other NHS trusts using this question. A great deal of focused improvement activity has taken place over the last year in response to public feedback. As a result our Friends and Family Test score has improved by 13 points from 51 to 64 and this shows that we have made some improvements in terms of patient experience.

Share your experience

We currently have electronic surveys available in the emergency department, maternity, outpatients, neonatal units and children's emergency department.

In February 2013 we redesigned our internal survey forms into a colour booklet to make them more appealing to patients. Survey holders have been put up in all areas that have a survey to ensure that patients are able to take a form if they want to and each area has a poster inviting feedback and comments from patients and the public.

Free text comments we receive as part of the survey are themed on a quarterly basis to identify areas that we are doing well in and areas where we can improve.

Public-facing dashboards

In February 2013 public-facing 'Caring at its best' dashboards were introduced. These allow staff, patients and visitors to see the wards' performance at a glance. Wards are asked to complete a template to display alongside these dashboards identifying what is being done to improve performance.

Message to Matron

Message to Matron cards are used for patients across all areas (called 'Postcard to Leicester' in outpatients and 'You Help us Learn' in maternity). People can leave their feedback on these cards either anonymously or by leaving their contact details. Matrons can then respond immediately to any concerns raised. We gather the feedback received from these cards and collate at an organisational level on a quarterly basis.

Patient feedback from people with dementia and their carers

The patient experience team has carried out work with support from the Alzheimer's Society, Age UK and carers' groups to get feedback from more than 100 local people with dementia and their carers.

We have carried out Dementia Care Mapping (DCM) on five wards for 16 patients over 32 hours with support from trained dementia care mappers. DCM measures patient activity and mood engagement, patient wellbeing and the quality of staff interactions as seen 'through the eyes' of the person with dementia.

Feedback from theses activities has highlighted positive experiences including; good end of life care, good communication, evidence of caring staff and situations where staff where exceptional at supporting carers. We are always keen to improve. Collecting feedback from both carers and patients has identified key themes for service improvements, which include:

- embedding the 'Patient Profile'
- supporting dementia awareness training

- improving patient safety and protected mealtimes
- reducing waiting time on day of discharge
- increasing meaningful activities resources
- enhancing the environment
- supporting our Dementia Champion network
- implementing a 'communication assistance' sign
- ensuring medical staff to follow the Dementia Care Pathway.

Information has been shared with the nursing executive team, dementia care action group and members of the patient experience group. A plan has been formulated based on recommendations for improvements in 2013/14.

Privacy and dignity: what does dignity mean to you?

Staff across our organisation receive privacy and dignity training so they understand how important it is for our patients and their families.

We regularly complete a privacy and dignity audit throughout our hospitals, and report and plan for any improvements needed in our clinical areas. The audit looks at the physical environment, how clinical staff work and also asks patients, their relatives and carers for their impressions of privacy and dignity in each ward or clinical area.

We have specific questions that are focused on privacy and dignity throughout the patient experience survey. In addition to this we have engaged with members, patients, public, staff and volunteers recently to ascertain 'what does dignity mean to you'. From this feedback we will develop promotional material to raise staff and patients' awareness and key actions for central and local ownership.

Improving patient experience – virtual hepatitis clinic

Our virtual hepatitis clinic was set up for stable patients with chronic viral hepatitis, mainly those with chronic hepatitis B who require long-term follow up blood tests and treatment. Patients' records are checked by a consultant before they attend clinic, blood tests and repeat prescriptions are organised and patients and GPs receive a letter after the clinic attendance. Patients can attend at a time of their choosing and do not wait to see a doctor unless they have medical concerns. Advantages include reduced waiting times, increased efficiency of the clinic leading to reduced waiting times to see new patients and increased patient satisfaction.

This was innovative and builds on a similar clinic model used for stable patients receiving treatment for chronic HIV infection.

Listening to carers

Following the Francis Report, it has become more critical than ever to ensure we have a clear plan for carer and family involvement. Recently we joined Leicestershire Partnership NHS Trust, Leicestershire County Council's adult and children's services, the local CCGs (Clinical Commissioning Groups) and other carers' groups to launch the carers' charter in a partnership approach designed by the Leicestershire LINks group.

Carers are invited to give feedback on their experience throughout the year, and during early 2013 we have focused on gaining carers' feedback across all three of our hospitals. The findings will help shape our work in 2013 /14 and beyond. They tell us they want to feel supported, be given the right information, have access to signposting and resources, as well as to be involved in decisions both about their loved ones, and the way services are designed and shaped. Internally collaboration continues with key focus in ward and outpatient areas, discharge teams and those clinical high priority need groups – for example those with dementia and elderly people.

Involving the wider public

In addition to our members, we continue to support Patient Advisors (members of the public who get involved in various areas to provide a lay perspective on our work). We have also continued to build on our good relationships with our Local Involvement Networks (LINks), holding a joint event in the city and meeting regularly to listen and respond to issues raised by the public. As the LINks come to an end and are replaced by the new Local Healthwatch organisations during 2013 we look forward to working with the new structure and to further develop our understanding of the needs and concerns of our local population.

Patient information and liaison service (PILS)

We value feedback from patients, their relatives and carers and see it as a valuable opportunity to improve the services we provide. Feedback can be provided in a number of ways, and talking to staff in the first instance is encouraged as it provides an opportunity for immediate action and resolution.

The Patient Information and Liaison Service (PILS) is available and they are able to provide advice on how concerns can be managed. They can be contacted via a free-phone telephone number, e-mail, our website or in writing.

Whilst the activity through the PILS team continues to increase reflecting the ease in reporting concerns, there has been a reduction in formal complaints in 2012/13 from the previous year. This demonstrates our commitment to find resolution to concerns quickly, without resorting to a formal process.

PILS activity	**2012/13**	**2011/12**	**2010/11**
Verbal complaints	1054	1152	1289
Formal complaints	1549	1723	1531
Concerns	343	66	
Requests for Information	292	434	356

Complaints 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 we managed complaints during the year.

	10 day				25 day			
Business Unit grouped by Division	**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**
ACUTE								
Emergency Department	21	19	2	**90%**	91	65	26	**71%**
Medicine	42	36	6	**86%**	187	149	38	**80%**
Cardiac, Critical Care and Renal	22	21	1	**95%**	63	49	14	**78%**
Respiratory and Thoracic	6	6	0	**100%**	29	22	7	**76%**
Divisional average	**Total 91**			**90%**	**Total 370**			**77%**
CORPORATE								
Facilities	14	11	3	**79%**	6	6	0	**100%**
Finance and Procurement	1	1	0	**100%**				
IM&T	1	1	0	**100%**	1	1	0	**100%**
Nursing	3	1	2	**33%**	7	4	3	
Operations					3	2	1	**67%**
Strategy	3	1	2	**33%**				
Trust Medical Director	1	1	0	**100%**				
Divisional average	**Total 23**			**78%**	**Total 17**			**76%**
PLANNED								
Specialist Surgery	76	76	0	**100%**	113	113	0	**100%**
GI Medicine/Surgery/Urology	52	51	1	**98%**	197	188	9	**95%**
Cancer/Haematology/Oncology	13	13	0	**100%**	28	28	0	**100%**
Musculoskeletal	24	24	0	**100%**	98	95	3	**97%**
Divisional average	**Total 165**			**99%**	**Total 436**			**97%**
CLINICAL SUPPORT								
Theatres, Anaesthesia, Pain Management & Sleep	6	6	0	**100%**	27	27	0	**100%**
Pathology	3	3	0	**100%**	5	5	0	**100%**
Professional Services	11	11	0	**100%**	18	18	0	**100%**
Imaging and Medical Physics	15	14	1	**93%**	14	13	1	**93%**
Divisional average	**Total 35**			**97%**	**Total 64**			**98%**
WOMEN'S AND CHILDREN'S								
Women's	19	19	0	**100%**	175	162	13	**93%**
Children's	2	2	0	**100%**	50	44	6	**88%**
Divisional average	**Total 21**				**Total 225**			**92%**
Totals:	**335**	**317**	**18**	**95%**	**1112**	**991**	**121**	**89%**

Preventing infections

We have had another successful year in the fight against two specific healthcare infections. The number of MRSA bloodstream infections fell to a record low of two in 12 months, against a Department of Health trajectory of six. Clostridium difficile (CDiff) diarrhoea cases also fell to 94 cases over the whole 12 months against our trajectory of 113.

For 2013/14 we have been set a target of no MRSA bloodstream infections – which will be a challenge for an organisation of our size as the causes of these infections may not always be avoidable – and no more than 67 CDiff infections.

We have a plan that builds on our success in tackling CDiff over the last five years, which we are currently implementing.

We are also ambitious in tackling other types of healthcare infections. Our strategy includes a commitment to carry out surgical site infection surveillance across our hospitals and to prevent infections caused by bacteria resistant to a wide range of antibiotics. Such bacteria has been detected in many places around the world over the last three years and hospitals affected by them have faced real challenges. We are determined that such infections will not happen in our hospitals and will work with health and local authorities as well as Leicester University and other research centres in order to fight these infections.

There are many patient and hospital benefits in having an effective and successful infection prevention programme and we are committed to ensuring these benefits are realised.

Focusing on discharge

In May 2012 we launched our BED Before 11am Discharge Project. The aim of this project is to improve the discharge experience of our current patients and create capacity for our new patients.

The project has created a focus for all our multidisciplinary teams to improve both the quality and timeliness of discharge of all patients through the introduction of proven and evidence based structures and processes starting on admission or before. Using an estimated date of discharge from admission, the introduction of ward-based discharge coordinators and setting up daily multidisciplinary discharge planning board rounds have all had a very positive impact and have resulted in noticeable change. For patients and their families this means:

- they get safely to the next step of their journey more quickly and spend less time in hospital
- they are less likely to have to wait to be admitted to an in-patient bed

- they will experience fewer transfers between wards
- they will feel less stressed and more in control and involved in their care and timely and safe discharge.

For the staff it reduces the number of 'outliers' (in other words, patients who are not on the ward that specialises in their particular condition) on their ward, allows them to provide more timely care for patients and improves the relationship with patients and carers with fewer complaints or concerns. All this will mean less frustration, stress and greater job satisfaction.

Being discharged with the appropriate medications

The TTO (To Take Out) CQUIN (Commissioning for Quality and Innovation) focuses on increasing the proportion of medicines to take out (TTOs) prescribed at least 24 hours before discharge. The most recent data shows we are prescribing 32.8 per cent of TTOs at least 24 hours prior to discharge, with particularly strong performance in the Medicine Clinical Business Unit, where 44.5per cent of TTOs currently meet this target. Improvements have been achieved through improved engagement with clinicians at board rounds and use of estimated discharge date, which have both helped with advance planning.

Discharge lounge staff have also been more proactive in identifying patients for discharge the following day and prompting medications to be prepared. Junior doctor and ward staff training on discharge planning has increased, and emphasises the importance of early planning. Within the Medicine Clinical Business Unit the role of the discharge coordinator has been developed and embedded, and we believe this has significantly contributed to the improved performance.

A discharge performance management process has been established with each Clinical Business Unit, including performance targets and focus on poorer performers. This has been supported by improved ward-level data on discharge planning performance including TTO prescribing in advance and development of the discharge dashboard for each ward, circulated on a fortnightly basis.

Improving our pharmacies

Our pharmacy service is committed to providing the best services to our patients and staff and we continue to work to improve the service through innovation. During the year we have worked on some key projects that have completed this year. We continue to put patient safety at the heart of our work alongside service efficiency and effectiveness.

During 2012/13 we completed a pilot with an external provider, Lloydspharmacy, to run outpatient pharmacies across our hospitals to improve response times for patients. That has been a real success and we are now in the process of finding a permanent partner to work with to continue to deliver improvements in our outpatient pharmacies.

We have continued to roll out electronic prescribing and medicines administration across our organisation and another 40 per cent of areas are now using the process to improve medicines safety and modernise the medicines use process.

We have finished a project to increase adherence to nebulised (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) antibiotics within the adult Cystic Fibrosis population and we've introduced specialist clinical pharmacist support and intervention. This project was funded through monies received following a successful national bid.

We have introduced a specialist pharmacist service for our COPD (chronic obstructive pulmonary disorder) patients to reduce hospital re-admissions and increase compliance with NICE guidance.

We carried out a three-month trial in our Discharge Lounge, using a pharmacy technician to speed up the discharge process. This increased the number of medicine information cards received by patients, counselling on their drug therapy and improved discharge times. We are now evaluating the results of this pilot along with other work being done by the Trust to improve the discharge process.

As part of our role in delivering the Trust's Strategic Direction we have moved to having two main dispensaries and one large satellite hub. This has resulted in the closure of one pharmacy robot resulting in efficiency savings. Currently this is allowing us to look at centralising our ward stock replenishment and then allow staff more time to focus on patient care on the wards.

We are in the process of refurbishing our aseptic facility to improve the safety and timeliness of chemotherapy production for our Cancer Hospital and upgraded our pharmacy computer system to give to improve the functionality of the aging system. A full time senior pharmacist has joined our team to support clinical trials and support our research agenda and aspirations.

We are also involved in a number of other projects involving process mapping to introduce greater efficiency into various process from investigative medicines processes in research and development to ward-based medicines ordering, administration and discharge processes.

Ward-based pharmacy reduces waits

Our patients 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.

Initial figures in March 2013 showed that 65 per cent of take-home medications were ready within 40 minutes and we are dispensing almost 300 items a week. 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.

Safeguarding adults and children

Safeguarding people from harm and abuse is integral to the delivery of care to our patients. It is recognised that people who use hospital services can be vulnerable and at higher risk. The circumstances that people find themselves in can sometimes be difficult and it is important that staff recognise and act accordingly.

Our safeguarding service continues to support frontline staff in the management of safeguarding, to ensure a supportive approach is adopted. It is not unusual for these cases to take a considerable period of time and resource to investigate and conclude. During the past year, the local safeguarding boards have expanded their remit to consider and review cases of domestic homicide; this has raised awareness of the risks associated with domestic violence and the importance helping people in these circumstances.

In the past year, we have seen an increase in the number of adult safeguarding cases reported to the service and we continue to be involved in a high level of complex child protection cases. Some of these cases have been considered through serious case reviews, which offer the opportunity for very detailed inter-agency scrutiny of a case, helping to check how well embedded safeguarding practices are.

During the year we took part in three serious case reviews and the findings of these have confirmed that there is improved reporting and awareness of safeguarding issues among staff, as well as consistent evidence of early interventions to safeguard people.

The services we offer to safeguard people is carried out by external agencies. We had one review of our adult safeguarding service by East Midlands Strategic Health Authority, which confirmed we are compliant with all key safety indicators. These have also been confirmed through the Primary Care Trust quality review process during two site visits to review safeguarding arrangements for children and adults. The Care Quality Commission also made an unannounced visit to review our safeguarding services. These confirmed compliance with the safeguarding standards developed.

In the past year we have continued to work with partner agencies to develop services. Earlier this year we launched a campaign to raising awareness about mental capacity, consent and deprivation of liberty safeguards. This work is to ensure that our staff can best represent and advocate for the people they care for, which continues to be our top priority in safeguarding.

Older People's Champions' Network

We have an active Older People's Champions' network which includes staff from a range of backgrounds and specialties who have volunteered to support older people within our hospitals. Their role is to promote excellence in practice and a responsive individualised service.

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

During the year we held three successful Older People's Champions forums to update our champions on current national and local initiatives for improving care for older people. Age UK supported the forums and shared valuable information of current issues older people in the community may experience and raised awareness of what support is available to older people when they leave hospital.

The Older People's Champions Celebration Event, entitled 'Dignity and Dementia' took place in September to support World Alzheimer's day. More than 100 champions accessed dementia-related workshops including communication, dementia care mapping and delirium. Champions also heard from staff in Leicester's Hospitals sharing new initiatives they are undertaking to help improve patient experience for people with dementia and their carers. Champions were recognised for their commitment and drive to improve care for older people and people with dementia with an award being presented to the 'Champion of Champions'.

In 2013/14, we will focus on feedback from older people's experience in Leicester's Hospitals to enable champions to understand what really matters most to older people when they are admitted to our hospitals. The network will also support key developments in Leicester Hospitals Strategic Direction in providing better services for frail older people.

Admission for investigation

My husband was admitted for severe abdominal pain one Sunday afternoon. He was treated promptly, efficiently and considerately. He had an operation on the following Tuesday and his treatment, nursing and care was wonderful for the following two weeks he was in hospital. His aftercare has also been very good - we are very appreciative of the care and treatment he has received.

Anonymous

Improving dementia care

To mark World Alzheimer's Day in September, we officially opened a 'meaningful activities' room for patients with dementia. The special room has been funded by generous donations from the WRVS and the Lord Mayor of Leicester's Forget-me-not Appeal 2010/11.

This new room, located on an older persons ward at the Royal Infirmary, includes a comfortable sofa, TV and dining area with meaningful activities such as games, puzzles and a piano which provides a soothing and calm environment for our patients with dementia.

Remembering our older patients at Christmas

Sadly on Christmas Day in 2011 there were almost 600 patients over the age of 70 in our three hospitals. Many of these patients didn't get presents or visitors at a time of the year when many of us are spending the day with our loved ones.

This year we decided to change that and in partnership with Age UK LeicesterShire and Rutland, we encouraged local people to consider donating a small gift to bring a smile to the face of one of our older patients.

The campaign was a huge success with local people and staff donating presents, which meant that all of our older patients across our three hospitals got a gift to open on Christmas morning. Ward staff handed out the generous gifts which contained things like books, socks, hand creams, biscuits and chocolates.

Local MP Jon Ashworth lent his support to the campaign, even bringing along his own gift. He said: "The support of local people has been magnificent and shows that the true spirit of Christmas is still strong in Leicester. I was pleased to be able to help out and deliver some of the gifts to patients in the Royal Infirmary."

Information governance

We continue to improve and extend the range of information governance services and standards to protect privacy, reduce risk and increase patient confidence.

At its heart, information governance is about delivering the right information to the right people at the right time. This requires all staff and partners to be aware of the need to protect and promote information governance standards and the past year has seen a greater focus on building staff skills and responding to patient issues and risks, including sharing information across the public sector.

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.

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

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

Information governance incidents			
Category	**Nature of the incident**	**2012/13**	**2011/12**
1	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	3	2
2	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0	1
3	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	2	1
4	Unauthorised disclosure	2	2
5	Other	0	0

Same-sex accommodation

We continue to achieve national standards for same sex accommodation. All of our wards are regularly examined as part of a formal walkabout process with facilities and senior staff. The patient survey also asks about sleeping and bathroom accommodation, and as a result we have altered the way the questions are asked for clarity. Posters are due for release soon, which will further clarify same sex accommodation principles. Find out more about our same sex accommodation pledge on our website.

Thank you

I recently spent almost two weeks at Glenfield, after being admitted with breathing difficulties. I was very ill and was placed in an induced coma because I needed ECMO treatment. I don't remember much, but my family, who visited daily were treated with kindness and understanding. Nothing was kept from them (even the possibility that I could have died). The care I received whilst asleep and after I woke was second to none.

The doctors and nurses were amazing, explaining to me what was happening. Their care and dedication is what helped me begin the recovery process.

I can't praise the hospital and all of the staff enough. So thank you from the bottom of my heart, for everything you did for me.

Lesley

Develop joined up emergency care that consistently meets patient expectations

Many of our patients begin their journey in the Emergency Department; we have to improve the models of care and the environment to deliver a better patient experience and better quality outcomes.

Improvements to our emergency care delivery

Creating improvements in our emergency care is a system-wide issue and a priority for us and other local health services. In November we started an improvement project looking at our emergency department and assessment processes moving on to ward processes and bed management.

The project is run under strict governance arrangements with our doctors leading the work, supported by experienced project managers. Each work stream is led by a senior doctor, and involves of further clinicians, managers, nursing staff and other health professionals to ensure that all views have been taken into account. These areas of work will not be completed until the end of May 2013.

In conjunction with this, the commissioners are incorporating the work of the Emergency Care Network into the system of change in effect creating further work streams under the same strict governance arrangements.

Improving our performance against the national target and the experience emergency patients receive is one of our key priorities. In our Strategic Direction, published in November we described, at a high level, the plans for each of our hospitals from a services and estates point of view. Principally emergency care would consolidate onto the Royal Infirmary site. Specialist care would be focused on the Glenfield, and outpatients and day case procedures would migrate to the General. In our recently agreed Annual Plan we have started to fill in the detail. In fact a good way of looking at the Annual Plan is to think about it as 'year one' of the five year plan.

It sets out some of the shorter-term improvements we want to make to our estate in order to deliver our longer terms aspirations. One of the main priorities is to create a new emergency floor to better deal with the pressures currently faced by our ED which are unsustainable. Putting it plainly, it is simply too small. It was designed for 115,000 patients, not 150,000!

So to address this issue we intend to create a new larger ED in the area of the Balmoral building currently occupied by outpatient (OPD) clinics (1-4). OPD 1-4 will move over to the General Hospital. By freeing up the space in OPD we can begin to create a new, bigger ED whilst continuing to run our current ED. In autumn 2014, the work should be complete for the move, leaving the space currently used by ED to be transformed into a new assessment unit.

You will hear more about these plans throughout 2013/14 as they begin to take shape.

Better services for frail older people

A wide variety of initiatives are underway, which are overseen by the Leicester, Leicestershire and Rutland Frail Older People's Network, chaired by Professor Mayur Lakhani on behalf of the three local CCGs. One key area of development has been the restructuring of acute care pathways for older people.

Frail older people are defined as people aged 65 or older who need help with activities of daily living, such as washing, dressing, eating and toileting. These people usually have multiple and complex care needs that require the support of health and social care professionals. Identifying this group can be difficult and we have chosen to include people aged 85-plus. We know that many people younger than 85 will be frail and some people older than 85 will be robust; using 85+ as a measure captures about two-thirds of frail older people.

There are increasing numbers of frail older people attending our emergency department. The rate is rising by approximately a five per cent each year. Frail older people have the highest 'conversion rate' (the proportion of people attending the emergency department that are admitted to hospital wards) – this is three-times that over other groups (75 per cent compared to 25 per cent). Frail older people admitted to hospital are at high risk of adverse events, are more likely to have long stays, more likely to be readmitted and require long-term care.

Despite making up less than half of all patients admitted, older people account for more than two-thirds of occupied bed days.

There are many interventions that can improve outcomes for frail older people as with young people; these include increasing access to health care and better communication systems. But there are also specific care pathways for frail older people based upon the national comprehensive geriatric assessment (CGA).

The CGA is a diagnostic process used to determine the medical, psychological, and functional abilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up. A typical team will include a geriatrician, a nurse specialist, an occupational therapist, a physiotherapist, a pharmacist and others as needed (e.g. speech and language therapy, dietetics). The CGA improves outcomes for older people in various settings, including reduced mortality or deterioration, improved cognition, improved quality of life, reduced length of stay, reduced readmission rates, reduced rates of long term care use and reduced costs.

As hospital length of stay has shortened over the years, it has become increasingly important to ensure that care pathways are developed across primary and secondary care to ensure effective continuity of the care.

Over the next few pages we will share with you just some of the specific projects we are working on to help us deliver improved care for older frail people.

Changing attitudes

Through close collaboration with GPs themselves, as well as CCGs, geriatricians and their teams have started to change this attitude. GPs now feel more confident to refer patients into ED/EFU for assessment, knowing that if appropriate, patients are likely to be discharged home on a robust care pathway.

Perhaps more importantly, patients are offered holistic patient-centred care, and satisfaction is increased, leading to fewer complaints, and inspiring greater confidence in the hospital.

Frail Older Peoples Advice and Liaison service (FOPAL)

The service has developed over the past two years and now focuses predominantly on in-patient wards at the Royal Infirmary and Glenfield hospitals, with some support to the General. FOPAL includes a consultant psychiatrist, consultant geriatrician physician assistant in geriatric medicine, community psychiatric nurses and administrative assistant.

FOPAL currently sees an average of 108 patients a month, with around 40 per cent requiring follow-up visits.

Community hospital wards

Geriatricians support hospital practitioners and ward teams in the delivery of CGA in 8 of 11 rehabilitation ward across the county, and in both city intermediate care units. The ambition is to extend this coverage to include all community hospital wards as well as the developing intensive community support service. The presence of geriatricians has increased substantially over the last 18 months, and along with other initiatives running in the community hospitals has led to important improvements in patient care as well as efficiency gains.

Between 2009 and 2011 community hospital length of stay remained relatively static at 25-26 days. Following the introduction of greater geriatric clinician presence in the community setting, length of stay has fallen to 20 days in 2012.

Allergy clinic

My daughter was assessed at the Allergy Clinic at the Glenfield. We were very impressed with the efficiency and friendliness of all the staff. No long waits to be seen and everything was carefully explained to her. The hospital was very clean in all areas. Thank you.

Anonymous

Access to community hospitals

Locally there was an enthusiasm for delivering acute care in community hospitals, which they were not resourced to deliver. This led to 10 per cent of patients being 'stepped up', i.e. referred to acute services within 24 hours and 40 per cent being referred in at some stage during their stay.

Following consultation with the CCGs we introduced an innovative single point of access (SPA) system, run by nurse practitioners. The SPA manages the liaison between GPs and consultant geriatricians prior to any community hospital admission.

GPs have one number to call, all calls are auditable and a geriatrician must respond within 20 minutes. The new referral pathways went live in March 2012. Data from May 2012 shows interaction between GPs and the EFU is already being converted into a length of stay reduction in community hospitals of one day per patient. A five per cent reduction in readmissions has also been achieved.

Locality geriatricians

A key ambition of the department has been to support the care of older people in community settings, especially concerning acute care pathways – aiming to support the delivery of CGA at all stage of the patient pathways. Efficiencies in community care translate to increased capacity and flow in the acute hospital setting and are given equal priority to conventional acute hospital activity.

Orthogeriatrics

Following a reconfiguration of our service that manages older people with hip fracture (orthogeriatrics) we moved from the bottom quarter of performance to the top quarter. Our geriatric services to provide daily input to orthopaedics through daily multidisciplinary team (MDT) meetings, daily ward rounds/reviews and weekly MDT meetings.

Key to the reduction in length of stay in orthopaedics has been the establishment of post-acute pathways delivering CGA across primary and secondary care. The orthogeriatricians all have a role in managing patients in the acute sectors as well a in the community setting.

Geriatric base wards

Geriatricians run 5.5 acute wards across the Royal Infirmary and Glenfield. These predominantly cater for the needs of frail older people and consistently deliver high quality CGA in a discrete, ward based setting.

Outpatient services

Outpatient falls services are provided at the General and in most community hospitals. Other geriatric medicine outpatient services offer expertise in the management of Parkinson's disease, syncope and gastrointestinal problems in older people.

Care for older patients is showcased nationally

Staff from Leicester's Hospitals and Leicestershire Partnership NHS Trust (LPT) were shortlisted for an NHS Innovation Award for their work to improve care for frail older people.

The team went up against other clinicians from across the country in a 'Dragon's Den' style panel in July and used this as an opportunity to showcase the work they do to care for frail older people in the city and county.

Mobile ECMO team clocks up the miles

In October, our unique mobile ECMO service for children and neonates at Glenfield broke its records as it hit the road six out of seven days in one week so the sickest children could receive the highly specialised treatment.

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

The mobile ECMO service is the only one for children and neonates in England and Wales. They receive referrals from hospitals across the country, travel to the patient in the referring hospital where they can quickly begin ECMO treatment in that hospital and while the patient travels back to Glenfield with them.

Emergency planning

This year we have furthered our commitment to emergency planning with the appointment of a new emergency planning officer to oversee all our emergency planning and business continuity. This post is pivotal in ensuring that we are best prepared to respond to the needs of the community during a major incident. We have also cemented the roles of our senior managers, directors and non-executive directors into emergency planning.

At the beginning of the year we came together with our multi-agency partners to respond to the potential fuel shortages and during the spring to deliver a successful Olympic Torch relay through Leicester, Leicestershire and Rutland. Since then we have been working hard to ensure that appropriate equipment is available and that staff training and exercising is taking place such as investment in our equipment and facilities to deal with contaminated casualties.

During 2013 we will see big changes in how the NHS is run and the organisation of our Information and Technology and Estates and Facilities services to third party suppliers. As a result we are working hard to ensure that these changes happen smoothly and that they don't disrupt our frontline services. Already a large-scale exercise across the Midlands region (Birmingham, Leicester and Cambridge) has identified that we have good arrangements in place to respond after the transition to the new NHS structure.

And we will further develop our arrangements to respond to an incident that may occur within our hospitals, ensuring that our staff can continue their work and patients undergo their treatment in safety.

Made me feel very relaxed about extraction

I had my first wisdom tooth removed just over a week ago. I opted to have a local as I didn't want to put asleep unless they felt it necessary.
The staff who removed my tooth (two ladies) were fabulous; they put me at ease before, during and after the extraction.
I was very pleased and made sure I requested the same staff to remove my two further ones in three weeks' time.

Melanie K

Consolidate our status as the provider of choice

Patients and GPs will want to use us….not just because we are local, but because we are consistently the best option.

This means that we are going to fundamentally change some of the ways we work. We will make sure that we take the 'hassle out of hospital' for patients, reducing cancellations and making sure that every hospital visit is delivered to the highest quality, safely and without delay.

Improving our maternity and gynaecology services

Over the years we have seen an increase in births and increased demand for our services – last year we delivered 11,000 babies. The Royal Infirmary provided care for more than 6,000 women, the General Hospital provided care for more than 4,000 women and St Marys Birth centre in Melton Mowbray provided care for 250 women.

The main challenge facing maternity services over the next five years is the continued increase in birth rates. We are investing £2.9m over the next two years expanding our maternity units at the Royal Infirmary and General hospitals to create four extra delivery rooms to improve capacity (two on each site); three additional high dependency care spaces; 13 additional ward beds; four bedded birth centre at the General and relocation of the birth centre at the Royal Infirmary, co-located to delivery suite. A maternity assessment centre situated away from labour wards on both sites; Refurbishment of ward 1 at the Royal Infirmary to facilitate efficiencies in Gynaecology Assessment Unit; Additional bathroom facilities for the majority of delivery rooms at the Royal Infirmary and refurbishment and upgrade of maternity theatres at both sites.

During the first phase we redesigned gynaecology, separating emergency and elective services. Emergency gynaecology is now centralised at the Royal Infirmary within the gynaecology assessment unit (GAU) to allow co-location with our emergency department. This is a 24-hour service led by a consultant gynaecologist and specialist nurses with one-stop diagnostic and treatment capability, inpatient beds and emergency surgical procedures.

A major change is the consultant-led service which offers dedicated sessions by a consultant to review patients with specific problems referred by GPs and early pregnancy assessment. Since implementation we have increased our appointments and offer more flexible opening hours and additional ultrasound scanning capacity to allow improved access, quicker diagnosis.

All elective gynaecology surgery is carried out at the General supported by the opening of a day of surgery arrivals (DOSA) service on ward 11 and the reconfiguration of ward 31 for elective surgery. A centralised nurse led pre-operative assessment service has been established in gynaecology outpatients providing specific anaesthetic sessions for high risk patients to support the elective service. Other benefits include improved facilities and environment for patients; streamlined care pathways; one-stop service for women suffering in early pregnancy; reduction in emergency admissions readmissions and length of stay; increased access to ambulatory gynaecology care and treatment; new ways of working and clarity of roles for staff; positive feedback on patient inpatient polling and a reduction in complaints.

Expanding our services

In August we unveiled plans for our £2.9m investment in our maternity services which should be complete in early summer 2014. The project will create two extra delivery rooms and further develop the four-bed birth centre at the General. At the Royal Infirmary we will create four extra delivery rooms, as well as 14 additional ward beds and additional bathroom facilities for most of the delivery rooms will be provided at the Royal Infirmary. Dedicated maternity assessment centres will be created at both hospitals.

Funding awarded to improve Leicester's maternity service

In January we were awarded £246,200 by the Government to improve and upgrade the maternity units at the Royal Infirmary and General hospitals.

Following a successful application, we were allocated a share of the government's £25 million fund to improve choice for women and improve their experience of maternity care.

The money has bought manually reclining armchairs for delivery rooms and a selection on the wards at both the General and Royal Infirmary which will allow partners the opportunity to stay and be comfortable.

It will also fund the refurbishment of our two current birthing pool rooms and increase the opportunity for women to use water for labour by adding a further two pools – one at each site.

Excellent maternity provision

A great staff working under a lot of pressure, but still managing to provide an excellent service.
Really impressed with the midwives and their colleagues, would be happy to return for our next baby.
Fair bit of waiting around but despite this they were caring and supportive.

Anonymous

High quality and safe

On 19 March our maternity service completed its CNST (Clinical Negligence Scheme for Trusts) assessment, and passed the Level 2 accreditation in Maternity Standards with flying colours.

The NHS Litigation Authority (NHSLA) provides an 'insurance scheme' to NHS Trusts against claims for clinical negligence through the Clinical Negligence Scheme for Trusts (CNST). Trusts have to meet standards of care that show they are promoting and using effective risk management to minimise the risk of harm to their patients. Because of the nature of claims in NHS maternity services (where payments for incidents are high as they often have to support the baby through their life), a separate set of CNST standards are in place for maternity services.

It is fantastic news and a real achievement for the staff who have been working really hard to make improvements in our services. We are delighted that we have achieved a Level 2 with our service passing 46 out of 50 criteria - scoring 92 per cent, way above the required 75 per cent pass rate. The five standards, applying to antenatal, intrapartum and postnatal services, including care of the newborn, midwifery led-care, obstetrics, anaesthetics and ultra-sonography, are organisation, clinical care, high-risk conditions, communication and postnatal and newborn care.

As well as showing external assessors we have processes in place, it also shows that our standards of clinical care meet national recommendations. But most importantly it means that we can assure mothers and mums to be of the high standard of care that we provide in our three units.

Work does not stop now as we work towards the next and highest level.

New-look fracture clinic

In January 2013 we officially opened the new-look fracture clinic in the Balmoral building at the Royal Infirmary, following its relocation and refurbishment.

The department is one of our busiest, seeing around 550 patients a week. Staff carry out assessments and treatment for patients with broken bones referred from the emergency department, wards and GPs.

The new area in our Balmoral building is bigger allowing staff more space and flexibility to streamline their activity, improve patient experience and reduce waiting times.

Emergency patients can now be seen in the Professor Harper Trauma Clinic, named in tribute to the late professor in recognition of his contribution to the trauma unit, and in the development of the Advanced Nurse Practitioner role within the department. This additional space has helped provide a dedicated trauma area for emergency patients.

Teenage and Young Adult Unit

In December 2012 we opened our newly refurbished children's cancer ward and our newly developed teenage and young adult unit after an 18-month campaign to raise £1.4m.

The success was due to the 'Our Space' project group, working with the Teenage Cancer Trust and other charities. This means that we now have facilities that are specific to the needs of children as well as teenagers and young adults. It helps us meet their psychological and physical needs and provides networking opportunities for patients as well as families at a time when they can feel so isolated and alone.

Throughout the project young people, children and families have been involved in designing the facility by giving their opinion on designs, wall art and furniture.

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

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

Small skin cancer removed

Just wonderful from the receptionist to the female doctor and the nurse who assisted her they were friendly kind and couldn't have been more efficient. I was on time and was seen just five minutes later than my appointment time.
Well done to all on Ward 3 at the Royal Infirmary. Thank you all

Jean Strong

Work with partners to offer integrated care closer to home

Our hospitals are crucial to the future success and sustainability of the local NHS. Our strategic direction must therefore take account of the needs and aspirations of local commissioners (GPs).

When we say that our hospitals will become smaller and more specialised it is in recognition of the fact that our patients, stakeholders and their GPs want to see more care available in the community that has traditionally been provided in hospitals. Bringing our care services 'closer to home' is there a key component of our strategy.

Better Care Together

The Better Care Together programme is the whole health economy's approach to planning high quality sustainable NHS services for the long term. It involves partners from all parts of the NHS: commissioners, hospitals, community providers, mental health and social care.

Against the backdrop of increasing demand for NHS services and little or no growth in NHS budgets, the plan recognises that for the NHS to continue to provide quality services, we will have to fundamentally change the way we do things.

The programme has four key work streams, with each work stream led by a senior NHS leader either from a commissioner or provider. Those work streams are:

- Urgent care
- Planned care
- Long term conditions
- Provider efficiency

The thoughts, ideas and plans developed by the work streams are monitored and ultimately sanctioned by the Better Care Together Board. The Better Care Together Board itself is advised by a Public and Patient Involvement Group and a Clinical Senate….thus ensuring that any proposals have clinical, patient and public involvement oversight.

The Better Care Together programme went through a process of reflection and reinvigoration during Spring 2013 and as a consequence the governance, vision and objectives are much clearer. Over the next few years we should expect to hear much more about Better Care Together as the local NHS begins to move from planning into implementation.

Building on our relationships with GPs

This year we have continued to build on improving our relationships with our GP colleagues and to strengthen our communication links. We provide a monthly GP newsletter to update primary care on developments within Leicester's Hospitals; offer educational sessions to GP practice staff using different media such as downloadable podcasts, practical sessions and clinical guidance, we maintain a website for healthcare professionals to easily access key information and provide a GP referrer's guide to explain our services.

A GP hotline was set up in May 2012 as part of a pilot to give GPs easier access to advice from consultants for their patients so that they may seek advice on where an admission may be avoided. The service has been well received and we hope to attract funding to continue this service from April 2013.

We have also repeated our GP survey to enable us to focus on what matters most to GPs.

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 their patient leaving hospital.

The better data helps to improve patient safety by reducing the risk of drug errors, it also reduces 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 are needed.

It will also help us to achieve our targets and standards. 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. We still have a way to go, but this is a positive start and we will continue to work with GP colleagues

Community hepatitis outreach clinics

Chronic hepatitis C leads to liver disease, cirrhosis and liver cancer and the majority of cases in the UK have acquired infection through previous drug use. Treatment with interferon and ribavirin is often successful and curative, but is lengthy and complicated. Outreach clinics for patients with chronic viral hepatitis, mainly those with chronic hepatitis C, were initially funded by pilot study grant. Patient attendance at clinic visits and compliance with treatment in the hospital setting is generally poor with relatively high DNA (do not arrive) rates.

The outreach service is led by the hepatitis clinical nurse specialist with consultant support from Infectious Diseases/Hepatology. It has developed to include clinics in the drug treatment centre, homeless care service, and local prisons including Gartree, Stocken, Glen Parva and HMP Leicester. The service has seen many people who would not have attended the hospital clinics. Prison services particularly appreciate the specialist input without the need to transport high risk prisoners to multiple hospital clinics. Patients treated in the community by the outreach services have similar treatment responses to those treated in the hospital setting.

The service is innovative and is based on similar services which have been successfully implemented in Nottingham and a few other centres. There is a national initiative and Department of Health Hepatitis C Action Plan to increase testing and treatment of hepatitis C to avoid a future epidemic of chronic liver disease.

Working with GPs to detect osteoporosis

A new fracture liaison service was launched in November by the Rheumatology department at the Royal Infirmary to detect osteoporosis.

The referral service, set up by consultant rheumatologist Dr Peter Sheldon and his team, within the fracture clinic and with local GPs to ensure that patients are offered a specialist scan to measure bone density.

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

The team then work with the patient's GP to recommend the specialist dual-energy x-ray absorptiometry (DXA) scan. Patients under the age of 75 are offered a scan to determine the best course of action to prevent or treat the development of osteoporosis. Those over the age of 75 are recommended treatment options without the need of a scan.

Outpatient parenteral antimicrobial therapy (OPAT) pilot service

We have received funding from a non-recurrent transformation fund (April 2012/2013) to develop an OPAT service. We provide a multidisciplinary infection specialist led service to administer IV antibiotics at home, in conjunction with a consistent and reliable contracted community OPAT nurse team (currently BUPA Home Healthcare).

Our aim is shared care with parent teams to avoid admissions or facilitate a safe early discharge to decrease length of stay. The service treated 65 patients over a six-month period and saved 1,316 total bed-days.

For patients this means a patient-centred service, with shorter hospital stays, a choice to have care at home, reduced risk of healthcare-associated infections, reduced financial and psycho-social impact on the patient and their family.

For health services the reduced length of stay improves bed capacity and better management of admissions and discharge, freeing up nursing and medical time. There is also a potential reduction in cancelled operations, reduced waiting times and associated penalties.

Activate Your Heart

Specialists at Leicester's Hospitals have developed the UK's first online cardiac rehabilitation programme to help patients manage their cardiac condition effectively.

Activate Your Heart – www.activateyourheart.org.uk – is an easy to access, self-management programme for cardiac patients. It is the first online programme of its type and has been developed by cardiac rehabilitation specialists and patients at Leicester's Hospitals, alongside the National Institute for Health Research Collaboration for Leadership in Applied Health and care for Leicestershire, Northamptonshire and Rutland (CLAHRC for LNR).

Cardiac rehabilitation is recognised as one of the most effective interventions to help individuals with coronary heart disease achieve a full and active life. Activate Your Heart offers an effective and alternative approach to cardiac rehabilitation.

Activate Your Heart allows patients to keep a record of their exercises, monitor their weight, and create their own goals. There is also a comprehensive range of educational resources: videos, diagrams, audio tracks and quizzes, providing advice on making lifestyle changes and reducing risk factors for coronary heart disease.

Traditional cardiac rehabilitation programmes are time constrained, structured programmes, usually in hospitals or leisure centres. This can be difficult for patients with commitments like work and families. The new online cardiac rehabilitation programme gives patients the flexibility to access cardiac rehabilitation at a time and a place that it convenient to them. Patients can also access Activate Your Heart through their smart phones.

Love is in the air

In February we marked Valentine's Day by launching our new website giving people in-depth advice and support so they make the right sexual health decisions.

We worked with Leicester, Leicestershire and Rutland PCT cluster to develop www.leicestersexualhealth.nhs.uk.

The site 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. 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.

Delivering dermatology care in the community

Dr Graham Johnston our Head of Dermatology was invited to chair the cross organisational Dermatology Pathway Transformation Project Board. This will make recommendations to commissioners that will maximise the opportunity for transformational change and realise benefits in the quality and efficiency of services where possible.

So far our plans include increasing capacity within community settings for general Dermatology out-patient services in East Leicestershire and Rutland (ELR) and West Leicestershire (WL) community hospital facilities.

General Dermatology out-patient services for the City Clinical Commissioning Group will remain within our hospitals, specifically the General Hospital in keeping with our strategic plan.

We will create a Dermatology specialist hub at the General Hospital for those highly specialised and regional activities that we are not planning or able to move into the community. This will incorporate skin cancer two-week wait clinics, and other high-level dermatology services, along with activity for the City Clinical Commissioning Group.

Transforming diabetes services across Leicester, Leicestershire and Rutland

Diabetes is an important chronic disease which reduces life expectancy by up to 15 years and is associated with high rates of complications, hospitalisation and increased bed days.

There are more than 54,000 patients in Leicester, Leicestershire and Rutland (LLR) diagnosed with diabetes, accounting for up to 12 per cent of NHS costs.

Spend on diabetes locally is in line with or greater than national benchmarks but outcomes are often at or below national averages (with some variation across the three LLR Clinical Commissioning Groups).

There is a strong evidence base on the types of the care which should be provided to people with diabetes, and how also it is best provided.

In view of the high impact and increasing prevalence of diabetes it is important that prevention and early detection are addressed, that self-care is optimised and care is delivered by appropriately trained health care professionals in the most appropriate setting. The majority of diabetes service provision does not need a hospital setting and there is evidence that much of the aforementioned is not achieved for many patients in LLR.

In 2012/13 £1m of transformational funding was allocated to a LLR diabetes transformation group in order to carry out a review of diabetes services, and make recommendations for future commissioning arrangements for this important long-term condition.

An expert multi partner project group has been set up and has met monthly, receiving reports form a number of expert subgroups and pilot projects which have been established. These have included Type 1 diabetes, primary care, pregnancy, children and adolescents, renal complications, pilot primary care projects Leicester city and ELCCG, pilot nursing home project (city-funded), EDEN professional education project (city-funded), and patient education.

We are working closely with our commissioners to implement some new models of care over the coming year which will see, over time, the vast majority of diabetes services will in future be provided outside the setting of the acute hospital.

Exemplary care by Coronary Care Unit

My 60-year-old husband was rushed to the Coronary Care Unit following a heart attack. He went from being fit and healthy to very scared.

The care was second to none. From the start of heart attack at home to fitting stents and then going onto the ward was a total of 3 hours. It saved damage to his heart. The emergency staff, nursing and ancillary staff were amazing and treated him like a vulnerable human being, rather than a number.

The wards were very clean without having that 'hospital' smell. The food was not gourmet but we don't pay for that either, but there was plenty of choice and was very palatable.

And, yes, the car park cost me £6 per day - but the bus fare would have been much higher and I had the convenience of being on the doorstep so am not complaining.

Overall, I hope we never have to visit a hospital again (because it will mean that either one of us are ill), but if we do then I hope it's the Glenfield.

Thank you most sincerely to all the people who saved and looked after my husband.

Jean

Enhance our reputation in research, innovation and clinical education

We will back those clinical services where we currently excel and we will build them to be even better. Education, research and development are key to our strategy.

Being a high quality training organisation is important for us to maintain quality and safe patient care. It also helps in maintaining the motivation and enthusiasm of staff and in attracting new high quality staff to work in our organisation. In collaboration with our academic partners, we undertake a wide portfolio of patient-centred research which includes almost every aspect of specialist medicine and surgery. Research and innovation brings both funding and clinical talent to Leicester; meaning that local people have access to new and better treatments and procedures before the rest of the country.

We recognise that our clinical services rely on other things too. So, we have the same high ambitions for creating high quality support services, for example, finance, IT and facilities management.

Research and development

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.

Success in the research and development arena is an important part of our overall strategy and we continue to support research by being responsible for more than 800 clinical research studies, involving thousands of patients from Leicestershire and the surrounding areas.

We host three Biomedical Research Units (BRU). 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 host three BRUs.

The Leicester Cardiovascular BRU at Glenfield 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.

The Respiratory BRU aims to focus on the development of new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD) and a new £2 million facility is due to open in summer 2013 at Glenfield Hospital.

The Nutrition, Diet and Lifestyle BRU focuses 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. The BRU is sited within the Leicester Diabetes Centre at the General Hospital, and enhances our excellent reputation in this nationally important area of research.

The Hope Unit is a dedicated oncology clinical trials unit, part funded by the local Hope Cancer charity and opened in May 2012. This research facility will be of direct benefit to cancer patients in Leicester and the surrounding areas.

With the addition in 2013 of the East Midlands & South Yorkshire Primary Care Research Network, we will host five NIHR research networks: the South East Midlands Diabetes Network, the Leicestershire, Northamptonshire and Rutland (LNR) Cancer Research Network, the Trent Stroke Research Network and the LNR 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.

We host the NIHR Collaboration in Leadership for Applied Health Research and Care (CLAHRC) which involves every NHS trust in our region and continues to make a real difference in understanding how best to manage long term conditions underpinned by evidence-based providers and commissioners.

New NIHR Biomedical Research Unit

The NIHR Leicester – Loughborough Diet, Lifestyle and Physical Activity BRU was awarded £4.5 million NIHR funding over five years from April 2012 plus £1.38 million capital funding by the Department of Health.

This new BRU is a collaboration between us, Loughborough University, and the University of Leicester. It provides an opportunity for researchers in the East Midlands to become some of the leading experts internationally in research into lifestyle, and in particular physical activity interventions to both prevent and treat diseases such as diabetes.

For example, these interventions could increase the amount of movement and physical activity people take part in, reduce time in sedentary behaviours, and use other approaches such as the interplay of exercise and appetite control, and minimising weight re-gain after bariatric (such as gastric band) surgery.

Research Over the last 12 months the Leicester Diabetes Centre group has produced 89 publications in 29 journals, with a further 23 pending.

The centre has also developed the Leicester Diabetes Self-Assessment Risk Score project, a diabetes risk assessment tool (a short questionnaire) which has been made available on the Diabetes UK website and used by more than 450,000 people. The tool has now been developed into software which can be implemented by GPs through their IT systems. The Leicester Diabetes Self-Assessment Risk Score is also recommended for use in the National Institute for Health and Clinical Excellence (NICE) guidelines on preventing type-2 diabetes.

NIHR Leicester Cardiovascular Biomedical Research Unit

Jointly with the University of Leicester we have been awarded £6.56m from 2012-2017 for a Biomedical Research Unit (BRU) in Cardiovascular Disease by the National Institute of Health Research (NIHR). This is a continuation of funding initially awarded in 2009. Additional funding of £1.03m has also been awarded for the Unit's participation in the NIHR BioResource, a national initiative to establish cohorts of patients and healthy volunteers who have agreed to provide clinical information and samples for recall by researchers into experimental medicine studies in local clinical research facilities. We are the only BRU to be involved in the BioResource, in recognition of our expertise in this area.

The unit conducts translational research into common cardiovascular diseases, including coronary artery disease, hypertension, heart failure and ventricular arrhythmias. The two main research themes of the unit are Cardiovascular Genetics and Biomarkers, and Novel Cardiovascular Interventions.

They employ 27 core staff and almost 50 staff in total, through a mix of core and industry funding and are involved in collaborative research with more than 30 industry partners across a range of studies aligned to their two core research areas. The unit is currently involved in more than 70 studies and has produced 77 papers in high impact peer reviewed journals this year alone.

Public and Patient Involvement (PPI) is a highly valued and integrated component of the unit. They have participated in five events this year attended by more than16,000 people, including the Leicester SkyRide, Leicester's Hospitals Annual Public Meeting and an Open Day in partnership with local research organisations.

The Leicester Cardiovascular BRU has a superb clinical research infrastructure, established through the capital award provided by the NIHR. The facilities have been further enhanced this year by the addition of a new £12.5m British Heart Foundation Cardiovascular Research Centre, which has state-of-the laboratory facilities, including a large Biobank capable of storing more than 500,000 samples. The Cardiovascular Research Centre also houses the bioinformatics hub of the Leicester Cardiovascular BRU, which links clinical and laboratory data.

New NIHR Respiratory Biomedical Research Unit

The Leicester respiratory community has been awarded an NIHR Biomedical Research Unit (BRU), with funding of £4.5m over five years starting from the 1st April 2012. This new BRU is a collaboration between ourselves and the University of Leicester.

One of the central aims of the Leicester Respiratory BRU is to help develop new medicines, starting with an original idea, often based on laboratory work, and then taking the treatment into the clinic by involving patients in clinical trials. The funding will allow us to implement a step change in our ability to carry out groundbreaking research into asthma, COPD and other important lung diseases such as tuberculosis and lung cancer.

Based at the Glenfield Hospital, the Leicester Respiratory BRU was awarded a further £2.2m to build a new, state of the art clinical research facility which will open in the spring of 2013.

Research Members of the Leicester respiratory community have attracted more than £60m in research funding since 2006 and have published more than 200 papers including six papers in the New England Journal of Medicine since 2002.

Diabetes Centre of Excellence

Leicester has a strong tradition in excellence in diabetes care dating back 60 years to the pioneering work of Dr Joan Walker, who established the first community diabetes clinics and the first diabetes research nurses in the UK. But it was only 12 years ago that Professor Melanie Davies and Professor Kamlesh Khunti started their research programme with one nurse and one researcher and have since developed a talented and diverse team of more than 120 researchers, clinicians and educationalists working together on an innovative research portfolio.

Our broad portfolio of research means we are able to move seamlessly from the generation of new ideas, to the development and evolution of new therapeutic approaches and health care tools/systems, and on to the implementation of these approaches into route clinical care. Our existing infrastructure includes:

- South East Midlands Diabetes Research Network SEM DRN
- NIHR Collaboration for Leadership in Applied Health Research and Care for Leicestershire Northamptonshire and Rutland
- The Diabetes Education and Self-Management for Ongoing and Diagnosed (DESMOND) programme
- MSc in diabetes prevention and BMJ Diploma

In March 2012 the new Leicester Diabetes Centre was opened, hosted within clinical space at the General Hospital with excellent access to patients, particularly BME groups in the East side of Leicester city. The Centre is now the largest facility in Europe for carrying out first class clinical research in diabetes, with a floor space of over 4000m^2.

The centre will continue to grow with phase two of the building works at the General Hospital is scheduled to be completed in July 2013. This will provide further teaching capacity and a bespoke state of the art exercise laboratory for the Biomedical Research Unit.

Newly diagnosed with diabetes

Nurse consultant Heather Daly received an award of Outstanding Educator in Diabetes at an awards ceremony in October.

Heather has worked for more than a decade to improve the education of those with Type 2 diabetes so they can better manage their condition. Recently her work has focused on those newly diagnosed through the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) programme. This has received national recognition and is now being used across the country and is receiving interest from abroad.

Heather offers six hours of education, not only for patients, but also community and healthcare professionals. Results have shown health improvements for those who have received the course after one and three years, compared to those who have not attended. She is now extending this to meet the needs of specific groups including Muslims as they observe Ramadan.

National Centre for Sport and Exercise Medicine: East Midlands (NCSEM-EM)

A proposal for a national centre for sports and exercise medicine was accepted as part of the legacy bid for the 2012 London Olympics. The concept was to include research and education in addition to clinical services. Initially, it was conceived as a single centre to promote sports and exercise medicine (SEM) for athletes and sports injuries. This has now broadened to become a network of three centres with slightly different configurations. The brief has also now been enlarged to include exercise as therapy in the context of chronic disease management.

The East Midlands consortium bid that includes us, University Hospitals of Nottingham NHS Trust, Nottinghamshire Healthcare NHS Trust and Loughborough, Nottingham and Leicester universities was accepted as one of the three centres along with London and Sheffield. We, along with the other stakeholders, contributed £10,000 towards the application development.

Last year a funding allocation of £30m, equally distributed between the centres of the network, was announced and a ministerial launch which took place in July 2012.

In the case of the East Midlands centre, the money will be gifted directly to Loughborough University for the purpose of erecting a building to house the centre. The plan is to enhance a building development that is already in progress to take advantage of the economies of scale and the improved timetable. It is envisaged that the building will be ready for occupation in 2015. Meanwhile work between the partner organisations continues to develop governance arrangements for research and clinical services and to develop the range of interests to populate the centre. The business activity themes within the centre will include sports injury/musculoskeletal, mental health/wellbeing, chronic disease (respiratory, cardiac, diabetes, renal) and prevention/ physical activity

We are playing an active part in the partnership by developing plans for some clinical services as well as expanding research collaborations through the Biomedical Research Units and CLARHRC. The current plans for possible involvement include:

- Development of clinical services (along the 'uhl@NCSEM-EM' model) – sports injuries/musculoskeletal, imaging for the whole centre, respiratory (airway) sports medicine, sports cardiology, flagship chronic disease rehabilitation/supported self-management programmes and telehealth
- Research collaborations – BRUs, CLARHC and individual specialities, other universities
- Educational developments – universities (MScs etc), charities (BLF /BHF Training Centres)

Events are moving swiftly with the centre development. Demolition work on the site has already begun and outline plans for the building have already been drawn up. Some of the clinical and research projects can begin before the building is ready. One joint project on the detection of early disability has already been funded by NHS England.

Heart attack eased

Just a few lines to say a very large thank-you to all the members of staff. When I had a heart attack within 30 minutes of the paramedic coming to my door I was in an operating theatre having two stents fitted in my heart and the relief from pain was instantaneous! All I have to show for it is a scratch on my arm where they worked from and some medication. I would also like to thank the staff of wards 18 and 33 who despite a heavy workload managed to make me feel cared for.
We are so lucky to live in a country where top class staff are available free of charge.

Michael Lynch

Identifying royal bones

Our imaging experts used computed tomography (CT) scanning to help identify the bones of King Richard III, after the University of Leicester discovery in a city centre car park.

The team from our Radiology department at the Royal Infirmary, scanned the bones using post mortem CT scanning protocols, similar to a normal clinical scan, to produce detailed images of the bones.

Dr Shona Campbell, consultant radiologist said: "We have had a research interest in post mortem CT scanning for many years now, involving close collaboration with Professor Guy Rutty and the Forensic Pathology department and Professor Bruno Morgan from imaging.

"This was the oldest of the human remains we have scanned, and opens up a new and interesting area of research with the University's Archaeology department."

The scans of King Richard III's skeleton showed numerous injuries and also a curvature of the spine. Initially the bones were laid out on the scanner as close as possible to the anatomical position in which they were found. After the initial analysis of the images, a further scan of the bones was taken, using a bespoke polystyrene template to better position the bones, in order to reconstruct the images to make a 'virtual' three-dimensional model.

Dr Jo Appleby, osteoarchaeologist at the University of Leicester, said: "The CT scans of the bones, carried out by the team at Royal Infirmary have been a crucial part of the investigations. The three-dimensional images of the skeleton that have been produced have played a central role in our interpretation of the injuries. In addition, the CT scans mean that we will have a full record of the skeleton even after the bones are reburied."

Record £7m donation

A seven-figure donation from the John and Lucille van Geest Foundation was announced in August 2012 to create a unique UK facility for cardiovascular science.

The donation enables Leicester University to build a new biomarker facility at the Cardiovascular Research Centre at Glenfield. This will help pave the way for a new era of 'personalised medicine' creating a unique facility in the UK.

A multi-million pound heart research fund will allow researchers to compete for funding for the most exciting and cutting-edge studies that will advance the fight against cardiovascular disease for years to come.

New hope to asthma patients

Our groundbreaking research has identified a promising new treatment for patients suffering with severe asthma. A team of medics led by Professor Ian Pavord from Glenfield have spent ten years researching the best way to treat patients with severe asthma.

They identified a subgroup of patients who might respond to a new antibody therapy called Mepolizumab. More than 600 patients from 13 countries were involved in the DREAM Trial – a controlled drug trial which compared the effect of Mepolizumab and placebo on the number of asthma attacks experienced by patients over a year.

Researchers found that there was 50 per cent fewer asthma attacks when patients were treated with a monthly injection of Mepolizumab. The drug works best in patients who have frequent asthma attacks. Importantly, patients who were given this innovative treatment did not report any adverse effects.

A world first

In August researchers announced that the UK's first operation to tackle heart failure (HF) took place at Glenfield with a novel nerve-stimulating procedure.

The operation, which is part of a clinical trial called INOVATE-HF by the University of Leicester, could pave the way for a revolutionary treatment of a condition that scientists say has reached 'epidemic proportions'.

INOVATE HF is a global study to determine the safety and efficacy of the CardioFit system, an implantable electrical stimulation device designed to improve heart function in patients with heart failure. The study will evaluate the system's ability to reduce hospitalisation and death amongst these patients, whilst also exploring whether combined treatment with CardioFit and prescription drug therapy is more effective than drug therapy alone.

The study's principal investigator at the site, and also the UK chief investigator, is Dr. André Ng, senior lecturer in cardiology at the University of Leicester and consultant cardiologist at Glenfield Hospital who carried out the world's first remote heart procedure using a robotic arm alongside 3D mapping in 2010.

Genetic links

A professor from Leicester's Hospitals has worked with colleagues from centres across the United Kingdom and the world to identify that genetics has an important part to play in the condition Barrett's Oesophagus.

The groundbreaking report was published in US scientific journal Nature Genetics at the end of 2012 and analysed 660,000 genetic variations in 1,800 patients with Barrett's Oesophagus.

Professor Janusz Jankowski, a gastroenterologist based at the Royal Infirmary, worked with medical colleagues to identify two genes associated with Barrett's Oesophagus.

The findings provide a basis for genetically screening 30 per cent of the western population who get acid reflux to see which 10 to 20 per cent of them will go on to develop Barrett's Oesophagus.

Barrett's Oesophagus occurs in about two-three per cent of the population, with the highest risk among men over 50 years old in developed countries. It is a condition associated with acid reflux and carries a risk of suffers developing cancer of the oesophagus.

Kidney health researchers shortlisted

In April 2012, a team of researchers from the University of Leicester, Leicester's Hospitals and the University of Loughborough were shortlisted for a prestigious medical award.

The Leicester Kidney Exercise Team, who aim to develop effective methods of exercise for kidney patients, were one of four teams shortlisted for the British Medical Journal's Sport and Exercise Team of the Year Award.

The work is part of the new NIHR Biomedical Research Unit in Diet, Nutrition and Lifestyle.

The Leicester Kidney Exercise Team believes physical exercise can have a positive impact on patients with health issues associated with declining renal functions and renal replacement therapy.

National Neonatal Simulation Programme

Dr Jonathon Cusack and Dr Joe Fawke have pioneered, developed and delivered a programme for the simulation of neonatal emergency life support. This gives the opportunity of teaching and practising emergency life support to neonates in a controlled environment with the aim of ensuring the best possible outcome for babies with life-threatening conditions.

They have been responsible for the delivery of the national neonatal simulation training to the East of England, West Midlands, Scotland and Guernsey and have led the way in this field of training. In March 2013 they delivered the first advanced neonatal life support course and produced a manual which is being used widely throughout the country.

This has been beneficial to all staff involved in neonatal intensive care and has been an excellent teaching and learning opportunity. The course will also enable practitioners to share their knowledge and learning with other colleagues to benefit babies with such serious conditions.

Revolutionary treatment

Dr Patrick Wheeler, consultant in sports and exercise medicine based at the General Hospital, is one of only a handful of NHS consultants offering blood injections to treat patients with tendon conditions such as plantar fasciitis as well as tennis elbow, golfer's elbow and patellar tendinopathy which causes pain just below the knee.

Dr Wheeler carries out autologous blood injections – a treatment which involves an injection of a small quantity of the patient's own blood into the site of the injury. This is because blood contains platelets and growth factors which help the healing process.

The five-minute treatment uses less than a teaspoon of the patients' own blood and has proved successful for patients where conventional treatments failed.

Professor named pioneer

In April 2012 Professor Ross Naylor, professor of vascular surgery at the Royal Infirmary, joined a distinguished group of physicians receiving the 2012 Pioneers in Performance Award for Europe. This recognition is sponsored by W. L. Gore & Associates for physicians demonstrating an unrelenting dedication to advancing endovascular therapy and minimally invasive treatment options for patients worldwide.

Professor Naylor received his award in the category of 'Dedication to Analysis of Clinical Outcomes' for demonstrating a strong and ongoing commitment to improving both clinical and patient outcomes through active collaboration.

Professor Naylor is professor of vascular surgery at the Royal Infirmary and President of the Vascular Society of Great Britain and Ireland.

Excellent
Excellent from beginning to end.
Several members of the team have been involved in my care as an outpatient, where I have had a few visits, plus I have been on the day ward several times as well. They have, at all times, been very pleasant and take time to discuss my condition and the plan for my care. When I have needed to be seen as an emergency, this has always been arranged promptly with outpatient reviews.
Team genuinely cares and is interested in patients.

Rosey

Hope Against Cancer

In May rugby hero Martin Johnson opened the Hope Against Cancer clinical trials centre. The unit, a partnership between the University of Leicester and Leicester's Hospitals, is based at the Royal Infirmary and funded by Leicester's Hospitals and local charity Hope Against Cancer. The unit will provide the East Midlands with a centre for the latest clinical cancer research.

The unit includes a treatment area for eight patients, two clinic rooms, a pharmacy area and a small laboratory. One of the first cancers to be researched in the unit and involving teams from the University of Leicester and Leicester's Hospitals is follicular lymphoma, a type of the blood cancer. The trial is investigating the use of a new unique antibody in combination with chemotherapy.

Curry's cancer-fighting properties

Compounds found in curry are being investigated as a way of improving drug response in patients with advanced bowel cancer in a study started during the year at the Royal Infirmary and the General Hospital.

Scientists at Cancer Research UK and National Institute for Health Research Experimental Cancer Medicine Centre (ECMC) in Leicester are investigating whether tablets containing curcumin – found in the spice turmeric – can be safely added to the standard treatment for bowel cancer that has spread. Earlier studies have shown that curcumin can enhance the ability of chemotherapy to kill bowel cancer cells in the lab.

The trial is being funded by Hope Against Cancer, The Royal College of Surgeons and the Bowel Disease Research Foundation.

Aneurysm screening in Leicester is saving lives

Figures released in November 2012 by the NHS Abdominal Aortic Aneurysm Screening (AAA) programme discovered 86 men with a previously undiagnosed abdominal aneurysm.

Out of these, 17 men required surgical treatment, which was performed successfully at the Royal Infirmary, with no adverse effects. One local man in his sixties was found to have a remarkable 10.6 cm aneurysm. If left undiagnosed, it could have proven fatal. Graham Burdett of Leicester underwent surgery the day after his screening and was discharged home a week later.

The results from the NHS National AAA Screening Programme show that there has been significant improvement in the outcomes for patients undergoing elective aneurysm repair. The Leicester vascular unit continues to maintain excellence in the treatment for this condition through its multidisciplinary team approach.

Eye disorders in infants

Generous donations from eye charities in 2012 have allowed the University of Leicester to buy a unique piece of retinal imaging equipment - the only one of its kind in the UK. The handheld retinal scanner will allow new research into eye disorders such as nystagmus, a condition that causes involuntary twitching movements of the eyes.

The device can create highly detailed three-dimensional maps of the inside of the eye, including the retina – the light-sensitive tissue that lines the inner eye and facilitates vision.

The new imager is handheld and portable, making it ideal for imaging the eyes of young children, and will allow scientists at the University of Leicester to study infant retinal development and its relation to nystagmus and other eye disorders.

Clinical education

The Department of Clinical Education (DCE) has developed a medical education strategy to support the delivery of high quality undergraduate and postgraduate medical education and training within our organisation. As part of this strategy we will improve the accountability of education and training resources and map resources to quality of education and training delivery. There are plans in place to continue to improve the learning facilities on the Royal Infirmary site with the development of a larger new library/learning centre.

DCE has been working to enhance engagement with doctors in training and has established a 'doctors in training' committee and developed a bi-monthly newsletter to improve communication about education and training issues.

Working closely with the Leicester Medical School to support undergraduate education we have appointed a senior undergraduate lead and new patient safety and professionalism lead roles.

We will host two East Midlands HIEC (Health Innovation & Education Cluster) projects investigating the impact of innovative educational approaches in improving aspects of prescribing and patient education. Work by the department on the Improving Outcomes in Acute Kidney Injury HIEC project has been shortlisted for a prestigious BMJ Healthcare Education Team of the Year award.

A recently introduced point of clinical care information resource UpTodate has been accessed by many of our staff in since it was launched in October and has also led to a surge in the use of other sources of evidence to support patient care.

We support numerous education fellows who are working on developing educational interventions to improve patient safety, service redesign to improve education and training and clinical simulation.

Pathology

We've continued to see an increase in the workload carried out by our pathology service. Last year we performed just under 13 million tests for patients across Leicestershire, an increase of almost five per cent from 2011/12. Almost all of this increase has come from local GPs and is in part due to recent emphasis on avoiding hospital admissions and caring for patients in the community. The testing for primary care is increasingly important to the laboratory and now forms around 45 per cent of our total work.

We are always looking for continuous improvement in pathology and several laboratory areas have been working this year with NHS improvement to embed 'lean' working. This has eliminated waste and shortened turnaround times for patients as well as providing better working conditions for staff.

We continue to work closely with other pathology services in our region. Over the last 18 months we have been planning joint working with the Pathology service in Nottingham University Hospitals NHS Trust. An agreement was signed between the both organisations in September. The joint venture, which has been given the name 'empath', has already delivered improved quality as well as cost efficiencies. A daily van service now runs between the two cities transferring work between the two laboratories. This arrangement allows us to do less common tests locally which otherwise would have been sent elsewhere. As a consequence the time to get a result for these tests has been reduced so patients can be diagnosed and treated much sooner.

We continue to see developments in bringing testing closer to patients, including the expansion of specialist testing in operating theatres to reduce the need for blood transfusions and also working with the Emergency Department to support their need for rapid results. Our cervical cytology laboratory has also consistently headed the national table by making sure all women get their smear test results inside two weeks. We continue to build up our portfolio of specialist work and now provide the highly specialist medical forensic testing for much of the East Midlands.

Went in with expected appendicitis, came out with a cyst on ovary

I went in on Sunday night with expected appendicitis after visiting the doctors on Friday afternoon and being told to wait until the pain got worse. The pain gradually got worse and I attended A&E at 6pm on Sunday night. The nurses and doctors worked really well to ensure I had the right care although one did lose my notes in A&E. I had morphine in A&E then got sent to Ward 8 in Balmoral.
I had an ultrasound scan and all the right pain relief on time. I was kept in for an extra night to make sure I was ok and the whole time staff worked extra hard to make sure I was comfortable and that I was cared for in the correct way.
The food was lovely and the doctor's consultant and all the nurses ensured my stay was a pleasant one bringing me more medication and food throughout the night with a smile on their face. They worked well as a team and made sure everything was done as quickly as possible.

Sophie-Louise

Estates and facilities – a new delivery

2012/13 was a momentous year for estates and facilities services. During the year, we joined together with the other NHS organisations in Leicester, Leicestershire and Rutland to complete one of the biggest estates and facilities programmes in the NHS, by successfully securing a new partnership for the delivery and development of services. The partnership with international support services and construction group, Interserve, began on 1 March 2013 following a two-year public procurement process which attracted the leading facilities management providers.

Interserve is now responsible for delivering facilities services, such as catering, cleaning, maintenance and security across more than 550 NHS buildings and properties of some 490,000sq metres with more than 3,000 beds. More than 2,000 staff from the NHS and from other private sector providers transferred across to Interserve as part of the deal. The new arrangements provide investment to improve the buildings and facilities we use to deliver services to thousands of patients every day, as well as significant savings for the NHS.

The local NHS and Interserve will work together to make the best use of the NHS buildings and estate. This means that developments in clinical services will be matched with developments in the facilities that help to deliver them. It is the first time the NHS has joined together to manage facilities and estates services across all local NHS services, including health centres, hospitals and community services.

We believe this is the best possible approach to ensuring that we can transform NHS facilities to meet the needs of patients, visitors and staff. Combining the knowledge and the experience of both the NHS and Interserve will achieve more together than the NHS working alone.

Estates and Facilities – developing our estate

In response to our Strategic Direction and Clinical Strategy, we developed a new Estate Transformation Plan in partnership with Capita.

Our Estates Transformation Plan is based on a strategy that efficient estate solutions will support our delivery of quality front line patient services, as well as achieving improved utilisation of the estate. The plan will:

- underpin our Strategic Direction
- support the delivery of our Clinical Strategy
- provide a clear implementation plan over the next five years to enhance the utilisation of our estate ensuring: buildings and equipment are in the right place; right condition and are able to respond to the changing needs of our patient services
- improve the patient and staff built environment
- identify key capital developments that will support clinical transformation.

Over the last twelve months we have invested in key patient services across all three sites including the following major developments:

Royal Infirmary

- Teenage Cancer Unit – supported by the Teenage Cancer Trust (TCT) – £1m
- Macmillan Information Centre within the Osborne Building – £149,000
- New fracture clinic unit within the Balmoral Building – £474,000
- Dedicated triage and assessment areas on the Acute Medical Unit – £50,000
- Conversion of former administrative space on wards 24, 36 and 38 to provide in-patient bays with en-suite facilities – £740,000

Investments made in supporting behind the scenes site utilities infrastructure including new water storage tanks and high and low voltage electrical distribution systems.

Glenfield Hospital

- Extension to the Clinical Decisions Unit to enhance the patient experience – £777,000
- Refurbishment of theatres 5 and 6 – £175,000
- Expansion of the Paediatric Intensive Care Unit – £794,000
- Programme of bathroom refurbishments throughout the site – £75,000

General Hospital

- Refurbishment of ward 3 as a stroke rehabilitation unit – £519,000
- Installation of two birthing pools within the maternity unit – £68,000.

Estates and Facilities – patient environment action team

We achieved excellent results for each site in every area under the annual Patient Environment Action Team (PEAT) assessment. PEAT is the way the NHS ensures improvements are made in all aspects of patient care including environment, food, privacy and dignity.

IM&T strategy for the future

Delivering world-class IT to support Leicester's Hospitals, our patients and staff is a key enabler to delivering our strategic direction.

To help our organisation transform through the use of much improved information technology we engaged a world-class partner to help us with that journey. Through 2012 we entered into a competitive procurement process to get the right partner. At the end of 2012 we reached agreement to create a partnership with IBM to deliver our vision.

Dr Kevin Harris, medical director at Leicester's Hospitals said: "This is a very exciting partnership and could be the single most important thing that we have ever done in terms of improving technology in our organisation. We're excited about the benefits it will bring about for our staff and our patients. There are a number of projects we're looking to get started to give some early benefits whilst we procure an EPR, one of them puts patient information at the fingertips of our doctors. We will be creating a clinical portal where doctors can access all of the information about their patients, from letters to results of diagnostic tests."

Through this partnership we will deliver a bold programme of IT to transform how we work across the whole diversity of the health economy and importantly how we interact with patients and the public. This approach is intended to create an innovative partnership that is focused on creating new ideas and exploiting the intellectual property we jointly create.

There is a roadmap now in place that will transform Leicester's Hospitals into a digital organisation, move us away from paper, and allow us to join up key information across the whole health community. We will initially be focusing on creating a single point of accessing all relevant information from the moment we begin care.

Deliver services through a professional valued and passionate workforce

More than 10,000 people work in our hospitals, making our Trust the second largest employer in Leicestershire and Rutland.

The professionalism, compassion, hard work and ingenuity of staff in all parts of the Trust is both the bedrock of our reputation and key to our future as a sustainable NHS Foundation Trust.

To support the strategic direction we will develop and implement a Trust Organisational Development Plan, which will support staff, reinforce our shared values and make the Trust a place where people are proud to work.

Our staff

We have a total of 9,860 substantive staff in post (as at 31 March 2013). They are broken down into the following groups:

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

*NB: The reduction in healthcare assistants and other support staff is due to the transfer of domestics, porters etc to Interserve towards the end of the financial year.

NHS staff survey

Our 2012 National NHS staff survey was carried out towards the end of 2012 and we have recently reviewed our results. They show an improvement in staff experience in a number of areas when compared to our 2011 results.

In general staff feel more satisfied with their jobs and that they are able to deliver patient care to a standard they are happier with (a seven per cent increase). They are also more likely to recommend the trust as a place to work or receive treatment than in 2011. Staff are happier with the fairness and effectiveness of incident reporting (six per cent increase) and there has been a 19 per cent increase from 2011in the number of staff receiving equality and diversity training. Staff also said they had more well structured appraisals in the last 12 months (94 per cent) than other acute trusts.

The survey results indicate that actions taken during 2012 have made a difference. The increased focus on patient quality, the production of our strategic direction, clinical strategy, the quality ambitions and revised organisational development plan are likely to have contributed to improved results. Also the inclusive way in which these developments have been created involving staff and asking their opinions will have helped. Additionally, work that has been taking place in the divisions and corporate directorates on developing new approaches to staff engagement will also have impacted positively to how staff are feeling about our organisation.

The five key findings where we are doing well – these reflect areas of focus detailed within our staff engagement action plan.

2012 top five ranking scores				
	Trust score 2011	**Trust score 2012**	**National average for acute trusts 2012**	**Best 2012 acute trusts**
KF7. Percentage of staff appraised in last 12 months	90%	94%	84%	94%
KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	new question	26%	30%	19%
KF8. Percentage of staff having well structured appraisals in last 12 months	37%	42%	36%	48%
KF17. Percentage of staff experiencing physical violence from staff in last 12 months	new question	2%	3%	0%
KF11. Percentage of staff suffering work related stress in last 12 months	28%	34%	37%	28%

Key areas where we need to improve These are key areas of focus for review, discussion and action planning. It is essential that this review links to the 'Listening into Action' and patient survey work (aligned to our quality commitment) that is being carried out.

2012 bottom five ranking scores				
	Trust score 2011	**Trust score 2012**	**National average for acute trusts 2012**	**Best 2012 acute trusts**
KF21. Percentage of staff reporting good communication between senior management and staff	new question	22%	27%	44%
KF20. Percentage of staff feeling pressure in last three months to attend work when feeling unwell	28%	32%	29%	21%
KF24. Staff recommendation of the Trust as a place to work or receive treatment	3.24	3.46	3.57	4.00
KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months	new question	79%	81%	89%
KF12. Percentage of staff saying hand washing materials are always available	57%	57%	60%	77%

Listening into Action

Listening into Action (LiA) has been developed through intensive, hands-on work with more than 75,000 staff and leaders from across more than 90 NHS trusts since 2007, with national endorsement and the backing of the Department of Health. LiA will introduce a new and ambitious way of working and give our staff the power to transform our hospitals and deliver 'Caring at its best'. This new way of working will raise the bar on the quality of care we provide to our patients, creating a revolution in staff and patient experience.

The foundations for LiA are based on:

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

Widespread adoption of LiA across the NHS over the past six years has helped improve performance in national staff survey results, but has also had a positive impact on staff morale. It has helped service improvements for patients, delivered and owned by teams who feel a new sense of enthusiasm and empowerment to affect the positive changes they want to see.

At Leicester's Hospitals the work is being sponsored by the chief executive and other executive and clinical leaders. This 'sponsor group' will meet without fail every two weeks for 90 minutes to focus entirely on navigating this journey of adoption across our trust and ensuring it is a success.

Reducing staff absence

In 2012 we again had the lowest sickness rates of all acute trusts in the East Midlands. Our average sickness absence rate in 2012 was 3.49 per cent – this equates to an average of 412 staff being off work at any one time. Our target over the next year is to reduce this to three per cent, which represents around 355 staff off work at any time.

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

Our health and wellbeing strategy is supported by a comprehensive programme to support improved attendance at work through the in-house occupational health service, a staff counselling service, fast-track physiotherapy and health awareness sessions for staff.

We have signed up to the Public Health Responsibility deal with two pledges relating to occupational health services – our occupational health service achieved the Safe, Effective Quality Occupational Health Service (SEQHS) accreditation in 2012 – and supporting staff with chronic conditions.

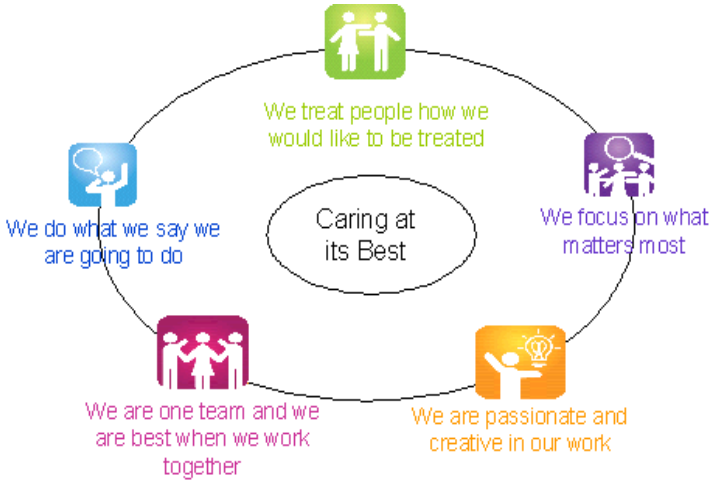
Our At Work for Patients project (@w4p) continues to support staff attending work regularly. This is closely supported by the staff lottery-funded health and wellbeing programme which continues to provide a range of holistic activities for staff, including exercise classes focusing on different abilities, a five-a-side football league – and now a Leicester's Hospitals football team, books clubs, regular Fitbug and walking challenges, health awareness and screening road shows for staff to understand their BMI, and alcohol, smoking, healthy eating habits. There are also alternative therapies such as reflexology and aromatherapy.

We will be continuing with our very popular seasonal coach trips to Christmas markets and seaside resorts and look forward to our Family Fun Day in the summer. Staff can also bid for funds to enhance their working life/environment.

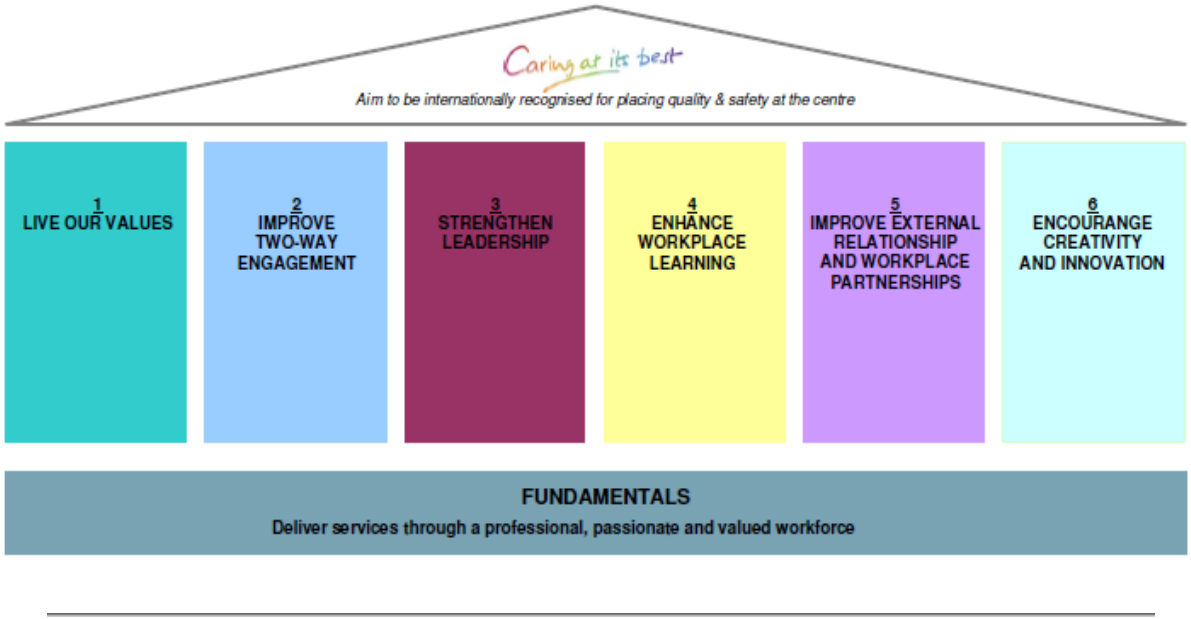
Consulting staff/ staff engagement

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

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



To deliver our vision of 'Caring at its best' and to facilitate change we are laying out an ambitious organisational development plan. Our priorities will be led through six work streams which each have a series of priories to help us build on current strengths and improve our organisational performance and culture. The work streams have been aligned to our values and support building pride in our organisation.



Learning and development

Ensuring all our staff have access to the right skills and knowledge is crucial if we are to deliver caring at its best, and we are committed to providing learning and development opportunities to all staff. Our learning and organisational development team coordinates a wide range of courses working together with local colleges and private training providers.

We have signed up to the National Skills Pledge and this confirms our commitment to help staff gain the skills and qualifications that will meet the needs of our organisation and support their future career progression.

In 2012/13, we invested £247,000 in learning and development, 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.

Celebrating achievements

Our annual training awards ceremony allows us to celebrate staff achievements in learning and development. At our annual event in March 2013, 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

We have been employing apprentices since September 2009 and to date have employed 159 apprentices. The roles vary and include administrators, porters, maternity care assistants, medical records assistants, ward clerks and plaster technicians. During 2013/14 we anticipate that a further 30–40 apprentices will join us and we will be piloting a health care assistant apprenticeship programme, following successful models in other regions. In 2012/13 26 apprentices completed their frameworks and secured employment in our organisation or other local healthcare organisations.

Work experience

A task group leads on accelerating work experience in all areas across the Trust. Its aim is to improve our provision and centralise the application process to maximise work experience opportunities. Currently we offer work experience for Year 12 and 13 students, degree graduates on clinical programmes and those doing health and social care related courses. In 2012/13 we supported more than 90 placements. We also nominated health ambassadors to support educational establishments at career fairs in promoting the NHS as a career choice.

Step up

We were successful in our application to support five Step-Up positions offering six-month work experience placements to young people aged 19 to 24 on job seeker's allowance. This helps them gain experience in a care setting enabling them to apply for jobs in the future that requires experience. These posts begin in May 2013.

Leicester Works

Working with Leicester City Council, Remploy and Leicester College, we continue to help young adults with learning disabilities to develop 'real work skills' through trialling a series of work placements in our organisations. The ultimate aim being for the students to secure long term paid employment as only eight to ten percent of people with a learning disability nationally are employed. To date 40 per cent of the students from the first two cohorts have gone on to secure permanent employment within either our organisation or our partner organisations.

Valuing our staff – reward and recognition

We recognise that our staff are the most valuable resource we have and they are vital to us delivering high quality services for the benefit of the population of Leicestershire, Leicester and Rutland.

The vast majority of our staff are on national NHS pay, terms and conditions which include a comprehensive set of employment policies and procedures. 'Salary maxing' is our range of employee benefits available through salary exchange (often known as salary sacrifice). Current schemes include childcare vouchers, onsite living accommodation and workplace car parking. We are looking to add schemes to our salary maxing portfolio to bring benefits to more of our staff.

However, it is also important that we recognise the individual successes of our staff, their innovations, quality care and exceptional work for patients. Our Caring at its Best Awards were launched in 2011 and have enabled us to recognise and reward more staff than ever before by moving to quarterly awards with an annual ceremony. The process involves asking not only staff, but also our patients and visitors to help us find those exceptional staff that are living our values and providing excellent care.

The Caring at its Best Awards reflect six categories, one for each of our values (nominated by staff) and one public nominated award.

All winners and highly commended staff from throughout the year were invited to the annual dinner hosted by our chairman in September. At the event all of our winners were celebrated and a judging panel made up of Liz Kendall MP, Chief Constable Simon Cole, Tony Donovan from LeicesterShire and Rutland Age UK, City GP Dr Tony Bentley, Councillor Manjula Sood, Ben Jackson from BBC Radio Leicester, and health reporter Cathy Buss from the Leicester Mercury who chose overall 'winners' who were presented with a certificate and trophy. We also, for the first time, presented an award in the category 'Volunteer of the Year' in thanks for the support and commitment they give to our organisation.

Thank you to Saturday Team!

Following my gall bladder operation I would like to say thank you so much to the excellent Saturday Team on Ward 24 (not forgetting the pre-op and follow-up teams too!)
Everyone, without exception, was professional, hardworking, caring and friendly.
Procedures were explained and I was given the opportunity to ask questions. Despite being extremely nervous I felt reassured and in safe hands!
I was also impressed by the standard of maintenance and cleanliness at this hospital,
Well done and thank you, Glenfield!

Heather Watson

Releasing Time To Care, the Productive Ward

Releasing Time To Care (RT2C) – the Productive Ward is now being rolled out to all in-patient wards with the final flurry of ward areas joining in January 2013, aiming for all wards to complete by May 2014.

This is a modular-based programme with each module focusing on a ward process, for example meals, medicine rounds and handover, carried out in ward areas. The overall aim is to improve these processes, systems and the environment to help nurses, therapists and others to spend more direct time with the patient and contribute to improving safety and efficiency.

This work will enhance and support all of our existing quality initiatives including:

- The twelve 'Caring at its Best' (C@IB) standards
- The aspects of care and communication that 'matter most' to our patients
- The Safety Thermometer and 5 Critical Safety Actions.

Through the work that has already done on wards and other clinical areas there is a standard operating procedure highlighting exactly how a process should be managed and service delivered, allowing some moderation for specific areas.

The foundation module 'Knowing How We are Doing' which allows us to measure improvements in wards and areas is continually reviewed to align with both our clinical priorities and that of the local Clinical Business Unit and ward areas.

The implementation of the 'Well Organised Ward' module continues to improve ward and clinical environment to help staff do their jobs. The latest part of the roll-out plan is the standardisation of nursing shift handover systems which is being successfully implemented across ward areas, adapted to suit individual ward and speciality teams. This helps through working in conjunction with the boards and visual management systems implemented through 'Patient Status at A Glance' module. This compliments the 5 Critical Safety Actions move to establish a standardised electronic handover system across our hospitals.

The programme also looks at supporting the standardisation of ward processes around meals, medicines, ward round, patient hygiene, admission and planned discharge, patient observations and nursing procedures in a similar way – standardising best practice and embedding innovation wherever possible.

Health and safety – ensuring the health and safety of our workforce

Our health and safety team work with key individuals in the development of suitable systems and arrangements to ensure the health, safety and welfare of our staff, patients and visitors. They provide practical advice and support to all of our staff as promoted during the 2012 'Worker Participation' campaign.

Working with the clinical procurement group, the health and safety team has developed a simple proforma to ensure compliance with legislation for clinical consumable equipment and devices. This has been pivotal in selecting suitable equipment and has resulted in a number of the products we use across Leicester's Hospitals being standardised.

By standardising the products we use, we reduce the need for training and product costs. This means improved safety and more staff time for direct patient care.

We are working to ensure that our systems for medical sharps are compliant with legislation due to come into force in May 2013, which is likely to result in a reduced risk of sharps injury.

Health and safety – protecting our staff

In response to the increased demands on staff and services, the health and safety team has streamlined stress management arrangements. Systems are now in place for managing team and individual stressors in recognition of the links between early intervention and positive outcomes. A collaborative stress management and emotional resilience package has been developed and introduced to provide managers with the necessary skills and knowledge to identify and manage stress.

Work continues to communicate the vision where health and safety is seen as a cornerstone where risk is identified, appreciated, understood and effectively managed.

Providing spiritual and religious care

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

Our chaplaincy service is a valuable part of our commitment to deliver 'Caring at its best' to patients and their relatives' right up to the end of life. Our 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 if a patient or family request to see a chaplain urgently (especially around the time of death) a chaplain is available day and night.

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

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

Remembrance service for lost little ones

In April and November a remembrance service for parents whose babies were stillborn or who died soon after birth, was held at the Royal Infirmary.

Members of our chaplaincy team held the non-denominational service in the chapel at the Royal Infirmary. The service, now in its eighth year, included prayers, readings, poems and music. During the service parents lit a candle in memory of their baby and can request the name of their child to be read out.

After the service refreshments were provided where Sands befrienders and hospital staff offered continued support for those who needed someone to talk to.

£100k revamp for our Bereavement Centre

In February 2013 we officially opened our bereavement centre at the Royal Infirmary following a £100,000 revamp.

The centre is designed as a peaceful place for relatives of patients who have died at the hospital to sit and wait while paperwork and other formalities are completed. The new centre has replaced the old cramped office and small waiting rooms with two upgraded private rooms which have views and access to a new courtyard garden.

Nervous patient really pleased with my treatment

The anaesthetist was really thorough and gave me a good insight into what he was going to do.
I'm nervous around needles and the anaesthetics team were lovely with me and helped me through it. The surgeon spoke to me before and checked nothing had changed. When I woke up I had one on one care when I was coming round. This really helped me.
When on the day ward afterwards they explained the drugs to my wife as I wasn't quite with it.
The job they did was very neat.

Rich F

Equality and diversity

We have adopted the Equality Delivery System framework as the means by which we meet the Public Sector Equality Duty and aligned to our strategic direction. In January 2013 we published our patient and workforce equality data for the previous year on our website to demonstrate our compliance.

Progress against the equality work programme is self-assessed internally through the quality advisory committee and externally by the equality advisory group (EAG). Our baseline position at March 2012 was amber and green in all areas. We have increased the number of green areas in recent months as a result of our equality programme.

We analyse and publish biannually some of our key performance and workforce data by protected characteristic (where data is collected).

Overall our workforce profile remains unchanged from 2011 despite a reduction in overall staff numbers. The profile shows good ethnic, gender and age representation within the general workforce. However, female and black and minority ethnic (BME) representation at a senior level remains our biggest challenge. In areas of disability, sexual orientation and religion/belief there remain high levels of 'unknown' status making it difficult to draw any concrete conclusions.

With patients, there is no indication that patient access or outcomes differ on the basis of age, gender and ethnicity. Patients aged 85 or over appear to be marginally less satisfied with their hospital experience than other patient groups.

A new service provider for interpreting and translation has led to an increase and more efficient service. We now provide, on average, 400 interpreting sessions a month. The number of patients supported by the acute liaison nurse service has increased and a new disability advisory service for staff has been introduced.

A significant number of our work placement students who have a learning disability have secured permanent paid employment within Leicester's Hospitals.

Engagement

We have an equality advisory group of local people affected by potential inequality. The group acts as an external reference group, as well as having additional responsibility for assessing our equality compliance.

During the year our equality and patient involvement manager visited visually impaired people across Leicestershire. In most instances the group felt that they had experienced good to very good care in our hospitals. The main areas for improvement cited were: more staff training in basic awareness of the needs of visually impaired people, reduced waiting times in outpatient clinics and improved signage.

Priorities for the coming year

Our priorities are to embed equality into initiatives such as Listening into Action, organisational development and quality commitment programmes and to set up workforce equality benchmarks with similar acute trusts to assess and report our performance in line with others. We will also identify and address any perceived or actual barriers to career progression for BME and female staff that remain under represented at senior management levels. We aim to increase the number of staff trained in equality from 3,000 to 4,000.

Key access, satisfaction and outcome performance data will be reported biannually by age, gender and ethnicity and address any identified inequity via the equality work programme.

Finally, next year we intend to address the satisfaction rates of older people using our services.

On time

My husband attended to have a small growth removed from his ear. His appointment was at 10.45am and he was called in at that time. I had difficulty in getting into the car park despite being 30 minutes early. When I arrived at the clinic I enquired if my husband had arrived, a nurse checked and took me to him where I was allowed to sit and watch the procedure.

The consultant and junior doctors treated him with the utmost courtesy explaining everything as they went along. There was even music playing softly in the background. After 45 minutes we left for a welcome cup of coffee.

What a pleasure the whole experience proved to be. Thank you to all concerned.

B. Cawdell

Be recognised as a sustainable, high performing NHS Foundation Trust

A Foundation Trust where local people and staff have a voice and a stake in the future.

Our aim is to become a NHS Foundation Trust by April 2014. FT status will give us more freedom to run the Trust in response to local people's aims and aspirations for their NHS. We currently have over 13,000 public members and 11,000 staff members.

As a FT we will hold elections for members of the public and members of staff to join our Council of Governors. The Governors will work alongside our Trust Board to determine local priorities and hold the Board accountable for delivering them. In one sense the greatest benefit to becoming a FT is that it puts nurses, doctors, managers and local people around the same table to think about what is best for patients; we think that is a powerful partnership. A closer relationship with our local population will not only improve how we run our services, it will also encourage us to become a more active partner in the broader life of the region. Through our membership and Governors we will gain a greater insight in to the role we play in local life and how we can positively contribute to the health, environment and circumstances of our community.

Our plans to become an NHS Foundation Trust

In the next five years our vision is to become a successful Foundation Trust (FT) that is internationally recognised for placing quality, safety and innovation at the centre of service provision. In recognition of the scale of the necessary transformation of our services and of the operational and financial issues that we have managed in 2012/13, we have proposed a deferral of our FT application to the NHS Trust Development Authority (which oversees the performance of NHS trusts and support them as they work to achieve NHS foundation trust status).

We remain committed to becoming an FT and our immediate focus has been on developing a robust Annual Plan for 2013/14 – which was signed off by our Trust Board on 5 April 2013.

Over the coming months we will be developing our five-year plan, which will describe how over the next five years, we make our strategy happen.

Involving our members

Over 14,000 people have now signed up as a public member of Leicester's Hospitals. Over the last year our members have been invited to a range of events and opportunities to get more involved with our Trust. For example, members were invited to a focus group to help us redesign the hospital maps that are sent out to our outpatients and more than 30 took part in an engagement event run by our Planned Care division to discuss the future of their services. Members have contributed to the redesign of our patient survey and many took the time to respond to a recent travel survey; some of our members were even involved in the recruitment of our new Chief Executive. In addition to this, several of our members have become involved with a new initiative called the Patient-led Assessment of the Clinical Environment (PLACE). This involves detailed inspection of clinical areas both within the Trust and in other areas across Leicester, Leicestershire and Rutland.

Our most active members are our volunteers. We now have more than1,000 volunteers working across our hospitals to support our patients and staff. Some of our volunteers recently took part in a pilot project to introduce 'Service Improvement Volunteers' into ward areas. Service Improvement Volunteers speak with patients and relatives to understand their experience of our services and then feed this back to ward managers.

Over the year we have continued to hold regular Medicine for Members talks. Among this year's sessions we have covered dementia, play therapy and introduced members to the range of support services that help to keep our busy hospitals running. In September 2012 we held our Annual Public Meeting which was given a historic theme in celebration of our centenary (it is 100 years since we were granted permission to use the prefix 'Royal' in our title). On the day our members enjoyed an exhibition of artefacts from our hospital museum as well as the chance to meet our senior team and put their questions to them.

In January 2013 we began a programme of special meetings for members interested in our Foundation Trust governor role. The Prospective Governor meetings are well attended and give members a real opportunity to have their say on some of the Trust's key issues and challenges. For example, in March we discussed the implications of the Francis Report and our early response to its findings. We also gave the group an opportunity to have some input in to our priorities for the coming year.

In addition to our members, we continue to support our Patient Advisors (members of the public who get involved in various services to provide a lay perspective on our work). Patient Advisors sit on a number of our Boards and Committees as well as getting involved in patient surveying and our regular executive walkabouts.

Over the last year we continued to build on our good relationships with Local Involvement Networks (LINks), holding a joint public engagement event in the city and meeting to listen and respond to issues raised by the public. Together with the county LINk we also carried out some engagement which explored the health needs of rural isolated older people. Representatives from the LINks have been meeting regularly with our chief executive to raise issues directly with him. The Trust was also represented at the monthly LINk Board meetings. LINk representatives have also supported the Trust in the Safe and Sustainable review of children's heart surgery provision. In April 2013 LINk organisations came to an end and have now been replaced by the new Local Healthwatch organisations. We now look forward to working with the new structure and to further develop our understanding of the needs and concerns of our local population.

We have continued to engage with members of our diverse local communities over the year. For example, our Patient Experience team and PPI and Membership Manager visited South Asian groups to explore their thoughts on hospital services. In November 2012 we introduced a new initiative to support organ donation: the 'Community Ambassador' programme. Community Ambassadors are drawn from a range of local communities and we train them to promote organ donation amongst their own community groups. To date, ten Community Ambassadors have been trained and further events are planned this year. Our Organ Donation team also participated in last year's Belgrave Mela, where more than 30 people signed up to become an organ donor and many more spoke with the team and took away information.

We have also been exploring the needs of people with disabilities. For example, the PPI and Membership Manager and Service Equality Manger have engaged with several VISTA groups to better understand the experience of people who are blind or partially sighted. We have also established an engagement group for people with learning disabilities and their carers. Our Service Equality Panel has also continued to meet on a bi-monthly basis to engage with faith communities and organisations representing local people with disabilities.

Volunteering

Over the last year we have focused on developing and enhancing the skills of our existing active volunteers to help improve the support that we can offer to patients and their families. Whenever we have an activity or an event that requires additional help we look to involve our volunteers to bring another dimension to patient and public support. Those events included the Trust's Annual Public Meeting, Patient Experience Conference on Dignity and Dementia, Induction training, surveys, Older people's Christmas gift campaign, and Dignity Action Day.

Directors rolled up their sleeves to join hospital volunteers

Some of our directors and managers stepped into volunteering roles in October to mark the Community Service Volunteers Make a Difference Day. Our chairman, chief executive, director of nursing and other management joined volunteers in their usual volunteering activity, to see first hand how valuable volunteers are in supporting the services delivered to patients.

Among the activities, our chairman, Martin Hindle, transported patients and visitors on the volunteer buggy, chief operating officer and chief nurse Suzanne Hinchliffe served tea in the WRVS cafe and the director of nursing Carole Ribbins provided hand massages for patients.

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 and applies to all public authorities, including us. Its purpose is to allow anyone to ask whether we hold information on a particular subject 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 2012/13, we received 370 Freedom of Information requests and/ or requests for environmental information, compared to 291 in 2011/12. This year we responded to 97.6 per cent of these requests within the statutory 20 working-day deadline. Many of these requests contained multiple individual questions, and information that needed to be obtained from more than area in the Trust.

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

Freedom of Information / Environmental Information Regulation requests received between 1 April 2012 and 31 March 2013 by division / corporate directorate		
Area	**Number of times asked to provide FOI data in 2012/13**	**Approx per cent of overall 2012/13 activity**
Finance and procurement	92	16.9%
Human resources	68	12.5%
Clinical support	54	9.9%
Operations	52	9.5%
Planned care	47	8.6%
Women's and children's division	45	8.3%
Acute care	40	7.3%
Corporate medical	36	6.6%
Facilities	32	5.9%
Corporate nursing	31	5.7%
Information, management and technology	29	5.3%
Corporate and legal	10	1.8%
Communications	4	0.7%
Strategy	2	0.3%
Research and development	0	0%

Many of the requests involve multiple directorates, so the numbers shown above are higher than the total number of 370 FOI requests received in 2012/13.

Sustainability

We take the challenge of providing modern healthcare from sustainable facilities very seriously. To ensure sustainability development is fully recognised, we are developing and updating our Sustainability Development Management Plan to set our sustainability goals, targets and vision to 2020 and beyond.

To support this initiative we are planning to carry out significant investment in building projects - funded both internally and externally – which will reduce our energy consumption and carbon emissions and we have submitted plans for investment worth £2.2m Combined Heat and Power (CHP) units funded from the £50m NHS Energy & Sustainability Fund.

Our strategy concentrates primarily on the building environment (energy and water), waste management, transport and procurement. The table below shows how we have reduced our utilities consumption and cost.

Description	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	Annual Change		Overall Change	
Gas Usage (KWh)	93,697,272	96,694,476	85,673,210	86,601,762	928,552	1.08%	-7,095,510	-7.57%
Electricity Usage (KWh)	36,426,819	39,489,130	42,535,080	46,390,022	3,854,942	9.06%	9,963,203	27.35%
Totals (KWh)	130,124,091	136,183,606	28,208,289	132,991,784	4,783,494	3.73%	2,867,693	2.20%
Costs (£)	£5,136,734	£5,282,765	£6,479,603	£7,223,638	744,035	11.48%	2,086,904	40.63%
CO2 Emissions (Tonnes)	36,910	39,236	38,881	41,334	2,453	6.31%	4,424	11.99%
CO2 Emissions (CRC Cost)	N/A	N/A	£376,571	£404,539	27,968	7.43%	N/A	N/A

Energy and carbon management

Electricity/gas/water management: We have invested significantly in local metering. Some buildings are now fitted with automatically read meters (AMR) and some wards and departments are fitted with building management addressable metres which provide accurate data which can then be interrogated remotely.
Lighting levels We have identified further opportunities to reduce electrical consumption by investing in low energy light fittings this will be further enhanced with the investment of LED lighting as technology advance has allowed for use within the hospital environment. This coupled with the use of local sensors ensures that lighting systems operate at maximum efficiency.

Building management systems We have invested in upgrading our energy management systems ensuring that the most economical controls of heating and ventilation systems are in place.

Plant and build services system We have invested in the replacement of various plant and building services systems – some of which have offered energy savings by installing more efficient equipment.

Waste disposal and recycling

In the last 12 months we have disposed of approx 2,000 tonnes of clinical waste to our Nottingham waste contractor for incineration. 95 per cent of it is recycled to provide steam which produces hot water for the Nottingham District Heating Scheme providing energy to more than 4,000 properties within Nottingham. Recycled waste from our hospitals provides 34 per cent of Nottingham's annual tonnage – 4,462,976 kWh per annum towards the heating scheme.

This plant is set to close in early 2014 so our waste will be treated by an alternative method which sterilises the waste and produces flock residue used as fuel for brick making kilns. This will maintain our recycling figures.

We have disposed of approximately 1,900 tonnes of general waste in the last 12 months. Our local companies have well-organised processes for sorting waste prior to it going to landfill. This year only 23 per cent of that 1,900 tonnes went to landfill. This method of segregation and recycling avoids us having to segregate at source both saving time, space and money as well as proving more efficient waste disposal methods.

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 from site free of charge in most cases.

Over the last 12 months 395 tonnes (inclusive of the above) special waste types have been taken from our sites for recycling.

Travel management

We currently provide 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 on-site cycle facilities, support of the Bike 2 Work week and inclusion in the citywide car-sharing scheme. We also aim to provide clear information for patients and visitors regarding accessing our hospitals in patient letters and the hospital website.

We are partners with local business and the local authorities: we are members of Smarter Travel Leicester, a group of key organisations within the city that work together to promote alternative sustainable travel. This enables us to offer various reduced rates for travel including reduced bus and train ticket prices.

We are really proud of our shuttle bus service which is used by around 12,000 passengers a week and are currently writing a new travel plan to provide a renewed focus on measures we can use to encourage the use of alternative sustainable transport.

Procurement and supplies

The strategic priorities for procurement meet the key recommendations of the Best Practice Guidelines – NHS Procurement 'Raising Our Game'. We will work to continue to improve procurement performance through leadership, people, process and partnership.

During 2012/13 we focused on a number of non-clinical reviews, particularly on procurement to get the best price, often taking cost out of supply chains to achieve our target of £10m savings by 2012 – 2014 in procurement savings and service improvement initiatives.

Over the past 12 months we've achieved major savings through developing services and by streamlining resources, ensuring we have the right skills and expertise in our contracting staff and creating a modern, safe and sustainable for the future.

Procurement has played a key active role in our annual cost improvement programme for 2012/13/14, and the £10m savings is divided and devolved to each category and service area to achieve through the following approaches to procurement and efficiencies.

We have embedded approaches to benchmark and sample prices paid for the many high spend items used in our hospitals and identify savings opportunities through standardising products, re-negotiating and re-tendering contracts. This has helped to maximise our purchasing power for commonly used items such as stationary and surgical gloves.

We have already seen the impact of our improved ways of buying services and products through a redesign and consolidation of supplies. This includes joint venture working with Nottingham University Hospitals NHS Trust on a pathology service. The redesign of the service and contract will be implemented in 2013/14 and offer a more efficient and effective centralised service. Other examples include the outsourcing of facilities management and the managed arrangement with IBM as the business partner for IM&T.

We have increased and improved the information we can gather about procurement through a web-enabled dashboard which tells us about procurement spend, trends, activity and by area. The work started in 2011/12 using raw transactional data from our finance systems and further work is planned in 2013/14 to enrich the information we hold.

We are required to develop and respond to the challenges of the NHS Standards of Procurement published in 2012 to meet the expectations of the good practice and deliver efficiencies. The NHS Standards of Procurement provide a clear vision of good procurement and identifies high quality procurement performance. Our aim is to achieve green status for level 1 by ensuring awareness and that building blocks are in place and then moving to amber for level 2 by achieving and making good progress in 2013/14.

Clinical engagement is key to ensuring that procurement supports the delivery of quality patient care that is delivered in a cost efficient way. The team meet regularly with clinical engagement groups to explore opportunities to save money through product standardisation initiatives and opportunities to switch to better value products that do not adversely impact on patient outcomes and experience.

Key priorities for 2013/14 include delivering the £10m cost improvement programme and ensuring continued compliance with NHS Standards of Procurement, as well as local, national and European procurement legislation. We will improve our Procurement 2 Pay tool which will help transform the way we control products and stock ordered by staff and manage the ordering and payment process ensuring we maximise efficiencies.

We will also continue to work with other trusts and/or procurement hubs to maximise buying power and harness relationships with suppliers to stimulate new innovation to deliver quality and value. We are committed to supporting using of local providers of goods and services where it is commercially appropriate and where compliance with procurement legislation is not compromised.

Our priorities for 2013/ 14

For the coming year, we have identified a range of priorities which are designed to take forward the key elements of the Strategic Direction that was developed last autumn. These are:

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

Most of the major things that what we will be doing to improve how we deliver our services will come under the banner of a new **Improvement and Innovation Framework,** which will replace our existing Transformation Plan.

Alongside developing our 2013/14 priorities, our Trust Board has been reviewing the Foundation Trust (FT) application timetable. There is much more we need to do in order to submit a strong FT application, for example we need longer to sort out some fundamentals particularly the emergency process and our underlying financial performance. So whilst we have put back our FT timetable by a year we will still spend 2013/14 ensuring that we are on the right track and have in place the appropriate plans to run a healthy and financially sustainable organisation.

Our Trust Board

NAME	POSITION	INTEREST(S) DECLARED
Mr M Hindle	Trust Chairman	Board member, Health Protection Agency, and Chair of its Finance Committee. Member of the Advisory Board, University of Bradford School of Management. Member of the Council of the University of Leicester for an initial three year period, effective from 1 April 2012. Son is a partner in Beachcroft LLP, which provides legal advice to the Trust (not directly involved). Non-Executive Director for the Medicines and Healthcare Products Regulatory Agency for three years with effect from 1 September 2012.
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 Participation Group for Countesthorpe Health Centre, and Non-Executive Chair for Swanbridge Hire and Sales Ltd.
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 J Adler	Chief Executive (from 7 January 2013)	None to declare.
Mr J Birrell	Interim Chief Executive (from 2 July 2012 to 20 December 2012)	Director and part-owner of J Birrell Ltd. Shareholder in J Birrell Ltd.
Mr M Lowe-Lauri	Chief Executive (until 30 June 2012)	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/Wellcome HICF

NAME	POSITION	INTEREST(S) DECLARED
Ms K Bradley	Director of Human Resources	None to declare.
Dr K Harris	Medical Director	Member (MD) of the NICE Interventional Procedures Advisory Panel.
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.
Mr J Tozer	Interim Director of Operations (post acts as adviser to the Trust Board)	None to declare.
Mr A Seddon	Director of Finance and Business Services	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 22 September 2012 at the Royal Infirmary, presenting the Trust's 2011/12 annual report and accounts and answering questions from the public. As part of the event on 22 September 2012, 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 & financial review

2012/13 was another challenging year both financially and clinically. I am pleased to report that, for the thirteenth year in succession we have met our financial duties and delivered a breakeven position.

We provide hospital and community based healthcare services to patients across Leicester, Leicestershire and Rutland and specialist services to patients throughout the UK. As such, our main sources of income are derived from 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 2013

We have met its financial and performance duties for 2012/13:

- **Balancing the books** – delivery of an income and expenditure surplus of £91,000
- **Managing cash** – undershot the External Financing Limit by £1.4m, which is permissible
- **Investment in buildings, equipment and technology** – invested £16.0m in capital developments.

Performance against our financial plan

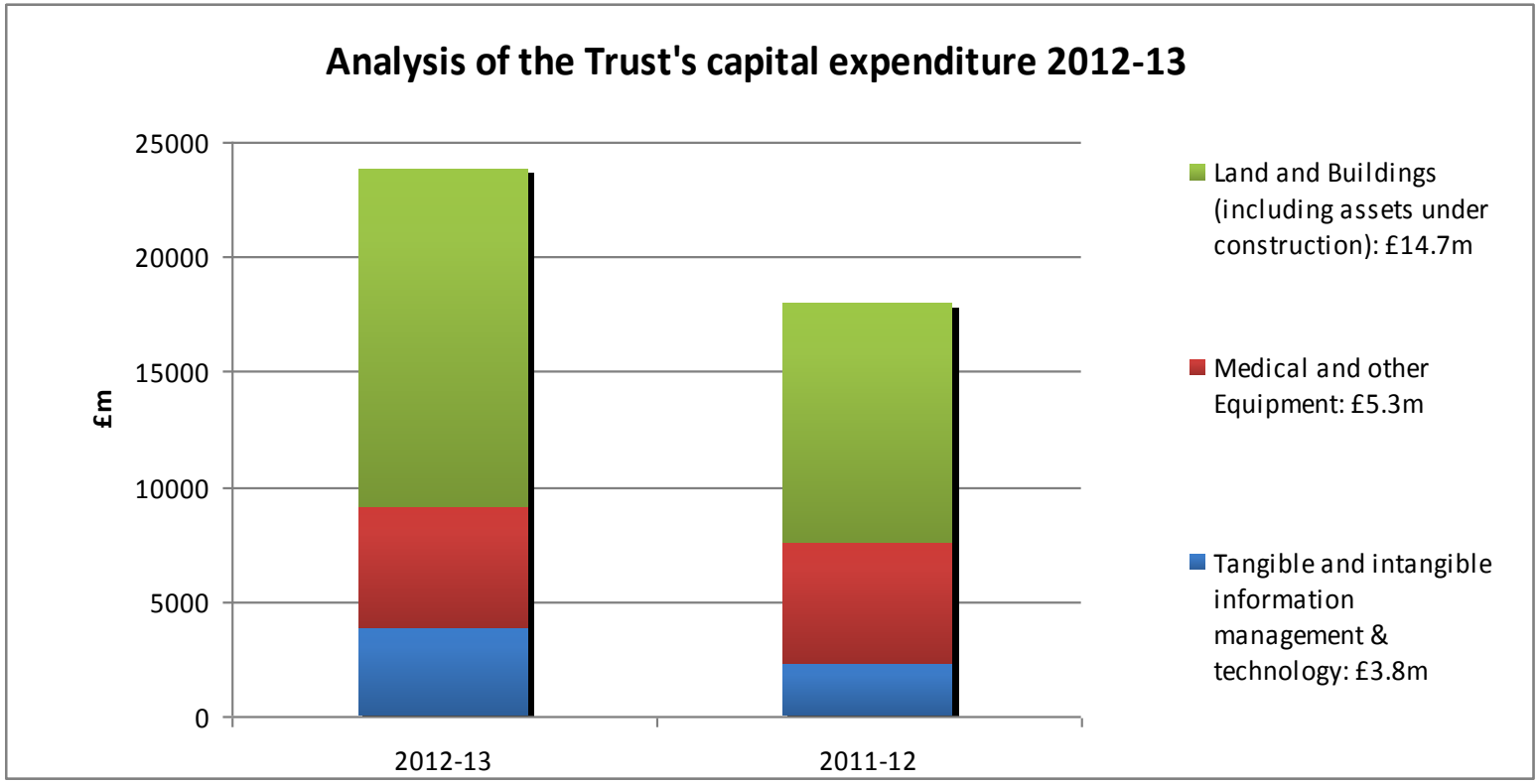
We delivered a £91,000 surplus against a planned outturn of £46,000. The plan included income of £720.2m (excluding the impact of donated assets) and expenditure of £720.2m.

The final year-end position showed the following:

- Total income (excluding the impact of donated assets) – £757.7m actual, £37.5m over plan of £720.2m
- Total expenditure – £757.6m actual, £37.4m over plan of £720.2m.

Capital expenditure

We spent £23.8m against a capital plan of £31.5m, detailed in the chart below



Balance sheet

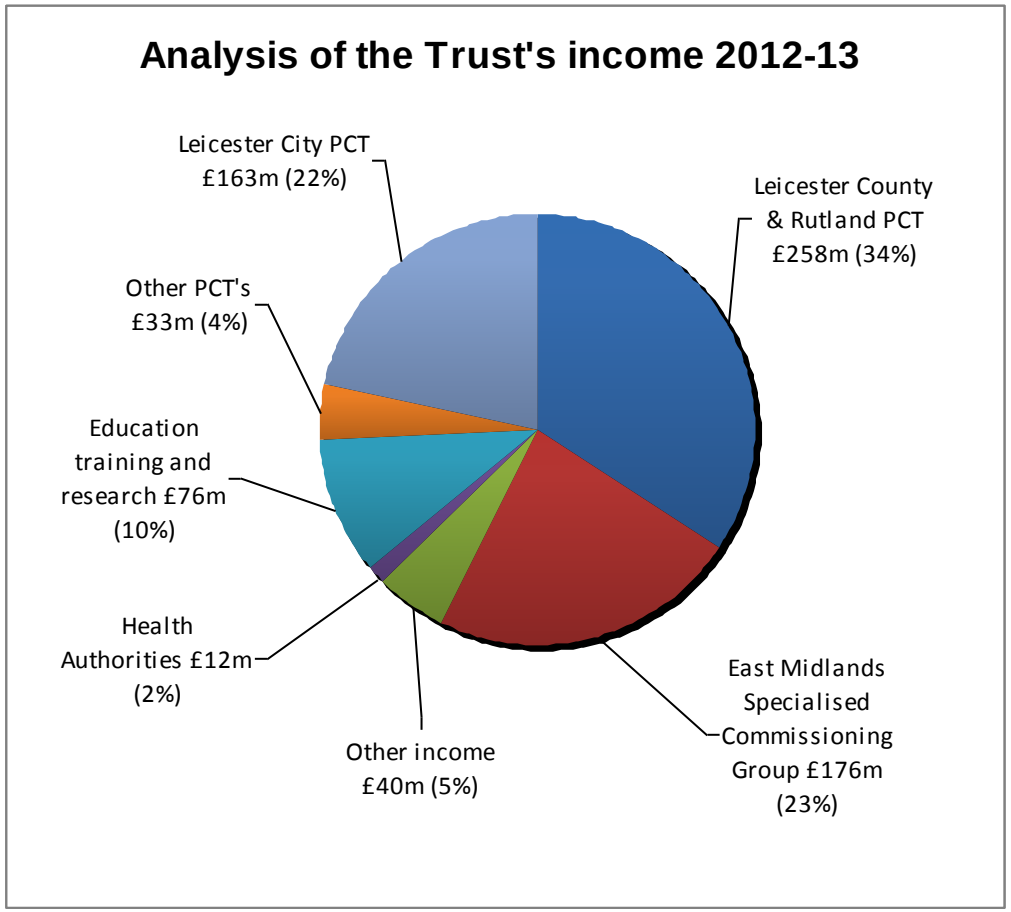
We planned to maintain our cash holdings at more than £18m at the end of March 2013, which we have achieved with an actual cash balance of £19.9m at the year-end.

Our debtors' position increased by £16.5m in 2012/13 and this includes several large debts outstanding with the local PCTs at the year-end, which have been received in April 2013. Our creditors' position has increased by £14.3m from the prior year. Managing a similar change in both debtors and creditors has also enabled the cash position to be maintained.

What we earned in 2012/13

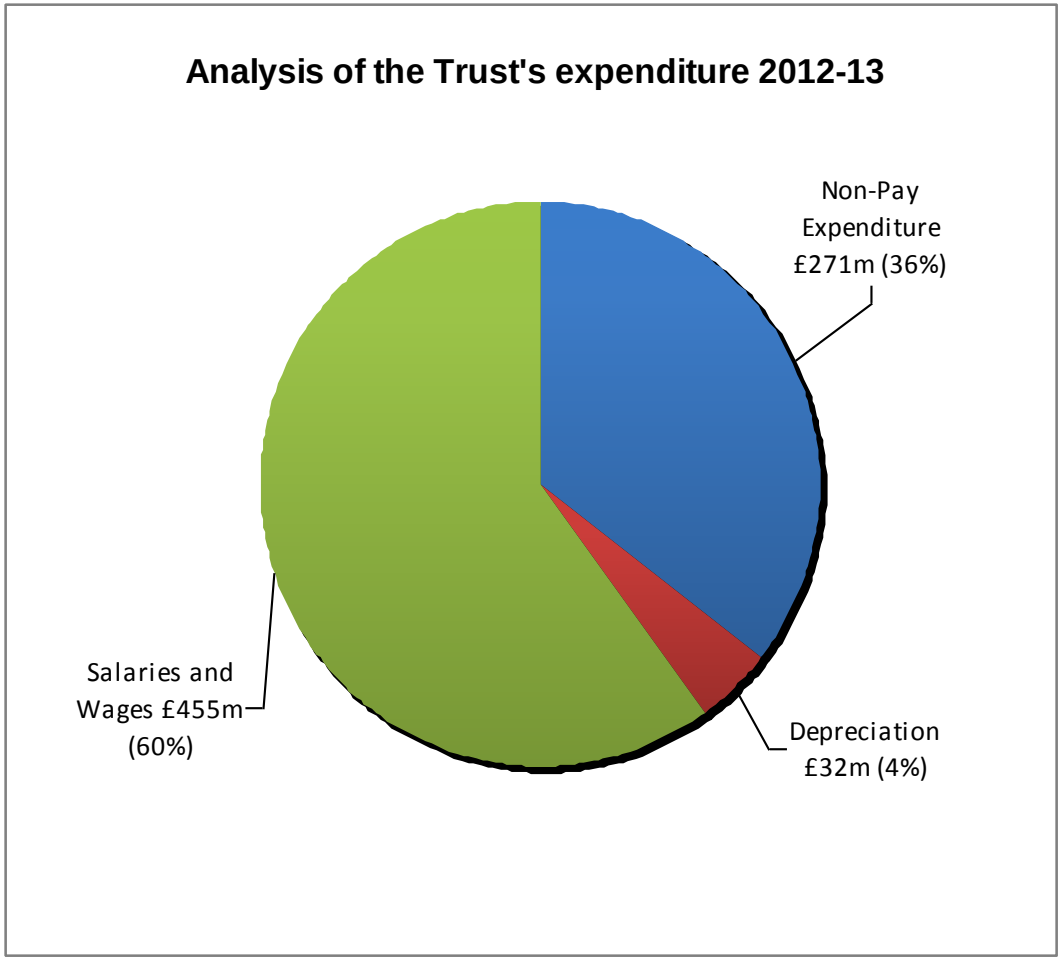
The chart overleaf details the £757.7m of income (excluding the impact of donated assets) we received. This is a £38.5m (5.4 per cent) increase from the £719.2m received in 2011/12, reflects:

- an increased PCT income of £34.0m
- an increased income from overseas patients of £1.3m.



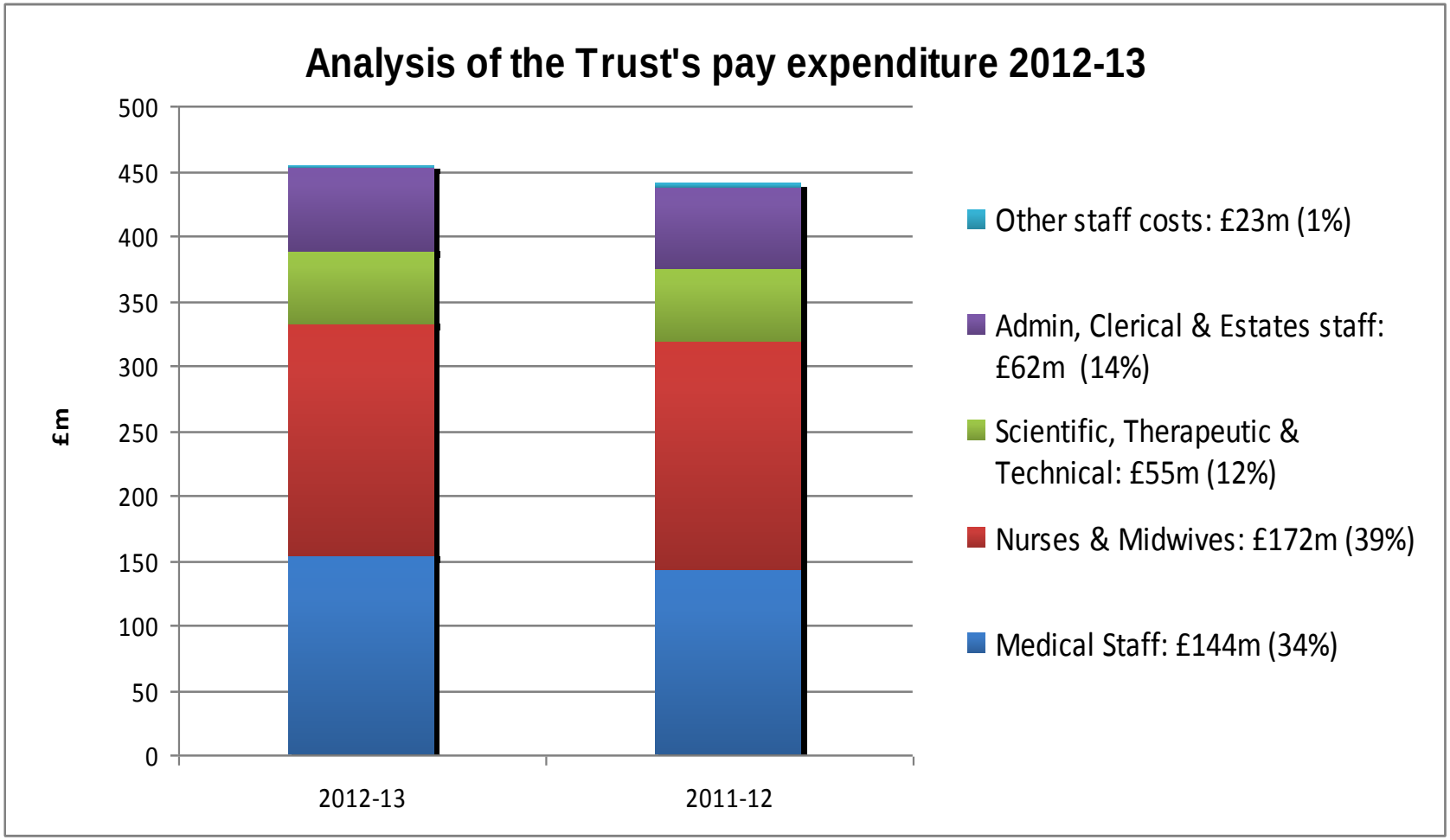
What we spent in 2012/13

The chart below details the £757.6m we spent during the year, and what we spent it on. This is a £38.5m (5.4%) increase from the £719.1m received in 2011/12.



What we spent on staff, by staff group, during 2012/13

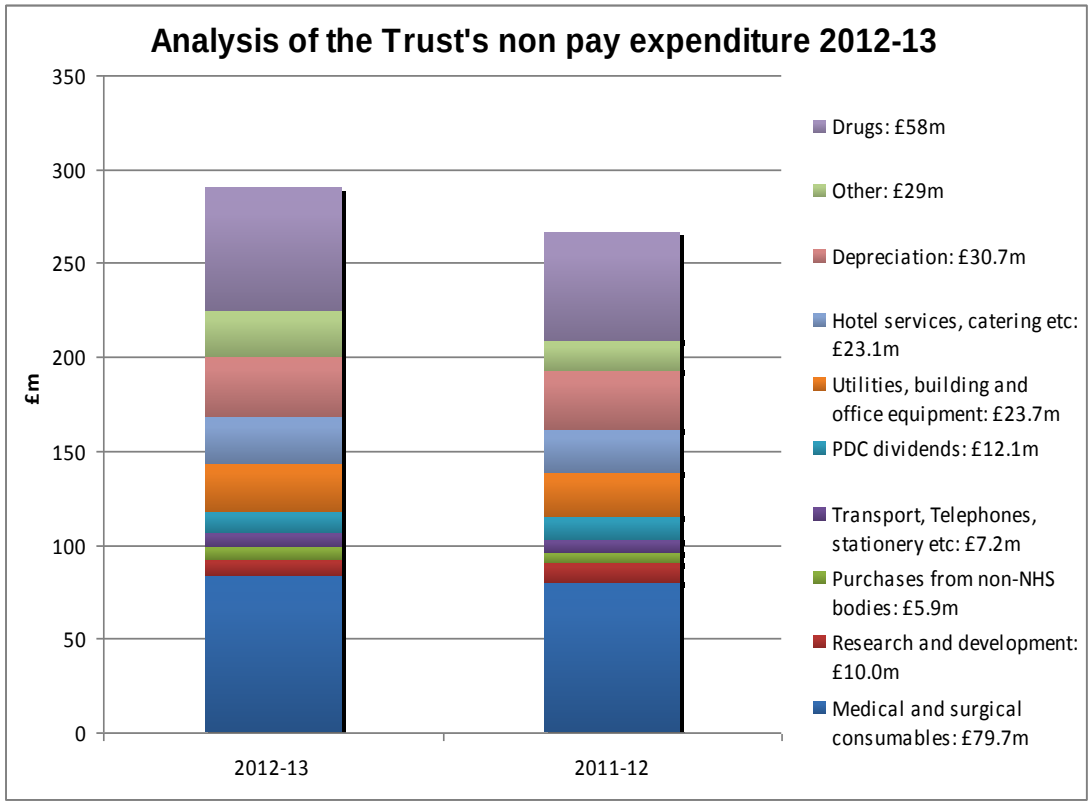
The chart below shows what we spent on pay during the year. We spent a total of £455.1m, which is a £14.7m more that we what we spent in 2011/12 (£440.4m).



Non-pay expenditure 2012/13

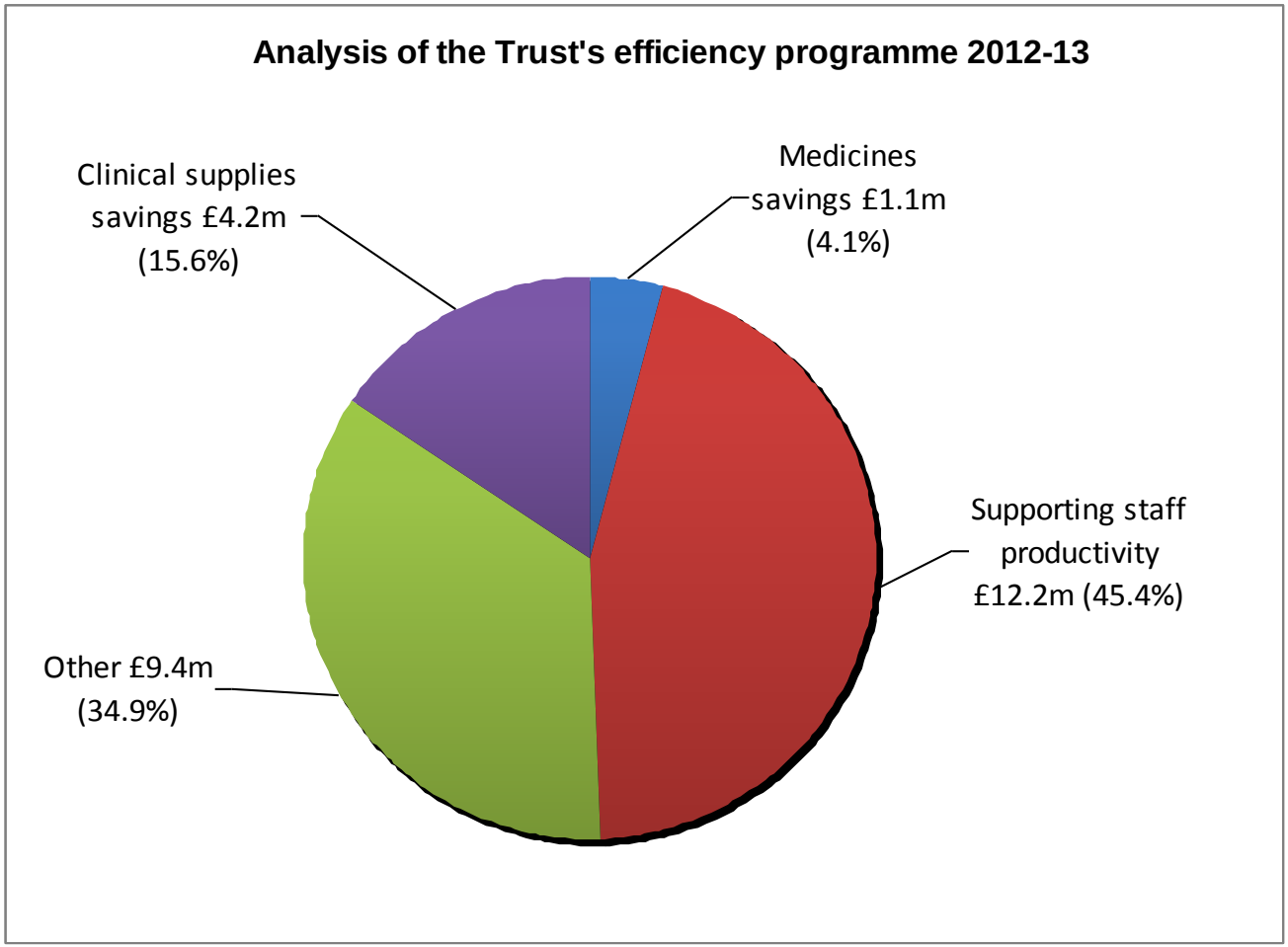
The chart below shows what we spent on running the hospitals – that's everything else except staff pay which is shown separately above. In 2012/13 we spent £290.7m, a £24.5m (9.2%) increase from the 2011/12 total of £266.2m we receive. This increase is due to a number of factors including:

- an increase of £11.6m on clinical supplies and services costs including additional investment in high cost therapies and drugs of £7.4m
- an increase of £2.7 million on premises costs as a consequence of price increases in utilities predominately electric, gas and water and sewerage (£1 million), and IT related costs of £1.4m
- an increase of £3.5 million on clinical negligence insurance costs over 2011/12 levels due to the inflationary increase on the contract and the full year impact of the Trust falling a level during 2011/12, which increased contribution costs
- an increase in other expenditure of £3.6 million from the 2011/12 total of £3.3m million



Our efficiency programme for 2012/13

We delivered £26.8 million of our £32 million cost improvement programme during the year. The major components of the delivery of the programme are outlined in the chart below. These were delivered as part of our focus on productivity whilst maintaining high quality patient services.



Managing risk

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

As in 2012/13, we will continue to manage key risks linked to management and control of infection, the patient experience, delivery of national waiting time targets, and delivery of financial balance.

Future challenges

In 2013/14 we have set a challenging efficiency target of £40m (representing 5.3 per cent of our total turnover) which includes schemes in the following key areas:

- buying goods and services
- reducing agency pay costs
- improvement in our theatre efficiency
- reducing outpatient cancellations and non-attenders (DNAs)
- length of stay reduction.

We are making a significant investment in new assets. The capital programme for 2013/14 involves £37.8m of investment. Major plans include:

- £2.8m to improve maternity services
- £5m to improve emergency admissions
- £2m to start work on developing an outpatients centre
- £4.6m to develop vascular services at Glenfield.

In addition we are investing £23.4m on replacing medical equipment, improving buildings and developing IT systems.

Foreword to the Summary Financial Statements

University Hospitals of Leicester NHS Trust

These accounts for the year ended 31 March 2013 have been prepared by the University Hospitals of Leicester NHS Trust under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

The accounts for 2012/13 have been prepared under International Financial Reporting Standards (IFRS), which have been effective for the NHS from 1st April 2009.

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

Assistant Director of Finance (Financial Accounting)

Trust Headquarters

Level 3

Balmoral Building

Leicester Royal Infirmary

Infirmary Square

LE1 5WW

0116 258 8557

Summary Financial Statements

Statement of comprehensive income for year ended 31 March 2013

	2012-13	2011-12
	£'000	£'000
Employee benefits	**(455,142)**	(440,415)
Other costs	**(290,721)**	(294,908)
Revenue from patient care activities	**649,145**	615,066
Other Operating revenue	**109,520**	104,762
Operating surplus/(deficit)	**12,802**	(15,495)
Investment revenue	**77**	66
Finance costs	**(612)**	(459)
Surplus/(deficit) for the financial year	**12,267**	(15,888)
Public dividend capital dividends payable	**(11,090)**	(12,097)
Retained (deficit) for the year	**1,177**	(27,985)
Other Comprehensive Income		
Impairments and reversals	**0**	(30,852)
Net gain on revaluation of property, plant & equipment	**0**	1,472
Net (loss) on other reserves	**0**	0
Total comprehensive income for the year	**1,177**	(57,365)
Financial performance for the year		
Retained surplus/(deficit) for the year	**1,177**	(27,985)
Impairments	**0**	28,073
Adjustment to remove the impact of donated asset receipts and depreciation	**(1,086)**	0
Adjusted retained surplus/(deficit)	**91**	88

Statement of Financial Position as at 31 March 2013		
	31 March 2013	31 March 2012
	£'000	£'000
Non-current assets:		
Property, plant and equipment	**354,658**	349,363
Intangible assets	**5,308**	5,242
Trade and other receivables	**3,155**	2,188
Total non-current assets	**363,121**	356,793
Current assets:		12,262
Inventories	**13,064**	29,126
Trade and other receivables	**45,649**	0
Cash and cash equivalents	**19,986**	18,369
Total current assets	**78,739**	59,757
Total assets	**441,860**	416,550
Current liabilities		
Trade and other payables	**(76,594)**	(62,277)
Provisions	**(1,906)**	(789)
Borrowings	**(2,727)**	(4,038)
Total current liabilities	**(81,227)**	(67,104)
Net current assets	**360,633**	349,446
Non-current liabilities		
Provisions	**(2,406)**	(2,121)
Borrowings	**(10,906)**	(1,427)
Total non-current liabilities	**(13,312)**	(3,548)
Total Assets Employed:	**347,321**	345,898
FINANCED BY:		
TAXPAYERS' EQUITY		
Public Dividend Capital	**277,733**	277,487
Retained earnings	**4,960**	3,705
Revaluation reserve	**64,628**	64,706
Total Taxpayers' Equity:	**347,321**	345,898

Statement of cash flows for the year ended 31 March 2013

	2012-13 £'000	2011-12 £'000
Cash Flows from Operating Activities		
Operating Surplus/Deficit	**12,802**	(15,495)
Depreciation and Amortisation	**32,097**	30,764
Impairments and Reversals	**0**	28,072
Donated Assets received credited to revenue but non-cash	**(1,617)**	(763)
Interest Paid	**(540)**	(361)
Dividend paid	**(10,030)**	(13,356)
(Increase)/Decrease in Inventories	**(802)**	(378)
(Increase)/Decrease in Trade and Other Receivables	**(18,283)**	(5,384)
Increase/(Decrease) in Trade and Other Payables	**11,289**	2,578
Provisions Utilised	**(667)**	(498)
Increase/(Decrease) in Provisions	**2,069**	509
Net Cash Inflow from Operating Activities	**26,318**	25,688
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**77**	65
(Payments) for Property, Plant and Equipment	**(18,838)**	(15,790)
(Payments) for Intangible Assets	**(1,938)**	(1,254)
Net Cash Outflow from Investing Activities	**(20,699**	(16,979)
NET CASH INFLOW BEFORE FINANCING	**5,619**	8,709
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	**246**	3,584
Capital Element of Payments in Respect of Finance Leases	**(4,248)**	(4,230)
Net Cash Outflow from Financing Activities	**(4,002)**	(646)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	**1,617**	8,063
Cash and Cash Equivalents at Beginning of the Period	**18,369**	10,306
Cash and Cash Equivalents at year end	**19,986**	18,369

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:

	£000s	Number
Non-NHS Payables		
Total non-NHS trade invoices paid in the year	**364,150**	**123,289**
Total non-NHS trade invoices paid within target	**307,704**	**104,995**
Percentage of non-NHS trade invoices paid within target	**85%**	**85%**
NHS Payables		
Total NHS trade invoices paid in the year	**147,687**	**4,857**
Total NHS trade invoices paid within target	**132,473**	**3,320**
Percentage of NHS trade invoices paid within target	**90%**	**68%**

Audit Fees

Our external auditor for statutory audit and services during 2012/13 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 2012/13 was £209k.

Pension liabilities

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

Statement of Directors

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

Salary and Pension entitlements of senior managers						
	2012-13			2011-12		
Name and Title	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £000	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100
M Hindle, Chairman	20-25	0	0	20-25	0	0
M Lowe-Lauri, Chief Executive (until 31 August 2012)	190-195	0	0	200-205	0	0
J Birrell, Interim Chief Executive (from 2nd July 2012 to 20th December 2012)	185-190	0	0	0	0	0
J Adler, Chief Executive	40-45	0	2	0	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	40-45	165-170	0
A Seddon, Director of Finance and Procurement	135-140	0	0	140-145	0	0
A Tierney, Director of Strategy	105-110	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

Salary and Pension entitlements of senior managers						
	2012-13			2011-12		
Name and Title	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £000	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100
J E Wilson, Non Executive Director	5-10	0	0	5-10	0	0
P Panchal, Non Executive Director	5-10	0	0	0-5	0	0
K Jenkins, Non Executive Director	5-10	0	0	0-5	0	0

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

Salary and Pension entitlements of senior managers - Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2500) £'000	Real increases in lump sum at age 60 at 31 March 2013 (bands of £2500) £'000	Total accrued pension at age 60 at 31 March 2013 (bands of £5000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5000) £'000	Cash equivalent transfer value at 31 March 2013 £'000	Cash equivalent transfer value at 31 March 2012 £'000	Real increase in cash equivalent transfer value £'000	Employers Contribution to Stakeholder Pension To nearest £100
M Lowe-Lauri, Chief Executive (until 31 August 2012)	(2.5-5.0)	(10.0-12.5)	80-85	250-255	1,698	1,693	(83)	0
J Adler, Chief Executive	0.0-2.5	2.5-5.0	50-55	155-160	972	0	48	0
A Seddon, Director of Finance and Procurement	0.0-2.5	2.5-5.0	15-20	50-55	358	304	38	0
S Hinchliffe, Chief Operating Officer	(0.0-2.5)	(2.5-5.0)	60-65	180-185	1,135	1,067	13	0
K Harris, Medical Director	0	0	0	0	0	0	0	0
K Bradley, Director of Human Resources	(0.0-2.5)	(0.0-2.5)	35-40	105-110	652	608	12	0
A Tierney, Director of Strategy	0-2.5	0	20-25	0	181	156	17	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	20-25	60-65	311	285	12	0
S Ward, Director of Corporate & Legal Affairs	(0.0-2.5)	(0.0-2.5)	35-40	110-115	702	660	8	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 University of Leicester pension scheme.

In respect of J Birrell, the nature of his employment with the Trust was such that we made no pension contributions for the duration of his employment with the Trust.

Exit Packages

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*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	**0**	**0**	**0**	7	0	7
£10,001-£25,000	**0**	**0**	**0**	1	0	1
£25,001-£50,000	**1**	**0**	**1**	2	0	2
£50,001-£100,000	**0**	**0**	**0**	1	0	1
£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
Total number of exit packages by type (total cost)	**1**	**0**	**1**	11	0	11
Total resource cost (£000s)	**1**	**0**	**1**	181	0	181

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

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

Pay multiples

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

The banded remuneration of the highest paid director in the University Hospitals of Leicester NHS Trust in the financial year 2012/13 was £190,000 – £195,000 (2011/12 was £200,000 - £205,000. This was 8.9 times (2011/12 was 7.9 times) the median remuneration of the workforce, which was in the banding £20,000 – £25,000 (2011/12 was £25,000 – £30,000).

We implemented a pay freeze across all staff groups in 2012/13 and 2011/12 in accordance with the national guidance. In 2012/13 and 2011/12, no employees received remuneration in excess of the highest-paid director. Remuneration across the Trust ranged from £1,000 – £195,000 (2011/12 was £5,000 - £205,000).

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 2012/13

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 who joined the Trust in January 2013. This was the only substantive change to Board membership in 2012/13. Mr J Birrell served as Interim Chief Executive between July and December 2012. A new Non-Executive Director, Dr Sarah Dauncey, has been recruited to succeed Mr David Tracy, who resigned with effect from 31 March 2013.

The Board is supported in its work by the Director of Marketing and Communications , Director of Corporate and Legal Affairs and Director of Strategy.

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 six domains: preventing death; positive experience of care; timely care; safe environment; 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 four key data quality components to assist the Board in gaining assurance;
- is complemented by commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

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

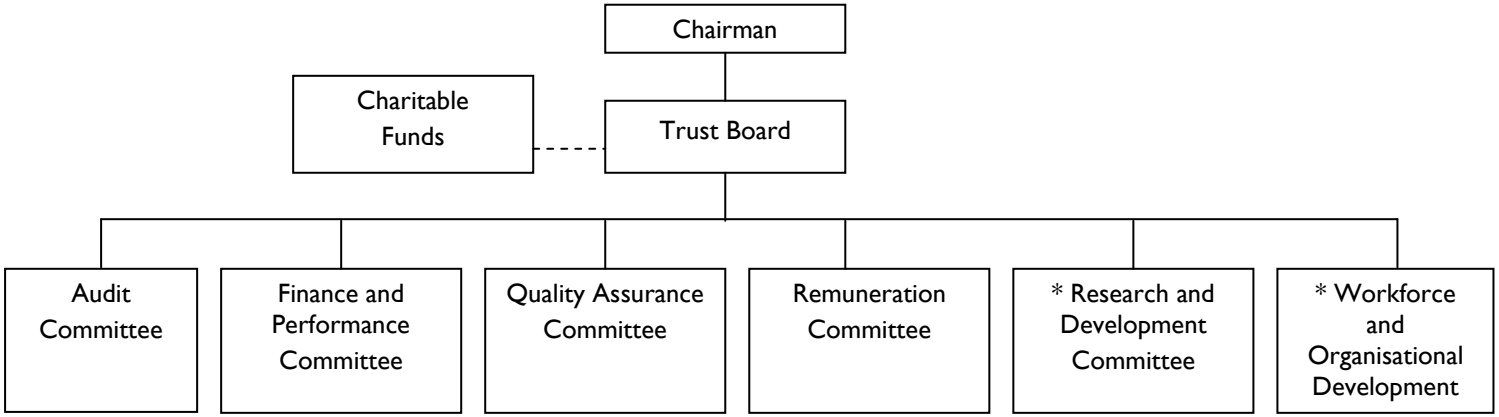
This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

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

Committee Structure

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



* With effect from 1 April 2013, these committees are disbanded as Board-level committees. Instead, the Board has agreed to receive reports quarterly on research and development and workforce and organisational matters, with exception reporting as required.

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 2012/13 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 2012/13 is set out below. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attenders as detailed in the terms of reference for each committee.

Name	Trust Board maximum - 14	Audit Committee maximum – 5	Finance & Performance Committee maximum – 11	Quality Assurance Committee maximum- 11	Research & Development Committee maximum – 7	Remuneration Committee maximum – 11	Workforce & Organisational Development Committee maximum – 4
Martin Hindle Chairman	14	N/A	N/A	N/A	7	11	N/A
Kiran Jenkins Non-Executive Director	13	5	N/A	N/A	N/A	6	N/A
Richard Kilner Non Executive Director	14	5	11	N/A	N/A	11	4
Prakash Panchal Non-Executive Director	13	N/A	N/A	7	7	8	4
Ian Reid Non-Executive Director	14	5	11	1	N/A	10	N/A
David Tracy Non-Executive Director	13	3	N/A	10	N/A	8	3
Jane Wilson Non-Executive Director	12	N/A	11	9	N/A	9	4
Prof. David Wynford-Thomas Non-Executive Director	8	N/A	N/A	6	4	7	N/A
John Adler Non-Executive Director 1	4	0	3	3	0	2	0
Jim Birrell Interim Chief Executive 2	5	0	3	0	0	3	0

Name	Trust Board maximum - 14	Audit Committee maximum – 5	Finance & Performance Committee maximum – 11	Quality Assurance Committee maximum- 11	Research & Development Committee maximum – 7	Remuneration Committee maximum – 11	Workforce & Organisational Development Committee maximum – 4
Kate Bradley Director of Human Resources	12	N/A	N/A	N/A	N/A	11	4
Dr Kevin Harris Medical Director	12	N/A	4	8	5	N/A	0
Suzanne Hinchliffe Chief Nurse/ Deputy Chief Executive	14	2	5	9	N/A	N/A	2
Malcolm Lowe-Lauri Chief Executive 3	5	2	2	2	2	2	1
Andrew Seddon Director of Finance & Business Services	14	5	11	N/A	N/A	N/A	N/A
Dr Abigail Tierney Director of Strategy 4	5	N/A	3	N/A	1	N/A	N/A
Jez Tozer Interim Directory of Operations 5	6	N/A	4	N/A	N/A	N/A	N/A
Stephen Ward Director of Corporate & Legal Affairs	13	4	N/A	5	N/A	10	N/A
Mark Wightman Director of Communications & External Relations	14	N/A	N/A	4	0	N/A	1

1. Joined the Trust as Chief Executive on 7 January 2013
2. Interim Chief Executive July – December 2012
3. Left the Trust on 31 August 2012
4. Took maternity leave from 1st September 2012 and left the Trust on 31st March 2013
5. Interim Director of Operations from October 2012 to 7 June 2013.

Board Effectiveness

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

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

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

The Board's review of effectiveness in 2012/13 has been given added focus by its completion of the Department of Health Board Governance Memorandum self-assessment, a mandatory requirement for aspirant NHS Foundation Trusts.

Outside of its formal meetings, the Board has held development sessions throughout 2012/13. Amongst the topics considered were risk management; and the development of the Trust's Integrated Business Plan; formulating the Trust's quality and safety commitment; and development of the draft Annual Operational Plan 2013/14.

The Chairman of the East Midlands Strategic Health Authority set objectives for the Trust Chairman for 2012/13.

The Trust Chairman set objectives for the Chief Executive and Non-Executive Directors for 2012/13. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2012/13. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively.

Corporate Governance

In managing the affairs of the Trust, the Trust Board is committed to achieving high standards of integrity, ethics and professionalism across all areas of activity. As a fundamental part of this commitment, the Board supports the highest standards of corporate governance within the statutory framework.

The Trust has in place a suite of corporate governance policies which are reviewed 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 adopted a new Code of Conduct : "Standards for NHS Board members and members of Clinical Commissioning Group governing bodies in the NHS in England" (Professional Standards Authority : November 2012).

Risk Assessment

The Trust operates a risk management process which enables the identification and control of risks at both a strategic and operational level. Central to this is the Trust's Risk Assessment Policy which sets out details of the risk assessment methodology used across the Trust. This methodology enables a suitable, trained and competent member of staff to identify and quantify risks in their respective area and to decide what action, if any, needs to be taken to reduce or eliminate risks. All risk assessments must be scored and recorded in line with the procedure set out in the Risk Assessment Policy. Completed risk assessments are held at Clinical Division and Corporate Directorate level and when they give rise to a significant residual risk must be linked to the Trust's risk register.

A common risk-scoring matrix is used by the Trust to quantify and prioritise risks identified through the risk assessment procedure. It is based on the frequency or likelihood of the harm combined with the possible severity or impact of that harm. The arrangement determines at what level in the organisation a risk should be managed and who needs to be assured management arrangements are in place.

The Trust recognises the importance of robust information governance. During 2012/13, the Director of Strategy and (while the postholder was on maternity leave) Director of Finance and Business Services led on information governance issues as the Trust's Senior Information Risk Owner, supported by a Privacy Manager. The Medical Director continued as the Trust's Caldicott Guardian during 2012/13.

The Trust took further actions during 2012/13 to secure improvement in its information governance arrangements. A Privacy and Information Risk Management Programme Board monitors and oversees compliance with information governance requirements. The Trust has fully supported NHS Midlands and East's information governance awareness campaign to promote secure handling of personal data ('NHS Confidential').

All NHS Trusts are required annually to undertake an information governance self-assessment using the NHS Information Governance Toolkit. This contains 45 standards of good practice. UHL's overall percentage score for 2012/13 was 82%, compared to 84% in 2011/12. This score, measured against more exacting standards in place for 2012/13, 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 2012/13. In respect of other personal data related incidents experienced during 2012/13, the Trust has undertaken investigations to ensure that the root causes are properly understood and addressed; in addition, patients have been contacted to inform them of the lapses and to provide them with assurance about the actions taken by the Trust to prevent recurrence.

The Risk and Control Framework

The Trust's Board-approved Risk Management Strategy describes an organisation-wide approach to risk management supported by effective and efficient systems and processes. The Strategy clearly describes the Trust's approach to risk management and the roles and responsibilities of the Trust Board, management and all staff.

Key strategic risks are documented in the Trust's Board Assurance Framework. Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team and Trust Board review the Framework on a monthly basis to identify and review the Trust's principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed.

The Trust's Annual Operational Plan 2013/14 responds to and addresses the strategic risks facing the Trust. The current Board Assurance Framework has been updated to reflect risks in the 2013/14 Plan and will continue to be reviewed at regular intervals by both the Executive Team and Trust Board.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Annual Quality Account

The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to NHS Trusts on the form and content of annual Quality Accounts which incorporates the above-mentioned legal guidance.

The Director of Clinical Quality, on behalf of the Chief Nurse co-ordinates the preparation of the Trust's Annual Quality Account. This is reviewed in draft form by the Trust's Quality Assurance Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2012/13, the Quality Assurance Committee has noted the Trust's internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – which Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 27 June 2013.

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 2012/13 and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance and Performance Committee and Quality Assurance Committee. During 2012/13, 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 2012/13, the Head of Internal Audit notes that 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 have resulted in high risk rated reports, action plans have been agreed by management to meet Internal Audit's recommendations and to strengthen internal control.

This is particularly the case in respect of the findings of Internal Audit following the review of the Trust's Business Continuity Management and IT Disaster Recovery arrangements. Here, Internal Audit identified two high risk issues : in consequence, the Trust has completed 'business impact assessments' for all areas of the Trust which are part of critical activities; and the development of business recovery plans for the failure of key third party suppliers has been partially completed and will be concluded by the end of September 2013.

In response to Internal Audit's findings following a review of waiting lists for imaging procedures, the Trust developed and implemented a comprehensive action plan to strengthen its arrangements in this area: the Audit Committee reviewed the issue in considerable detail and was able to provide assurance to the Trust Board on management's action plan. The action plan focused on improving the policies in place regarding how imaging waiting times should be administered and monitored so that they are clear, consistent and understood by those who use them; and, secondly, to ensure that the policies are applied accurately in practice.

During 2012/13, Internal Audit reviewed the Trust's Cost Improvement Programme. Key findings highlighted the need to improve controls and processes relating to the Transformation Support Office (TSO) (Improvement Support Office), documentation, key performance indicators and milestones, and stakeholder engagement. The Trust is committed to acting responsively to the findings of Internal Audit to continue to improve the overall governance arrangements relating to the Cost Improvement Programme.

The Head of Internal Audit's Opinion 2012/13 (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.

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 external support to help drive improvements to the emergency care pathway. During 2013/14, Internal Audit is to carry out a review of the adequacy of winter planning arrangements within the Emergency Department and evaluate whether recent changes in the emergency care pathway have resulted in sustained performance improvement.

Using its Board Assurance Framework, the Trust Board has also identified actions to mitigate other risks in 2013/14 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;

(c) the trajectory relating to the Trust's application for NHS Foundation Trust status, and

(d) the inability to recruit, retain, develop and motivate staff.

In addition to the issues identified above, further work will be undertaken in 2013/14 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 2013/14 and beyond.

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

Signed: 

Chief Executive (on behalf of the Trust Board)

Date: 30/05/2013

Independent auditor's statement to the Board of Directors of the 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 2013.

This report is made solely to the Board of Directors of University Hospitals of Leicester NHS Trust in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust 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 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 2013 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, 7 June 2013 and the date of this statement.

Andrew Bostock
For and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

10 September 2013

Glossary of terms

Admission the point at which a person begins an episode of care, e.g. arriving at an inpatient ward.

Acute Care is specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

Care Plan a plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy.

CCG (Clinical Commissioning Group) Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Clinical Governance is a framework that ensures that NHS organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.

Clinical Negligence Scheme for Trust (CNST) is a scheme for assessing a Trust's arrangements to minimise clinical risk for service users and staff. Trusts need to pay 'insurance' which can offset the costs of legal claims against the Trust. Achieving CNST Levels (1, 2 or 3) shows the Trust's success in minimising clinical risk and reduces the premium that the Trust must pay.

Clinician is a person who provides direct care to a patient such as a doctor, nurse, therapist, pharmacist, psychologist etc).

Commissioning is the process of identifying a community's social and/or health care needs and finding services to meet them.

Community Care aims to provide health and social care services in the community to enable people live as independently as possible in their own homes or in other accommodation in the community.

Co-morbidity is the presence of two or more disorders at the same time. For example, a person with depression may also have diabetes.

Diagnosis is identifying an illness or problem by its symptoms and signs.

Discharge is the point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).

Emergency Admission when a patient admitted to hospital at short notice because of clinical need or because alternative care is not available.

Emergency Department is a hospital department that assesses and treats people with serious and life-threatening injuries and those in need of emergency treatment.

Foundation Trusts are a type of NHS hospital run by local managers, staff and members of the public, which are tailored to the needs of the local population.

General Practitioner (GP) is a family doctor, usually patient's first point of contact with the health service.

Health Care Assistants (can also be referred to as Health Care Support Workers) are non-qualified nursing staff who carry out assigned tasks involving direct care in support of a registered/qualified nurse. There are two grades of Health Care Assistants, A and B grade. A grades would expect to be more closely supervised, while B grades may regularly work without supervision for all or most of their shift, or lead on A grade.

Human Resources is a department found in most organisations that works to recruit staff, assist in their development (e.g. providing training) and ensure that staff work in good conditions.

Information Management and Technology (IM&T) refers to the use of information held by the Trust, in particular computerised information and the department that manages those services.

Intermediate Care Services are services that promote independence, prevent hospital admission and/or enable early discharge. Intermediate care typically provides community-based alternatives to traditional hospital care.

Liverpool Care Pathway is a care pathway used in the UK covering palliative care options for patients in the final days or hours of life. It has been developed to help doctors and nurses provide quality end-of-life care.

Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.

NICE is the National Institute for Health and Clinical Excellence, an the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Non-executive Director is a member of the Trust Board. They act a two way representative. They bring the experiences, views and wishes of the community and patients to the Trust Board. They also represent the interests of the NHS organisation to the Community.

Out of Hours (OOH) is the provision of GP services when your local surgery is closed, usually during the night, at weekends and Bank Holidays.

Palliative care is an area of healthcare that focuses on relieving and preventing the suffering of patients.

Peri-natal mortality is the number of stillbirths and deaths in the first week of life per 1,000 live births, after 24 weeks gestation.

Primary Care is the care will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Risk assessment identifies aspects of a service which could lead to injury to a patient or staff member and/or to financial loss for an individual or Trust.

Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

Serious Untoward Incidents (SUI) is a to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.

Stakeholders are a range of people and organisations that are affected by or have an interest in, the services offered by an organisation.

Tertiary Care is when a hospital consultant decides that more specialist care is needed. Mental Health Services are included in this (see also Secondary care).

TTO (To-take-out) are medicines supplied by the hospital pharmacy for patients to take with them when they are discharged (see discharge) from hospital.

Triage a system which sorts medical cases in order of urgency to determine how quickly patients receive treatment.

Walk-in-Centre (WiC) an NHS medical centre patients can attend without an appointment.

Whistle blowing is the act of informing a relevant person in an organisation of instances or services in which patients are at risk.

Please help us to improve the way we 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 2013.
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

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

4 Do you have another comments or suggestions about our annual report or any of our other publications?

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If you would like to be notified when the 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 in another language or format, please contact the service equality manager on 0116 250 2959

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

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

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

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

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

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

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

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

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

University Hospitals of Leicester NHS

NHS Trust

Caring at its best

Transforming technology & healthcare

Annual Report & Accounts 2012-2013