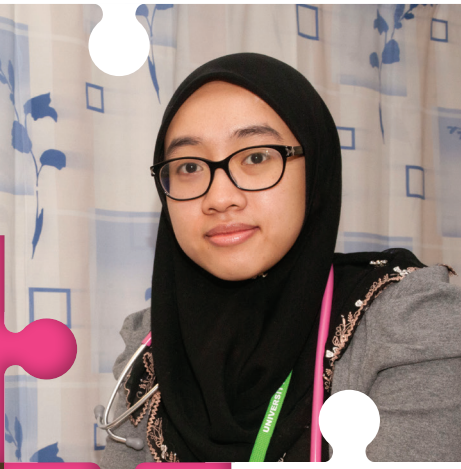
2016-17
Annual Report & Accounts

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best



Our Values

NHS
University Hospitals of Leicester
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

Contents

About Leicester's Hospitals

Our patients are the most important thing to us and we are constantly striving to improve the care they receive, through looking at the ways we work, ensuring our staff are highly trained and encouraging research which allows us to offer our patients the latest technologies, techniques and medicines – and attract and retain our enviable team of more than 15,000 highly skilled staff.

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

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

We continue to work with many different organisations throughout the world to push the boundaries of research and new surgical procedures for the benefit of our patients, with around 1,000 clinical trials taking place every year. We are now home to an NIHR Biomedical Research Centre which supports key research including lifestyle, diabetes, and cardio-respiratory diseases, and for the first time we have been successfully designated as an NIHR Clinical Research Facility. We are also extremely proud that we have an Experimental Cancer Medicine Centre and our HOPE Unit is an instrumental factor in delivering clinical trials of new cancer treatments, and is generously supported by the locally-based charity Hope Against Cancer. We are providing access to cutting edge genetic medicine for our patients by participating in the 100,000 Genomes Project. All of this means that thousands of our patients are amongst the first to try the latest medicines and techniques.

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

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

Our purpose is to provide 'Caring at its best' by living a set of values created by our staff that embody who we are and what we are here to do. They are:

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

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

Welcome from the Chairman and Chief Executive

2016/17 has been another very challenging year for the NHS, with increases in demand across many services and increasing numbers of patients with complex, multiple long terms illnesses.

In Leicester we continue to strive to improve the quality and effectiveness of patient care against a backdrop of national financial constraints. Despite these challenging times, the magnificent dedication and consistent efforts of our staff, means we have ended the year having performed well against most of our key targets and within our revised financial forecast.

During 2016/17 we made decent progress on improving the quality of the care we provide our patients. We have kept waiting times for planned care low and despite an 8 per cent increase in cancer referrals we have still managed to see 93 per cent of patients within two weeks. We are below our trajectory for cases of Clostridium Difficile and had no avoidable cases of MRSA, making us one of the best performing trusts in the country for infections. There are low wait times for diagnostic treatment, and we have seen less patient falls and avoidable pressure ulcers on our wards. Nonetheless, some key standards have remained a challenge; for example, the numbers of patients waiting over 4-hours in our Emergency Department, the length of time it takes to offload ambulances at times of high pressure, the numbers of patients with broken hips who are operated on within 35 hours and the delivery of some of our RTT (Referral to Treatment) times have suffered as a consequence of non-emergency patients being cancelled when emergency pressures are at their greatest.

In terms of our finances we have ended the year £7m off our original financial plan – that is just 0.1 per cent off budget and whilst it is clearly preferable to be on target we know many other Trusts have found their financial positions equally, if not more, challenging.

That dedication and commitment to do more and better was certainly seen by Care Quality Commission (CQC) inspectors when they visited us in June 2016 for their announced inspection. We told the CQC that our greatest strength was our staff; their motivation, compassion and ambition to improve services for patients. The CQC saw this for themselves and it was echoed in their feedback. They told us that they found our staff to be *"universally welcoming, open and transparent"* and they were clearly very impressed by the care, professionalism and loyalty of everyone they encountered. This is reflected in the fact that "Caring" has been rated "Good" across all three hospital sites.

We were also honest with the CQC about the challenges that we face. We told them that we are steadily improving quality whilst dealing with large increases in demand. That we were working better with our partners to tackle longstanding strategic issues such as emergency care and the configuration of our services, and that along the way we were building a more empowered, open culture. The CQC rated our Trust overall, as 'Requires Improvement'. The report says *"Although the overall rating we gave the trust in this inspection was the same as they were awarded in their 2014 inspection, we did find improvements had been made. These were particularly evident in staff engagement and confidence in the leadership team."*

Staying with staff, our most recent staff survey results have shown a significant improvement. Our response rate was 36.2 per cent, an increase of 11.2 per cent from the previous year. We have seen improvements across a number of areas, but most notably we have seen our position in the league table of acute Trust jump 17 places to 47th (out of 97 Trusts). This puts us amongst the cohort of Trusts that are performing above the national average and we hope to see this trend continue in future surveys.

There are some years when things happen that you were least expecting. This was the case in June 2016 when NHS England wrote to us to say that following their assessment of our congenital heart services they considered that our organisation did not meet all the April 2016 requirements and that they felt we were unlikely to be able to do so in the future. As a result they told us they "*were minded to cease commissioning level 1 Congenital Heart Disease services from the East Midlands Congenital Heart Centre at the Glenfield*".

This came as a shock, not least because NHS England had previously said that they did not expect that closures of centres would be necessary under the terms of the new congenital review. Needless to say we disagreed with their position regarding the future of the service at the Glenfield. Since then we have seen a wealth of support from local people, patients, charities and MPs. As I write this we are still in the midst of the public consultation (extended due to the snap General Election) so we do not know what the outcome will be, but I would like to thank all of the staff in the service, who despite the strain, have never faltered in their delivery of an outstanding service. In fact the CQC told us following their inspection that the effectiveness of that service is 'outstanding'. I would also like to thank everyone who has supported us; we really appreciate it.

When John arrived in Leicester in 2013 there was a legacy of under-investment in our hospitals. Over the last 18 months we have seen that change; last year with the new multi-storey car park and this year with the completion and opening our new £48m Emergency Department – the biggest investment in our hospitals since the completion of the Osborne Building in 1997. Given the challenges Trusts have to capital funding we were lucky to be able to have the support to complete this much needed development.

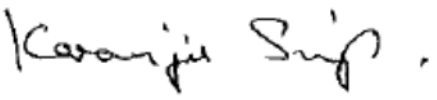
2017/18 has already become a busy year. We continue to see huge pressures on emergency care driven by an imbalance between what is needed (demand) and what we have (capacity). We will continue to work with our colleagues in health and social care across Leicester, Leicestershire and Rutland to reduce the reliance on emergency care and create sustainable alternatives.

We will also continue work with these same partners to deliver the plans we set out in Better Care Together (our local Sustainability and Transformation Plan), starting with a public consultation when we are given approval by NHS England to do so.

During the year there have been a number of changes in the composition of our Trust Board. We said goodbye to Professor Alison Goodall, our representative from the University of Leicester, who stood down from her role as a Non-Executive Director on 30 June and was succeeded by Professor Philip Baker, Head of the College of Medicine, Biological Sciences and Psychology. Dr Sarah Dauncey resigned in July and our two newest Non-Executives were Mr Ballu Patel who took up the position on 1st August 2016 and Dr Shirley Crawshaw who joined us on 1st January 2017.

We would like to end the introduction to this report by saying thank you. To our volunteers, Patient Partners, Healthwatch, local Clinical Commissioning Groups, Local Authority partners, and GPs for their continued help and support.

Finally, our unreserved thanks, and on behalf of the whole Trust Board, go to our staff. Year in, year out, they work tirelessly to provide the best service they can for our patients and in doing so remain committed to continuing to improve the quality of services that we provide. We look forward to working with and supporting them through the coming year.



Karamjit Singh CBE, Chairman

John Adler, Chief Executive

Our Trust Board

Declaration of Interests

 Karamjit Singh CBE Trust Chairman	Family member is a Partner with Lakeside Practice, Corby.
 Professor Philip Baker (from 1.7.16) and Dean of the University of Leicester Medical School Non-Executive Director	Minority shareholder of Metabolomic Diagnostics; Trustee of 'The Bridge' (charity).
 Dr Shirley Crawshaw (from 3.1.17) Non-Executive Director	None to declare
 Colonel (Ret'd) Ian Crowe Non-Executive Director	Consultant to General Dynamics Information Technology (relates to defence contracts only); Chair Leicester Hospitals Charity (appointed 1 April 2016); Brother – Order of St John (by award, not active in the organisation); Member – Royal British Legion; Member – Royal Army Medical Corps Association
 Dr Sarah Dauncey (up to 14.7.16) Non-Executive Director	Trustee on the Board of Leicester Grammar School Trust.
 Professor Alison Goodall (up to 30.6.16) Non-Executive Director	Non-Executive Director of Haemostatix Ltd; Minority shareholder Haemostatix Ltd.
 Andrew Johnson Non-Executive Director	Director Glebe Terriers Ltd.
 Richard Moore Non-Executive Director	Director of the following companies: 555 Fussball Projekt GmbH; Soccerworld Deutschland GmbH; EAI 555 Ltd; Peppercorn Serviced Offices Ltd; Momentum Advisers Ltd; Momentum 002 Ltd.
 Ballu Patel (from 1.8.16) Non-Executive Director	Member of PPG Highfields Surgery.
 Martin Traynor Non-Executive Director	Managing Partner – Traynor Consulting & Training LLP; Non-Executive Chairman – The Forest Experience Ltd; Non-Executive Chairman – King Richard III Visitor Centre Trust Ltd; Non-Executive Director – Leicestershire Promotions Ltd; Non-Executive Chairman – Leicestershire Rural Community Council Ltd; Trustee – The National Forest Charitable Trust Ltd; Trustee – Menphys Ltd; Member HM Govt's Regulatory Policy Committee.

Our Trust Board

Declaration of Interests

John Adler
Chief Executive

Trusteeship of NHS Providers (unpaid) Occasional part-time Consultant to Guidepoint Consulting – all earnings given to charity

Andrew Furlong
Medical Director

None to declare

Richard Mitchell
Chief Operating Officer

None to declare

Julie Smith
Chief Nurse

None to declare

Paul Traynor
Chief Financial Officer

Spouse is currently working as an Interim Business Development Manager at LLR Alliance

Directors who provide advice to the Board

Louise Tibbert
Director of Workforce and OD

Director on National NHS Pension Board from January 2016 – appointed by DOH; Director Public Services People Managers Association (PPMA) from 2013 to next AGM in June 2016

Stephen Ward
Director of Corporate and Legal Affairs

None to declare

Mark Wightman
Director of Marketing and Communications

None to declare

What is a Non-Executive Director

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

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

Some of the Non-Executive Directors chair key committees that support accountability. With the exception of the Trust Chairman (who cannot attend the Audit Committee), all Non-Executive Directors are also encouraged to attend any of the Trust Board Committee meetings (Audit Committee, Charitable Funds Committee, Quality Assurance Committee, Integrated Finance Performance and Investment Committee) – those who are not formal members of those groups will attend in a non-voting capacity. The Chairman and all Non-Executive Directors are members of the Trust's Remuneration Committee.

These are the Committee Chairing roles that our Non-Executive Directors carried out over the last 12 months:

Board member	Chairs
Karamjit Singh, CBE	Trust Board and the Remuneration Committee
Col (Ret'd) Ian Crowe	Quality Assurance Committee (as of July 2016), and chaired the Charitable Funds Committee from April 2016 – July 2016)
Sarah Dauncey	Quality Assurance Committee until July 2016 (when she left UHL as a Non-Executive Director)
Andrew Johnson	Charitable Funds Committee (as of July 2016)
Richard Moore	Audit Committee
Martin Traynor, OBE	Integrated Finance, Performance and Investment Committee

Trust Board meetings

Our Trust Board meetings are held in public and details of dates are on our public website. The meetings move between our three hospital sites, and both staff and members of the public are welcome to attend the public session of each meeting. We held our Annual Public Meeting on Thursday 8 September 2016 at "The Big Shed" on Freeman's Common in Leicester, presenting our 2015-16 annual report and accounts and answering questions from the public. There was also a health and wellbeing fair for members of the public.

Partners on our Trust Board

Dr Nil Sanganee was the nominated representative of the three Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) who attended and contributed to our monthly public Trust Board meetings as a non-voting/co-opted member. The idea behind having such a person at our Board meetings is to help forge

more collaborative working between ourselves and commissioners on matters of mutual interest for the benefit of our patients. In 2016/17 Dr Sanganee carried out this role until the end of August 2016.

Mr David Henson was a nominated representative of Leicester, Leicestershire and Rutland Healthwatch who also attended and contributed to our public Trust Board meetings as a non-voting/co-opted member. We hope that by having a representative of Healthwatch at the Board table, it opens up the Board to a different perspective – that of the patient/ public voice – which serves to enrich the Board's deliberations and decisions.

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).

Signed 

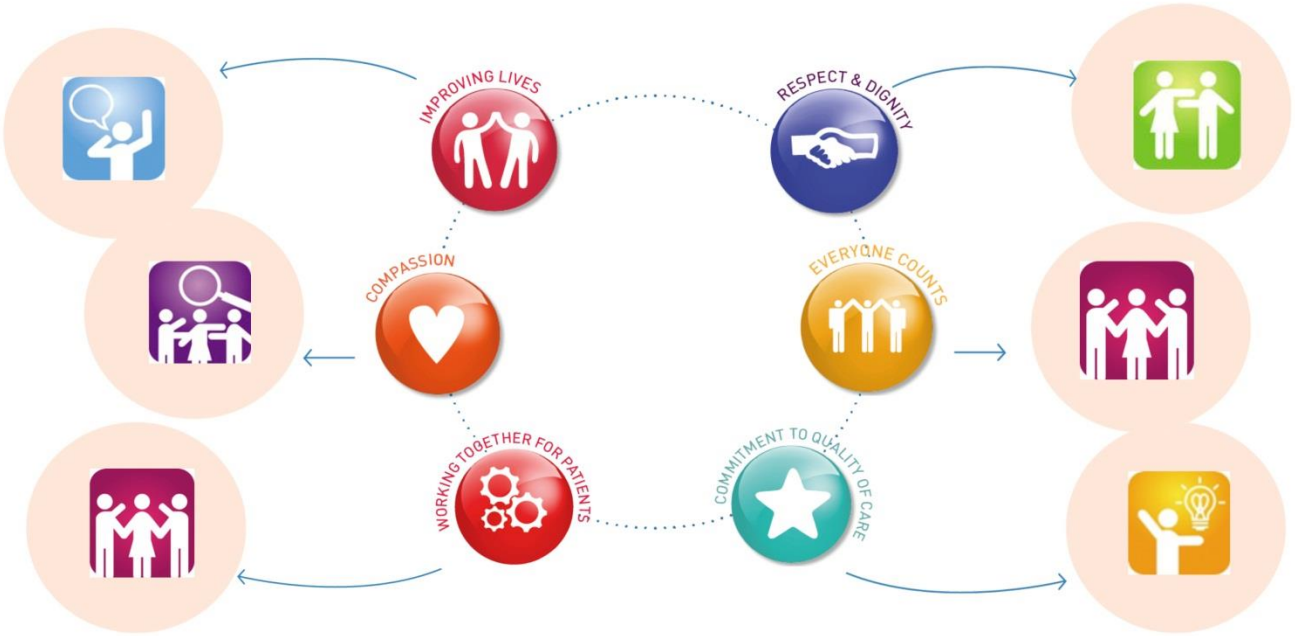
Chief Executive (on behalf of the Trust Board)

Date: 1 June 2017

Strategic Report

Our values and the NHS Constitution

We created our values with staff over three 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. This diagram shows how our values map to the NHS Constitution.



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

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

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

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

and the CQC's new fundamental standards – must reinforce and be aligned with the Constitution. You can read their report and recommendations here.

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

Delivering Caring at its Best – our 5-year plan

We first published our Strategic Direction in November 2012 and following the publication of the 'NHS 5 Year Forward View' nationally and work locally through the 'Better Care Together' programme we updated our Strategic Direction in 2015 setting out our plans for the coming 5 years.

What we know is that now than ever we cannot be a strong, sustainable, high quality acute Trust without there being equally strong and sustainable local primary care and social care… in that sense our future and our ability to provide high quality care for the 1.1m people living in the richly diverse communities across the City and Counties is interwoven with that of our partners.

Restricted by access to capital funding we have continued to deliver what we can of our 5-year plan and ensure that it fits with the plans of partners through the Sustainability and Transformation plan for the local area – what we call Better Care Together.

This is woven into our priorities for the coming year (2017/18).

You can read our 5 year plan in full on our website http://www.leicestershospitals.nhs.uk/aboutus/our-purpose-strategy-and-values/our-5-year-strategy/ or for a hard copy contact communications@uhl-tr.nhs.uk

Our priorities for 2016/17

1. **Safe, high quality, patient centred care – 2016/17 Quality Commitment**
   a) Reduce avoidable mortality and re-admissions through screening of deaths and use of the re-admissions toolkit *(Andrew Furlong)*
   b) Reduce harm through core 7-day standards, new Early Warning System and observation processes and safer use of insulin *(Andrew Furlong)*
   c) Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients *(Julie Smith)*
   d) Prepare effectively for the 2016 Care Quality Commission inspection *(Julie Smith)*
   e) Develop a high quality in-house Estates and Facilities service *(Darryn Kerr)*

2. **An excellent, integrated emergency care system**
   a) Reduce ambulance handover delays in order to improve patient experience, care and safety (*Richard Mitchell*)
   b) Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including Intensive Community Support) *(Richard Mitchell)*
   c) Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps *(Richard Mitchell)*
   d) Diagnose and reduce delays in the in-patient process to increase effective capacity *(Richard Mitchell)*

3. **Services which consistently meet national access standards**
   a) Maintain 18-week RTT and diagnostic access standard compliance *(Richard Mitchell)*
   b) Deliver all cancer access standards sustainably *(Richard Mitchell)*

4. **Integrated care in partnership with others**
   a) Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the Leicester, Leicestershire and Rutland vision (including formal consultation) *(Mark Wightman)*
   b) Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region *(Mark Wightman)*
   c) Progress the implementation of the EMPATH strategic outline case *(Paul Traynor)*

5. **An enhanced reputation in research, innovation and clinical education**
   a) Deliver a successful bid for a Biomedical Research Centre *(Andrew Furlong)*
   b) Support the development of the Genomic Medical Centre and Precision Medicine Institute *(Andrew Furlong)*
   c) Develop and exploit the OptiMeD project, scaling this up across the Trust *(Paul Traynor)*
   d) Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum *(Andrew Furlong)*
   e) Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities *(Paul Traynor)*
   f) Launch the Leicester Academy for the Study of Ageing (LASA) *(Julie Smith)*

6. **A caring, professional, passionate and engaged workforce**
   a) Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability *(Louise Tibbert)*
   b) Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development *(Louise Tibbert)*
   c) Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders *(Louise Tibbert)*

d) Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture *(Louise Tibbert)*

e) Developing a more inclusive and diverse workforce to better represent the communities we serve and to provide services that meet the needs of all patients *(Louise Tibbert)*

7. A clinically sustainable configuration of services, operating from excellent facilities

a) Complete and open Phase 1 of the new Emergency Floor *(Darryn Kerr)*

b) Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services) *(Paul Traynor)*

c) Develop and deliver a new model of care that support our reconfiguration plans *(Richard Mitchell)*

d) Develop outline business cases for our integrated Children's Hospital, Women's Services and planned ambulatory care hub *(Paul Traynor)*

8. A financially sustainable NHS Trust

a) Deliver our CIP target in full *(Richard Mitchell)*

b) Reduce our deficit in line with our 5-Year Plan *(Paul Traynor)*

c) Reduce our agency spend to the national cash target *(Louise Tibbert)*

d) Implement service line reporting through the programme of service reviews to ensure the ongoing viability of our clinical services *(Paul Traynor)*

e) Deliver operational productivity and efficiency improvements in line with the Carter Report *(Paul Traynor)*

9. Enabled by excellent IM&T

a) Improve access to and integration of our IT systems (John Clarke)

b) Conclude the EPR business case and start implementation (*John Clarke*)

Progress against our Annual Priorities 2016/17

STRATEGIC OBJECTIVE/ANNUAL PRIORITY	COMMENTS ON PROGRESS	Q1	Q2	Q3	Q4
Safe, high quality, patient centred care					
a) Reduce avoidable mortality and re-admissions through screening of deaths and use of the re-admissions toolkit	Latest data shows mortality (SHMI) at 101 (target 101) but still within expected range.	Q1	Q2	Q3	Q4
b) Reduce harm through core 7-day standards, new early warning system and observation processes and safer use of insulin	Data shows further reduction in harms as well as continuing falls/on target rates in e.g. pressure ulcers and infections. Outturn will be well within target range	Q1	Q2	Q3	Q4
c) Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients	Inpatient FFT test has continued at 96% but ED has bounced back to 95%	Q1	Q2	Q3	Q4
d) Prepare effectively for the 2016 Care Quality Commission Inspection	Thorough preparation and organisation of the inspection itself. Rating Requires Improvement overall, matching Trust self-assessment. Positive Quality Summit	Q1	Q2	Q3	Q4
e) Develop a high quality in-house Estates and Facilities service.	Recruitment to vacant posts continues. Significant improvements in catering. Resources constraining improvement in cleaning.	Q1	Q2	Q3	Q4
An excellent, integrated emergency care system					
a) Reduce ambulance handover delays in order to improve patient experience, care and safety	Very high delays in January but major improvements in February and March back to lowest levels seen in past 2 years	Q1	Q2	Q3	Q4
b) Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including ICS)	Relocation of GPAU to ED has substantially reduced admissions complements wide range of ambulatory pathways. Plateauing continuing in Q4	Q1	Q2	Q3	Q4
c) Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps	Modelling for 2016/17 showed deficit – partially offset by opening additional beds at LRI and GH. More advanced model complete for 2017/18 with detailed plan to address gap	Q1	Q2	Q3	Q4

Progress against our Annual Priorities 2016/17					
STRATEGIC OBJECTIVE/ANNUAL PRIORITY	**COMMENTS ON PROGRESS**	**Q1**	**Q2**	**Q3**	**Q4**
d) Diagnose and reduce delays in the in-patient process to increase effective capacity	"3W" UHL Way exemplar superseded by SAFER/Red2Green bundle implementation at scale. Positive initial impact - now being rolled out to LGH and GGH	Q1	Q2	Q3	Q4
Services which consistently meet national access standards					
a) Maintain 18-week Referral to Treatment(RTT) and diagnostic access standard compliance	Failed standard in Q4 due to high referrals, capacity constraints and cancellations, as well as deliberate switching of capacity to medicine to address emergency pressures	Q1	Q2	Q3	Q4
b) Deliver all cancer access standards sustainably	2WW continues to be achieved. 31 and 62 day not achieved as planned due to cancellations. However, 62 day backlog now at sustainable level	Q1	Q2	Q3	Q4
Integrated care in partnership with others					
a) Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the LLR vision (including formal consultation)	Agreed STP submitted and well received by regional and national bodies. STP meets national requirements re sustainability but will be challenging to deliver. Good progress in Q4 with key STP work streams – Integrated Teams and Home First	Q1	Q2	Q3	Q4
b) Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region	Further progress with South-East Midlands Oncology Alliance but other initiatives (e.g. urology) constrained by existing capacity/performance issues. However, overall good progress in year	Q1	Q2	Q3	Q4
c) Progress the implementation of the East Midlands Pathology (EMPATH) strategic outline case	New implementation model agreed which has better prospects of delivering benefits in short and medium term. Granted national Pathfinder status (1 of 4)	Q1	Q2	Q3	Q4
An enhanced reputation in research, innovation and clinical education					
a) Deliver a successful bid for a Biomedical Research Centre	Bid successful, albeit with reduced funding compared to the 3 BRUs. Arrangements in place for 1/4/17 start	Q1	Q2	Q3	Q4

Progress against our Annual Priorities 2016/17					
STRATEGIC OBJECTIVE/ANNUAL PRIORITY	**COMMENTS ON PROGRESS**	**Q1**	**Q2**	**Q3**	**Q4**
b) Support the development of the Genomic Medical Centre and Precision Medicine Institute	Ahead of rare diseases trajectory in Q3. Cancer trajectory challenging but key building blocks in place	Q1	Q2	Q3	Q4
c) Develop and exploit the OptiMeD project, scaling this up across the Trust	Business case progressing but slow progress due to awaiting commissioner sign-off	Q1	Q2	Q3	Q4
d) Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum	Latest data shows significantly improved retention of graduates, so signs that approach is working. More to do	Q1	Q2	Q3	Q4
e) Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities	Draft strategy produced – consideration by Board deferred until early 2017/18	Q1	Q2	Q3	Q4
f) Launch the Leicester Academy for the Study of Ageing (LASA)	Successful high-profile launch and appointment of Co-Directors. However, profile appears to have slipped in recent months	Q1	Q2	Q3	Q4
A caring, professional, passionate and engaged workforce					
a) Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability	Strong multi-strand strategy now in place with delivery becoming evident, notably in new approaches to recruitment and launch of UHL Academy programmes.	Q1	Q2	Q3	Q4
b) Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and improvement	Better Teams (LiA), Better Teams and Academy all working well. Better Change requires new approach to embedding – developed for 2017/18	Q1	Q2	Q3	Q4
c) Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders	Very successful launch of Nurse Associate scheme and new education centre	Q1	Q2	Q3	Q4

Progress against our Annual Priorities 2016/17					
STRATEGIC OBJECTIVE/ANNUAL PRIORITY	**COMMENTS ON PROGRESS**	**Q1**	**Q2**	**Q3**	**Q4**
d) Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture	Progressing to schedule. Focus groups held with staff to inform approach. FTSU Guardian appointed and in post	Q1	Q2	Q3	Q4
e) Developing a more inclusive and diverse workforce to better represent the communities we serve and to provide services that meet the needs of all patients	Progressing to schedule. Targets for BME representation at more senior levels issued. However, short term impact hard to evidence	Q1	Q2	Q3	Q4
A clinically sustainable configuration of services, operating from excellent facilities					
a) Complete and open Phase 1 of the new Emergency Floor	Plans fully in place for opening on 26th April. Key outstanding issues addressed	Q1	Q2	Q3	Q4
b) Deliver our reconfiguration business cases for vascular and level 3 Intensive Care Unit (ICU) and dependent services	Vascular builds progressing to schedule and move confirmed as 8th may 2017. ICU and related schemes delayed by lack of capital	Q1	Q2	Q3	Q4
c) Develop new models of care that will support the development of our services and our reconfiguration plans	Team structure review complete. Key strands being taken forward but resources limiting extent of the work	Q1	Q2	Q3	Q4
d) Develop outline business cases for our integrated Children's Hospital, Women's Services and planned ambulatory care hub	EMCHC element separated from Children's Hospital to ensure compliance with CHD standards. Other elements progressing but awaiting new national capital prioritization process	Q1	Q2	Q3	Q4
A financially sustainable NHS Trust					
a) Deliver our cost improvement programme target in full	On Plan for fully target delivery in 2016/17	Q1	Q2	Q3	Q4
b) Reduce our deficit in line with our 5-Year Plan	Will be off-plan by £6.8m. Revised forecast confirmed to NHSI	Q1	Q2	Q3	Q4

Progress against our Annual Priorities 2016/17					
STRATEGIC OBJECTIVE/ANNUAL PRIORITY	**COMMENTS ON PROGRESS**	**Q1**	**Q2**	**Q3**	**Q4**
c) Reduce our agency spend to the national cash target	Appeal recap rejected so target is more challenging than expected. Trend well above plan and has been exacerbated by opening of additional medical ward. Good progress on regional collaboration to reduce medical costs	Q1	Q2	Q3	Q4
d) Implement service line reporting through the programme of service reviews to ensure the on-going viability of our clinical services	Approach under review linked to models of care above	Q1	Q2	Q3	Q4
e) Deliver operational productivity and efficiency improvements in line with the Carter Report	Range of work making good progress especially on procurement and pharmacy	Q1	Q2	Q3	Q4
Enabled by excellent IM&T					
a) Improve access to and integration of our IT systems	Large scale programme in progress. Improvements in user interface but some issues with delivery	Q1	Q2	Q3	Q4
b) Conclude the Electronic Patient Record (EPR) business case and start implementation	EPR case rejected as unaffordable by NHS Improvement. Alternative strategic options developed - final decision in Q1 2017/18	Q1	Q2	Q3	Q4

Signed 

Chief Executive (on behalf of the Trust Board)

Date: 1 June 2017

Quality Report

Quality: our 2016/17 Quality Commitment

Last year (2016/17) we set the following three priorities:

- To reduce avoidable deaths
- To reduce harm caused by unwarranted clinical variation
- To use patient feedback to drive improvement to services

We said we would: Reduce avoidable deaths and reduce avoidable re-admissions

In 2016/17 we:

- Have focussed on the early recognition of sepsis and Acute Kidney Injury (AKI) through the implementation of the Sepsis Care Bundle and the AKI Bundle
- Embedded the screening of all in-hospital deaths by medical examiners. Over 800 patient records have been screened by the medical examiners (over 90 per cent of adult deaths at the Royal Infirmary) with 20 per cent of these being referred for further review by our speciality morbidity and mortality groups
- Have been an early adopter with our participation in the National Retrospective Case Review
- Supported daily use of PARR 30 (Patient's Risk of Re-admission within 30 days) incorporating discharge planning

Further improvements we need to make are:

- Extending the medical examiner process to the General Hospital and Glenfield
- Improving the collation of morbidity and mortality review findings
- Increasing the numbers of cases where death classification is confirmed
- Including PARR30 scores in our electronic patient information systems

Results:

- The latest published figure for Summary Hospital Mortality Index (SHMI) covers the period July 2015 to June 2016. Our SHMI is 101 which is above our Quality Commitment threshold but still within the national expected average
- For the period April 2016 to January 2017 our 30 day emergency re-admission rate was 8.5 per cent, a reduction on the 2015/16 rate of 8.9 per cent

We said we would: Reduce harm caused by unwarranted clinical variation

In 2016/17 we:

- Have improved compliance with the four core 7 day service standards
- Further rollout of Early Warning Scores (EWS) and e-observations
- Implemented the Safe Use of Insulin Strategy

Further improvements we need to make are:

- Ensuring cardiology and respiratory emergency admissions are seen and thoroughly assessed as soon as possible but at the latest within 14 hours from the time of arrival at hospital
- Moving away from manual reporting of EWS and pilot daily electronic reporting within one clinical area
- Developing trigger and track 'clinical rules' to improve the identification of sepsis and AKI
- Increasing the number of medical staff who have completed the 'Six Steps' insulin training
- Implementing the Point of Contact system for monitoring blood glucose levels

Results:

- **At the end of December 2016 we were on track to meet our Quality Commitment target of a 5 per cent reduction in harm by March 2017**

We said we would: To use patient feedback to drive improvements to services and care

In 2016/17 we:

- Have improved the use of individualised care plans in keeping with the '5 priorities for care'
- Kept patients informed and involved in their care
- Reduced the 'in clinic' waiting times in Ophthalmology
- Improved clinical correspondence turnaround times

Further improvements we need to make are:

- Evaluating the role of End Of Life Facilitators in providing extra support to wards caring for the dying person
- Showing an improvement in patients feeling involved and informed in their care
- Increasing the number of patients seen within 30 minutes of their appointment time, within Ophthalmology from 23.6 per cent
- Ensuring patients receive correspondence within 14 days of their consultation

Results:

- **At the end of December 2016 we were on track to achieve a 6 per cent improvement in patient involvement scores**
- **Met the quarter 3 Quality Commitment target for the 14 day standard for correspondence**
- **Failed to meet the target set for reducing the number of patients wait more than 30 minutes to be seen in Ophthalmology**

Safe, high quality, patient centred healthcare

Our priorities for the year were to:

- Reduce avoidable mortality and re-admissions through screening of deaths and use of the re-admissions toolkit
- Reduce harm through core 7-day standards, new Early Warning System and observation processes and safer use of insulin
- Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients
- Prepare effectively for the 2016 Care Quality Commission inspection
- Develop a high quality in-house Estates and Facilities service

Reduce avoidable mortality and re-admissions through screening of deaths and use of the re-admissions toolkit

One of the indicators used nationally to provide information on hospital deaths is the Summary Hospital level Mortality Index (SHMI)* and we have a SHMI of 102 for the period October 2015 to September 2016 which is above the national average of 100, but within the expected range for the population we serve.

The importance of tracking mortality is reflected in the fact that this has been in our Quality Commitment over the past three years. Our SHMI was 105 for 2013/14, which also was within our expected range, but in a desire to improve we reviewed and revised a number of our clinical pathways. One of these was the implementation of a Pneumonia Care Bundle which contributed to significant improvements. We are also focussing on earlier recognition of patients whose clinical conditions deteriorate unexpectedly, in particular from sepsis and acute kidney injury.

Other areas of focus have been to increase cardiology input at the Royal Infirmary site and also improve the patient pathway for patients admitted with gastro-intestinal haemorrhage as both of these diagnosis groups have a higher risk of mortality.

In addition to monitoring our mortality rates, and carrying out further analysis or investigation where applicable, we continue to embed the Medical Examiner process at the Royal Infirmary. This started in July as part of our response to the national focus on improving outcomes in the NHS. The Medical Examiner process involves 'screening' of deceased patients' case notes to see whether there were any problems in care or potential for learning and improvement. The Medical Examiners also speak to the next of kin of deceased patients' to ask if they have any concerns about the care their relative received, and if so, these are investigated appropriately. Our plan is to extend this process to both the General and Glenfield Hospitals early in 2017/18.

Where the screening process suggests there may have been problems in care, or there is a particular focus on a condition, a full review of the case notes will be carried out by the relevant specialty using a recently developed national tool. This full review will then be presented and discussed at regular Specialty Mortality and Morbidity meetings to ensure appropriate learning and actions take place. Outcomes from specialty reviews are then collected centrally and lessons shared throughout the organisation.

Over the past three years there has been a year on year increase in the numbers of patients being re-admitted as an emergency within 30 days of being discharged from one of our hospitals. Evidence suggests the rate of avoidable readmissions can be reduced by improving core discharge planning and the discharge process; improving transitions and care coordination at the interfaces between care settings; and enhancing education, and support for patient self-management.

Our 2016/17 Quality Commitment included reduction in readmissions to 8.5 per cent or below (from a previous year's baseline of 8.9 per cent) and this has been achieved.

Significant actions that were taken to bring about this reduction were:

- a pilot of case managers to support patients at high risk of readmission at the point of discharge – this included improving discharge planning, patient education about managing their condition, and referral for post discharge well-being checks, if applicable;
- embedding the use of the 'Re-admission Risk tool' (PARR30 score) into the NerveCentre board round view in order to inform discharge discussions at board rounds;
- the development and launch of a trust-wide guideline on actions to be taken where patients are identified at higher risk of readmission;
- instigation of a regular Red 2 Green 'Dragons' Den' meeting within the emergency specialty medicine wards at the Royal Infirmary to review patients with long lengths of stay, and high risk of readmission.

For the forthcoming year this work-stream has been embedded within the Red 2 Green work that continues within our organisation.

Reduce harm through core 7-day standards, new Early Warning System and observation processes and safer use of insulin

We are an early implementer for the improvement in the four priority standards of ten key clinical standards across seven days a week. We are pleased to report that significant strides forward continue to be made in achieving compliance with the standards. For example, Clinical Standard 08 - Twice daily reviews - has improved from 35per cent to 100 per cent compliance; Clinical Standard 02 - first consultant review- has improved from 59 per cent to 84 per cent compliance and Clinical Standard 08 - Daily reviews – has improved from 44 per cent to 90 per cent compliance.

Further results from the National Survey were published in January 2017:

- Managing the deteriorating patient - date and time of the first NEWS/PEWS score which triggered the need for a response according to your local protocol - where for UHL 89 per cent response to EWS on same day as the trigger was recorded;
- Patient involvement – proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission was recorded as 71 per cent. A significant improvement from the previous survey which showed 32 per cent.

Improvements have been made in Surgery, CDU (Clinical Decisions Unit), Pharmacy, Trauma, Imaging, Medicine which will support 7-day services, but there are still some resource gaps to meet the standards fully.

Successful bids amounting to £160,000 for four projects to support 7-day services have been received. Projects will be in Pharmacy, Trauma (Fractured Neck of Femur) Respiratory and 7-day Services.

An assessment of providers of urgent network specialised services against the four priority standards, in four services showed that:

- Clinical Standard 02 - time to consultant review - was achieved 100 per cent in the Coronary Care Unit, Childrens Intensive Care, and Stroke and 80 per cent in vascular.
- Clinical Standard 08 – on-going review was achieved 100 per cent in the Coronary Care Unit, Childrens Intensive Care, and Stroke and 88 per cent in vascular.

These services are required to reach 90 per cent compliance by November 2017.

Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients

Improving the experience of our patients: We seek feedback from patients, their families, carers and the public through a range of mechanisms. Within every ward there are patient surveys to complete asking specific satisfaction questions and also allowing patients to comment on the care they have received. There are also 'Message to Matron' cards available so patients can tell staff what went well and what could be

improved. The public can also give feedback via our public website, NHS Choices, Patient Opinion, social media and also the touchscreens on the exits to our three hospitals.

The vast majority of feedback we receive is extremely positive, but to ensure developments are in response to what is important to patient we also bring together all the different feedback mechanisms and collects all the comments from patients, their family and carers to elicit what needs to improve.

At the beginning of 2016/17 the feedback from patients focused the organisation on improving patient feeling involved and informed about their treatment and care, and this was assessed by patients knowing the answer to seven key questions.

During quarter one 2016/17 a total of 838 patients, staff and members of the public were asked 'how' to improve patients feeling involved or informed in their treatment and care. This engagement activity provided a clear direction for improvement for the clinical staff.

Over the last 12 months staff have worked to implement changes identified by the public that would improve patients feeling involved and informed in their healthcare. The results below clearly show significant improvements in patients knowing the answers to the key questions following an audit in Quarter Four involving 1,000 patients in Quarter One (being asked 3,702 questions) and 500 patients in Quarter Four (being asked 1,859 questions).

Question	Abbreviated Question	Baseline	Q4
Do you know what is wrong with you (your diagnosis), or what needs to happen to determine this?	Diagnosis	91	97
Do you know what is going to happen to you today?	Happening today	74	86
Do you know what is going to happen to you tomorrow?	Happening tomorrow	52	64
Do you know what needs to be done to get you home and when this will be done?	Need done to get home	71	80
Do you know when you are going home?	When going home	37	52
Do you know the name of your consultant?	Name of consultant	59	72
Do you know the name of the nurse who is looking after you today?	Name of nurse	66	80
	OVERALL YES % COMPLIANCE	**64**	**76**

The overall yes % compliance is based on the total 'Yes' responses from all of the questions (1,452) as a proportion of the total responses from patients (1,859).

Patient experience in Outpatients

We recognise that a large number of patients attend outpatient clinics every day and their experience of care is very important. Feedback from patients has always been collected via touchscreens positioned at the entrances to many outpatients departments but we recognised that many patients did not use these machines.

Following consultation with patients we trialled the used of texting to allow patients to provide feedback following their outpatients consultation. This trial started in December 2016 and proved very successful. We received over 5,000 text responses from patients providing their comments on the service they had received. As this was so successful, this will continue during 2017 to allow the doctors, nurses, therapy staff and technicians to hear directly from patients about their experiences on care in our outpatients departments.

Meaningful activity and dementia care

This year we launched a new three year Dementia Strategy. The main focus of the strategy is to provide appropriate support for people living with dementia coming into hospital from admission to discharge. The Royal Infirmary also took part in the National Audit of Dementia to ensure that the care we give to people living with dementia, their families and carers is following national recommendations and best practice.

Throughout the year an additional 80 staff and volunteers became Dementia Champions; there are now more than 450 dementia champions across our organisation who are dedicated to improving the experience for patients living with dementia. We continue to raise staff awareness of dementia through training and 84 per cent of our staff have had dementia awareness training

Patients and carers told us they would like a way for all staff in the hospital to know they had dementia, so they could be supported appropriately. This year we have been working to identify patients with dementia as early as possible during their stay in hospital or when they arrive in our Emergency Department. Staff have helped with this work by adding a small forget me not flower to the notes of patients with dementia, this raises awareness for colleagues and helps them provide appropriate support patients and carers.

Our Meaningful Activities Service focuses on the well-being of patients with dementia to make their hospital stay as meaningful and as comfortable as possible. Patients are supported through activities carried out on the wards, such as arts and crafts, games, puzzles, reminiscence, and music to name a few. Additional support is provided to families, friends and carers of patients with dementia, helping them to be involved in and carry out activities with their loved one and sharing useful information.

We have support from trained Forget Me Not Volunteers, who are passionate about dementia care. In the last year we have held events both inside and outside of our hospitals to promote dementia awareness Meaningful Activities, and to raise funds for future activities.

Better end of life planning

The Specialist Palliative Care Team, End of life Care Facilitators (who are part of the Specialist Palliative Care Team) and members of the End of Life and Palliative Care Committee have been part of a large programme of work over the last year that has seen real improvements in the care of patients in the last days of life.

The 2015/16 Royal College of Physicians audit found that just 19 per cent of patients who died in our hospitals had their care in the last days of life supported by a holistic plan of care. With this in mind we set out to improve the use of individualised plans of care.

It remains difficult to identify from patients notes whether plans of care were followed and so our End of Life care plan has been promoted as the preferred tool to support care. Education has been the main driver of change, including ward education and study days with amendments to policies and procedures and quarterly audits helping shape that work.

It is important to note that since this CQUIN began, there has been both an increase in the use of our care plan for patients in the last days of life, and individualised plans of care made in patients notes when the End of Life care plan is not used. However, we recognise that there is still work to be done and it is hoped that the use of electronic systems and an on-going and detailed education package in 2017 can ensure sustained use of individualised plans of care and improvements in the way we care for patients in their final days.

Patients can receive subcutaneous infusions of palliative medications in a variety of contexts, including chemotherapy or disease related vomiting or when they have symptoms and are no longer able to swallow. The End of Life and Palliative Care Committee has coordinated work, which will continue in 2017/18, to ensure that patients all have access to safe and ambulatory subcutaneous infusion pumps (syringe drivers). A video has been produced that is available on the intranet to support staff around syringe driver set up.

This year has seen continued increase in the number of patients assessed and supported by the Specialist Palliative Care Team. The team provide a 7-day service and have seen an increasing need for input over the weekend. As a consequence we now have an additional Specialist Palliative Care Nurse working across our hospitals on a Saturday, with further increases dependent on funding additional staff. There have been a number of new appointments in the team, but no increase in staffing as yet to meet the additional demands.

As well as addressing complex symptoms, psychological needs and specialist support to those who are dying, the Specialist Palliative Care Team helps ensure what really matters to the person and their family is considered. For example, they helped recognise that a patient was agitated because of concerns about her dog so helped ease those concerns by allowing the dog to be brought in to see her which really did seem to calm the situation. They also helped ward staff organise party for dying relative on ward. These are just small examples of the importance of individualised care that the Specialist Palliative Care Team helps with.

One of our patient partner's has been involved this year in palliative and end of life care. As a result we are already benefitting from her thoughtful and sensitive approach and her passion to make a difference. We envisage her role growing over the coming year as she ensures the work of the End of Life and Palliative Care Committee has input from patients and families in a proactive and informative way.

It has been challenging at times to arrange timely discharges and support for patients who are approaching the end of their lives. Through engagement by the End of Life Care lead doctor and nurse, and involvement of board members, we have worked hard to ensure our voice is heard amongst the planned changes to the way services are delivered in our local area. A complex needs analysis and planned change has been proposed locally and Dr Rosie Bronnert recently presented the case for change at the Systems Leadership Board. There remain uncertainties about how this will work, but it is hoped that the next year will see some benefit to our patients, both by enabling more rapid discharge and preventing some admissions.

The Bereavement Support Service continues to offer compassionate and coordinated support to the families of people who have died within our hospitals. It is clear that giving families the opportunity to talk through their experiences at an early stage is helpful and means that things that concern or worry relatives or friends can be identified early and resolved by the team. This should make a real difference to families' experience of bereavement, hopefully reducing the risks of unresolved grief issues around care. The compliments and collation of learning provided by the bereavement team provides real time feedback to clinicians and our services to help us develop and it is fantastic to hear so many positive comments from families about the care we have provided at a difficult time.

To learn from the complaints we get about end of life care, the End of Life and Palliative Care Committee is supporting an evolving project which reviews all complaints flagged as 'end of life' by the complaints team. Communication features as a main theme for 56 per cent of complaints, whilst in 15 per cent of complaints relate to lack of dignity or basic care. There is still progress to be made in the capture of end of life concerns at the point of triaging and logging complaints and these numbers are currently likely to under-represent the true scale of the end of life issues faced by our patients and their relatives. It is hoped in 2017/18 this work can be used more actively to inform education and change, potentially through liaison with the medical examiners and Bereavement Service, who are already compiling and acting on the information they receive.

The Specialist Palliative and End of Life Care Team have delivered a diverse and extensive education programme. Education has included a 'priorities for care of the dying' study day, training two volunteers to take part in Volunteers At Life's End (VALE) project, weekly engagement and teaching sessions to improve understanding in Emergency Decisions Unit and Emergency Department. This is supported by resource folders which are now available for all adult wards. During 2017/18 work will continue with individualised support to wards focussing on their existing skills and challenges.

Prepare effectively for the 2016 Care Quality Commission inspection

We are required to register with the Care Quality Commission (CQC) and our current registration status is 'Requires Improvement' following our recent comprehensive inspection between the 20th and the 23rd June 2016. The aim of a comprehensive inspection is to check whether the services that we are providing are safe, caring, effective, responsive to people's needs and well-led.

This inspection covered seven of the eight core services:

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatient services and diagnostic imaging (such as x-rays and scans)

On Thursday 26th January 2017, the CQC published their final reports along with their ratings of the care provided, a summary of which is:

Overall Trust ratings						
Safe	Effective	Caring	Responsive	Well-led		Overall
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement

Royal Infirmary								
Medical Care	Surgery	Intensive/ Critical Care	Maternity & Gynaecology	Services for children & young people	End of Life Care	Outpatients & diagnostic imaging		Overall
Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement		Requires improvement

General Hospital							
Medical Care	Surgery	Intensive/ Critical Care	Maternity & Gynaecology	End of Life Care	Outpatients & diagnostic Imaging		Overall
Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement		Requires improvement

Glenfield							
Medical Care	Surgery	Intensive/ Critical Care	Services for children & young people	End of Life Care	Outpatients & diagnostic Imaging		Overall
Good	Good	Good	Good	Requires improvement	Requires improvement		Requires improvement

Of the 100 ratings in total (for each domain of each main service grouping), 1 is Outstanding (for the effectiveness of our East Midlands Congenital Heart service at Glenfield), 55 are Good, 41 are Requires Improvement and 1 is Inadequate (the Responsive domain of emergency care at the Royal). Two elements were unrated for technical reasons.

When the CQC carried out their inspection we told them that our biggest strength was our staff; their strong motivation, commitment and ambition to improve our services for our patients and for each other.

The CQC saw this for themselves and it was echoed in their feedback. They told us that they found our staff to be "*universally welcoming, open and transparent*" and they were clearly very impressed by the compassion, professionalism and loyalty of everyone they encountered. This is reflected in the fact that 'Caring' domain has been rated 'Good' across all three of our hospitals.

We have not participated in any special reviews or investigations by the CQC during the reporting period, however the CQC has taken enforcement action against us during 2016/17 as follows:

In June 2016 Leicester's Hospitals had a Section 31 condition in place following the unannounced CQC inspection of our Emergency Department in November 2015. This Section 31 required weekly reporting to the CQC against staffing in the Emergency Department, sepsis and time to assessment.

We provided the CQC with sufficient evidence of improvement which meant that they lifted this condition on the 15th November 2016.

We have made the following progress by 31st March 2017 in taking such action:

Since the inspection in June 2016 a number of improvements have been made and some concluded. These are captured in an improvement action plan which is monitored through our Trust Board.

You can read the full reports on our website:
http://www.leicestershospitals.nhs.uk/aboutus/performance/care-quality-commission/

Develop a high quality in-house Estates and Facilities services

It has been an exceptional year for the Estates and Facilities Directorate. At the beginning of the year in April 2016 we were working as hard as possible in making the final preparations for the handover of services and some 1700 staff from Interserve FM Ltd following the dissolving of their contract with us.

The handover formally took place at midnight on 30th April 2016, and with the extensive planning we had done we managed to seamlessly carry on delivering services. All the IT systems functioned on switchover; there were no major infrastructure issues or failures. We made sure that all patients were fed and on time and all in all the hiccups we encountered were relatively minor with staff on hand to resolve as soon as they happened.

Since then the year of running has been about 'steadying the ship' in the first months and starting to improve standards whilst starting the process of a wholesale review of all the services to achieve the high performing quality estates and facilities service that we are aiming to achieve.

The main challenges we have faced have been around staffing levels that we inherited, in particular a high backlog of vacancies and recruiting staff to address and try to keep pace with this. This has especially been the case with the cleaning service. Keeping the hospital clean is naturally a key priority for us, especially our clinical areas where we are focussed on a role in patient safety and prevention of infection. A clean hospital environment is also important in terms of maintaining patient and visitor confidence in quality overall.

Having assessed standards over the course of the year we have tracked a very steady level of improvement to the point where we are almost there in achieving the nationally guided cleanliness standards across all three hospital sites. There is still room for improvement and challenges around specific areas such as entrances and corridors that are subject to particularly heavy pedestrian traffic and the amount of building work on site - especially at the Royal Infirmary.

Other key service areas such as providing patient meals and portering have been delivered to a good standard overall throughout the year. Maintaining the buildings and the entire engineering infrastructure has also continued to function without any significant issues. When we have checked what patients and visitors think of the service through the various mechanisms of feedback that we use, the story is much the same in that given the amount of activity we carry out there is only a small amount of negative comments.

Work has already started on developing services and introducing change that is more efficient, effective and sustainable for the future. We are introducing improved electronic systems to help us make better use of our team of porters, to monitor and report on cleaning standards and to allocate and manage the reactive maintenance service. We are also looking at ways to function more commercially working in partnership with other organisations to share services and attract more business in relation to retail catering services for example.

All in all we are pleased with the first year of running our in-house Estates and Facilities service.

Improvements in stroke care

The Sentinel Stroke National Audit Programme (SSNAP) places us in the top four of seven East Midland Trusts admitting acute stroke patients. They have rated us as 'Good and Improving' and currently 'B'.

We have continued to see improvements in our stroke performance over recent months but there is no sense of complacency. There is a strong determination by the team to improve our stroke performance further to 'A' which we hope to see happen during 2017/18.

Commissioning for Quality and Innovation (CQUINS)

The Commissioning for Quality and Innovation (CQUINs) payments framework is intended to deliver clinical quality improvements and drive transformational change. These can impact on reducing inequalities in access to services, the experiences of using them and the outcomes achieved.

Designed by NHS England, the 2016/17 CQUINS were influenced by the ambitions of the Five Year Forward View. It is not believed that in isolation CQUINs will be able to address these issues, but if aligned with the Sustainability and Transformation Plans (STPs) covering the whole health and social care systems, they can be a strong lever to help bring about changes to deliver improved quality of care to patients through clinical and service transformation.

A proportion of our 2016/17 income was conditional upon achieving quality improvement and innovation goals agreed between ourselves and our commissioners (CCGs and NHS England Specialised Commissioning). For 2016/17 the baseline value for national, local commissioning and specialised CQUINS was £16,147,504. This means that when we agreed contracts with commissioners and NHS England it was agreed that a percentage of contract value would be received if we achieved certain quality indicators.

Unfortunately we did not fully meet the targets set for the following CQUINS:

- Next Steps local commissioning CQUIN; this CQUIN aims to ensure that every patient on a cancer two week wait pathway knows what their next step will be, when it will be and where it will be;
- Hepatitis C Virus Improving Treatment Pathways through Operational Delivery Networks;
- we opted to pursue an 'in house solution' rather than subscribe to one of the 'NHS England framework companies' software' and therefore we did not meet the CQUIN threshold for Clinical Utilisation Review Tool.

Complaints

Complaints are a vital source of information about the views of our patients, families and carers about the quality of our services and standards of our care. Our Patient Information and Liaison service (PILS) handle all formal complaints, concerns, and other provider concerns to include General Practitioner (GP) concerns received from the Clinical Commissioning Groups (CCGs).

From April 2016 to March 2017 we received **1,443** formal complaints, **1,363** concerns, and **579** CCG / GP complaints/concerns.

The table overleaf shows the top five themes of formal complaints received by the Clinical Management Groups from 1st April 2016 to 31st March 2017

Table showing top 5 subjects of formal complaints by CMG for 2016/17

The top five subjects account for 1,029 (71 per cent) of the 1,443 formal complaints we received

Top 5 Subjects of Formal Complaints by CMG 2016/17	CMG 1 (CHUGGS)	CMG 2 (RRCV)	CMG 3 (ESM)	CMG 4 (ITAPS)	CMG 5 (MSK & SS)	CMG 6 (CSI)	CMG 7 (W&C)	The Alliance	Corporate Directorates	Total
Medical Care	101	50	109	6	48	4	77	8	1	**404**
Waiting times	30	14	52	4	43	13	10	10	1	**177**
Communication	43	23	42	5	17	3	30	2	5	**170**
Staff attitude	25	7	52	3	18	13	12	10	7	**147**
Appointments including delays & cancellations	34	11	19	9	34	1	16	6	1	**131**
Totals:	**233**	**105**	**274**	**27**	**160**	**34**	**145**	**36**	**15**	**1,029**

10, 25 & 45 day formal complaints - April 2016 to March 2017 (data correct as at 09.05.17)

	10 days				25 days				45 days			
Clinical Management Group	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	Number received	No. replied within 45 days	No. replied over 45 days	% replied within 45 days
CMG 1 (CHUGGS)	34	33	1	**97%**	234	204	30	**87%**	22	18	4	**82%**
CMG 2 (RRC)	7	7	0	**100%**	118	107	11	**91%**	12	11	1	**92%**
CMG 3 (ESM)	31	24	7	**77%**	346	297	49	**86%**	78	51	27	**65%**
CMG 4 (ITAPS)	2	2	0	**100%**	30	30	0	**100%**	1	1	0	**100%**
CMG 5 (MSK & SS)	26	22	4	**85%**	148	135	13	**91%**	6	6	0	**100%**
CMG 6 (CSI)	5	4	1	**80%**	42	42	0	**100%**	4	4	0	**100%**
CMG 7 (W&C)	6	6	0	**100%**	172	165	7	**96%**	36	30	6	**83%**
The Alliance	2	2	0	**100%**	33	33	0	**100%**	3	2	1	**67%**
Corporate Medical					2	2	0	**100%**				
EFMC	4	3	1	**75%**	24	24	0	**100%**				
Human Resources	1	1	0	**100%**	2	1	1	**50%**				
IM&T					2	2	0	**100%**				
Nursing					4	3	1	**75%**				
Operations	1	1	0	**100%**	3	3	0	**100%**	2	2	0	**100%**
Totals	**119**	**105**	**14**	**88%**	**1160**	**1048**	**112**	**90%**	**164**	**125**	**39**	**76%**

Throughout the year we have continued to participate in the Independent Complaints Review Panel process. The purpose of the panel is to review a sample of complaints from the patient perspective and to report back to the PILS team on what was handled well and what could have been done better. The feedback provided by the Independent Complaints Review Panel is used for reflection, learning and improvement both within the PILS and to our Clinical Management Groups.

Actions for 2016/17 to further improve complaints engagement and learning were:

- GP engagement event – we have worked collaboratively with the CCGs to review the themes of the GP concerns and use this information to prioritise larger scale safety improvement projects within our organisation. Improving the discharge of the patient on warfarin therapy is an example of this collective work;
- Two community based Patient Information and Liaison (PILS) clinics – we have been working closely with Healthwatch and endeavour to arrange an initial clinic or be part of a public engagement event during 2017;
- Collaboration with the University of Leicester with work on the quality of apology in our complaints response letters – this has been completed and involved a review of the existing literature on apologies and analysing a sample of our written and verbal apologies. Results from this will be used to develop training and other supportive material to support staff in providing good quality apologies both written and face to face.

We continue to strive to improve our complaints process and handling of cases. Actions for 2017/18 are:

- Carry out a new complaints satisfaction survey using new approaches
- Coach and further develop the skills of the Patient Information and Liaison Service team to improve the quality of call handling and drafting of responses using Plain English
- Develop further training for staff to enable them to manage and resolve concerns locally and earlier

Reopened Complaints

This year we have seen an average of 8.35 per cent of formal complaints reopened.

Number of formal complaints received and number of those reopened by financial quarter - 2016/17

	Formal complaints received	Formal complaints reopened	% resolved at first response
16/17 Q1	316	37	88%
16/17 Q2	373	30	92%
16/17 Q3	384	34	91%
16/17 Q4	370	20	95%
Totals:	**1443**	**121**	**92%**

Parliamentary Health Service Ombudsman

This year we have had less upheld cases by the Parliamentary Health Service Ombudsman.

Parliamentary Health Service Ombudsman complaints - April 2014

	2014/15	2015/16	2016/17	Total
Enquiry only - no investigation	**3**	**3**	**5**	**11**
Investigated - not upheld	**6**	**10**	**10**	**26**
Investigated - fully upheld	**0**	**0**	**0**	**0**
Investigated - partially upheld	**7**	**4**	**1**	**12**
Complaint withdrawn	**0**	**0**	**4**	**5**
No Decision made yet	**0**	**1**	**4**	**5**
Total	**16**	**18**	**21**	**55**

The theme from the upheld case this year was a failure to provide accurate discharge information to a community health care provider.

Patient Information and Liaison Service (PILS)

Feedback from our patients, their families and carers gives us a valuable opportunity to review our services and make improvements. PILS is an integral part of the corporate patient safety team and acts as a single point of contact for members of the public who wish to raise complaints, concerns and compliments.

The service is responsible for coordinating the process and managing the responses once the investigations and updates are received from relevant services or individuals. They are contactable by a free phone telephone number, email, website, in writing or in person.

PILS activity (formal complaints, verbal complaints, requests for information and concerns) by financial year - April 2010 to March 2017

	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017
Formal complaints	1531	1723	1513	2030	2110	1553	**1443**
Verbal complaints	1289	1152	1054	1391	975	1445	**1081**
Requests for Information	356	434	292	203	234	433	**326**
Concern (excludes CCG & GP)	0	66	341	343	472	703	**1363**
Totals:	3176	3375	3200	3967	3791	4134	**4213**
Percentage change against previous year	-	6% increase	5% decrease	24% increase	4% decrease	9% increase	**2% increase**

Freedom of Information

The Freedom of Information (FOI) Act was passed on 30 November 2000, and the full Act came into force on 1 January 2005.

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

In 2016/17, we received 695 FOI requests and/or requests for environmental information, compared to 590 in 2015/16 (an 18 per cent rise in requests).

We responded to 96 per cent of these requests within the statutory 20 working-day deadline in 2016/17. Many of these requests contained multiple individual questions, with information needing to be obtained from more than one clinical or corporate area of our organisation – this amounted to 1,036 instances that areas had to provide information. The table below shows the number of times that different areas had to provide information during the year to respond to those 695 FOI requests.

Some information (such as patient information leaflets and Trust Board papers) is already publicly available on our FOI publication scheme – you can find this on our external website in the FOI section.

Freedom of Information/Environmental Information Regulation requests received between 1 April 2016 and 31 March 2017, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2016/17**	**Approx % of overall 2016/17 FOI activity (in terms of times needing to provide information)**
Finance and Procurement	143	13.8%
Operations	139	13.41%
Human Resources	115	11.10%

Freedom of Information/Environmental Information Regulation requests received between 1 April 2016 and 31 March 2017, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2016/17**	**Approx % of overall 2016/17 FOI activity (in terms of times needing to provide information)**
Clinical Support and Imaging CMG	107	10.32%
Corporate Nursing	102	9.84%
IM&T	73	7.04%
Women's and Children's CMG	63	6.08%
Facilities & Estates	59	5.69%
Cancer, Haematology, Urology, Gastroenterology and General Surgery CMG	56	5.4%
Corporate Medical	54	5.21%
Emergency and Specialist Medicine CMG	34	3.28%
Musculoskeletal and Specialist Surgery CMG	29	2.79%
Corporate & Legal Affairs	27	2.6%
Renal, Respiratory and Cardiac CMG	20	1.93%
Critical Care, Theatres, Anaesthesia, Pain and Sleep CMG	15	1.44%
Strategy	2	0.2%
Marketing and Communications	4	0.4%
Research and Innovation	1	0.09%
The Alliance	1	0.09%

Please note that some requests required a response from all/multiple clinical and corporate areas, which is why the numbers shown above (which add up to 1036 times that areas had to provide information) are higher than the total of 695 requests received.

NHSLA 'Sign up to Safety' Programme

In 2015 we were allocated £1,581,587 (one of the largest successful bids in England) from the National Health Service Litigation Authority (NHSLA) to support the delivery of our safety improvement plan.

Our 'Sign up to Safety' safety improvement plan priorities are aimed at improving the recognition, escalation, response and effective on going management of the deteriorating patient.

As part of the 'Sign up to Safety' campaign this year we have:

- we have introduced electronic observations for both adults and paediatrics across all three hospitals through the implementation of Nervecentre;
- provided structured feedback to ward clinicians for all emergency patients admitted with sepsis to the Intensive Care Unit at the Royal Infirmary; these sessions provide the space for continual learning from peers;
- embedded a sepsis training module into the trust-wide statutory resuscitation training;
- placed Sepsis Black Boxes in all of our resuscitation trolleys;
- introduced a Red Flag Sepsis Pathway to ensure patients receive the treatment they need within 1 hour;

- developed a Patient Safety Portal to help staff adopt best practice, share information and lessons learnt from incidents and complaints and work with other departments to improve patient safety and reduce avoidable harm;
- developed a partnership with Kettering hospital to implement the Red Flag Sepsis Pathway, Sepsis Black Boxes and training;
- created a hypoxic-ischemic encephalopathy obstetrics video training package, which includes of a series of six mini video's to be used for individual and group training sessions to share best practice and improve patient safety;
- created human factors e-learning modules to train staff carrying out investigations whilst providing all healthcare staff with an introduction to the ergonomics and human factors discipline and how the application of relevant methods and knowledge is critical to patient safety.

Providing spiritual and religious care - our Chaplaincy Service

We offer pastoral, spiritual and religious support to patients and families and our diverse team ensures that they have chaplains from a wide variety of faiths' to support them. We offer a 24/7 availability to support patients or families in urgent situations, especially around the time of a death. We have also been working closely with the Leicestershire Partnership Trust's chaplaincy team.

We are here to support all who face emotional distress arising from questions concerning life, death, meaning and purpose - questions that can be acutely highlighted by illness and suffering.

We provide multi-faith chapels and prayer facilities on each site, for the use of patients, visitors and staff. These provide a place for prayer or quiet contemplation and are in constant use.

Over the year our chaplains and chaplaincy volunteers made almost 14,000 visits to patients - an invaluable part of our commitment to delivering "Caring at its best". We benefitted from about 3,800 hours donated to the Trust by volunteers.

Our non-religious Pastoral Carer (a national first for Leicester) has completed over a year working as a part of the Chaplaincy. A report outlining the contribution she has made so far has highlighted many positive responses from patients and staff. The post is funded by the *Leicester Hospitals' Charity* until the end of 2017.

The chaplaincy also organised the second "Celebrating Caring at its Best" event, held in July. This focussed on celebrating positive patient experiences and the motivation of staff and volunteers who deliver "Caring at its Best".

Patient and public involvement and engagement

This year our public membership continued to grow and now stands at 16,489 people, spread across Leicester, Leicestershire and Rutland. This is the largest it has ever been. Over the year the number of our younger members has also increased, with many joining as a first step to volunteering with our hospitals.

Members are invited to participate in a range of engagement opportunities, as well as coming along to our monthly "Leicester's Marvellous Medicine" talks. Attendance at these talks has grown over the year and members have enjoyed sessions on a wide range of topics including the treatment of burns, advances in medical prosthetics and a debate on whether Cannabis may be considered as a viable medicine.

In August last year, the Trust Board held a "Thinking Day" which was dedicated to Patient and Public Involvement (PPI). Representatives from nine of our local Patient Groups participated in the event and were asked to consider what they felt the Trust ought to be focusing on over the coming year. As a follow up to this event, we have now held several meetings which aim to bring those groups together on a more regular basis to share concerns and matters of interest relating to our hospitals.

In January 2017, the Trust Board approved a new programme of community engagement which will see the establishment of quarterly Community Engagement Forums (held in venues across the region) as well as a rolling programme of smaller scale engagement opportunities with our diverse local communities.

One of our key priorities this year has been to expand the numbers of people working with us as Patient Partners. Patient Partners are members of the public who provide a patient's or carer's perspective on all

aspects relating to the experience of Leicester's Hospitals by patients and the wider public. We conducted a successful recruitment campaign in the early part of 2017 and have now almost doubled the size of our Patient Partner group with 24 people, form a wide range of backgrounds, now signed up to work in partnership with our clinical and managerial staff.

Generosity at Christmas

Every Christmas we see and feel the generosity of local people for our patients and staff. This past Christmas was no different, in fact it might have been the most generous we have ever seen!

Children in our Childrens Hospital had the chance to meet their heroes from local sports teams: Leicester Tigers, Leicester City F.C., Leicester City Women's Team and Leicester Riders, who all visited with their players and mascots, taking time out from their busy fixture lists.

Visits were also arranged for our older patients in hospital, which included carol singing from the cast of the Curve's production of Grease and a swing dance class from Anstey who delighted our patients with their 1940s style outfits and routines. We also welcomed several local choirs who sang in the main receptions at our hospitals to welcome people in and out. These included the Semper Singers and Sing to Breathe Easy Choir.

Our older patients also received a present on Christmas Day following our successful 'Making Christmas Special Campaign', which saw over 1500 presents donated by companies, staff and the public in Leicester, Leicestershire and further afield! Our army of volunteers delivered the presents to those of our patients who are not well enough to be at home on Christmas Day. Thank you to Jon Ashworth, MP for Leicester South and Tony Donovan, Executive Director Age UK Leicester Shire and Rutland, for their visit and for their continued support of our unique campaign.

We also ran a neonatal campaign for people to donate gifts to our smallest patients. We were inundated with knitted hats and are extremely grateful for the generosity shown by people across the world (we even had someone from Canada ask if they could help).

Decorations, including Christmas trees were put up across the hospital, many of them were donated to us by companies including Marks and Spencer, British Gas, Close Brothers Motor Finance, Santander and Nottingham Building Society.

We also received an abundance of new toys for children in our hospitals, including a special delivery from The Community Giants, a social enterprise in Leicester who help unemployed young people, who brought a treasure chest full of goodies for our children's wards.

A special thank you to Zuffar Haq, Non-Executive director at Leicester City CGG and David Gorrod, patient partner for Leicester's Hospitals who donated gifts for our hard-working staff in the Emergency Department and Leicester Hospitals Charity, who have arranged a free Christmas Meal for all of our staff who worked on Christmas Day.

These are all just examples of your generosity and there are too many people to thank individually!

Modern Slavery Act (MSA) Statement

We are committed to ensuring the absence of slavery in our organisation and supply chain.

In line with the requirements of the Modern Slavery Act (MSA) which came in to statute in 2015; we continue to take the following actions:

- On-going assessment of our contracts which have the highest risk of modern slavery;
- Use of national MSA compliant supplier Pre-Qualification Questionnaire (PQQ); to support assurance that our supplier's comply with the MSA;
- Inclusion of MSA clause in our standard terms and conditions.

An effective and integrated emergency care system

Our priorities for the year were to:

- Reduce ambulance handover delays in order to improve patient experience, care and safety
- Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including Intensive Community Support)
- Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps
- Diagnose and reduce delays in the in-patient process to increase effective capacity

Reduce ambulance handover delays in order to improve patient experience, care and safety

We continue to work in partnership with EMAS (East Midlands Ambulance Service) to improve the time it takes to handover patients that they bring to our Emergency Department (ED) by ambulance.

During the beginning of the year we saw improvements in ambulance handover times, however the position deteriorated significantly in December and January.

This year, we have developed and implemented key actions as part of an ambulance handover improvement action plan with our system partners, to:

- Reduce the attendance to the ED by using community and primary care alternatives
- Increase the size and speed of take at the Clinical Decisions Unit at Glenfield
- Increase the cohorting capacity of the ED by implementing a proactive policy to enact when the department has patients waiting for beds in the main hospital
- Create a ward or wards on one of our three sites where patients who are medically fit for discharge can be cared for whilst arrangements are made for their discharge
- Reduce external delays to the discharge of individual patients who are waiting for packages of care at home or in the community.

By February 2017 we were back down to the levels we reported in June 2016. However, despite this improvement, we acknowledge that we still have unacceptable delays in this process and this remains one of our top priorities for improvement this year (2017/18).

During this year, we have worked with the Emergency Care Improvement Programme (ECIP) to look at how we improve our performance in this area; this will continue in 2017/18.

Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including Intensive Community Support)

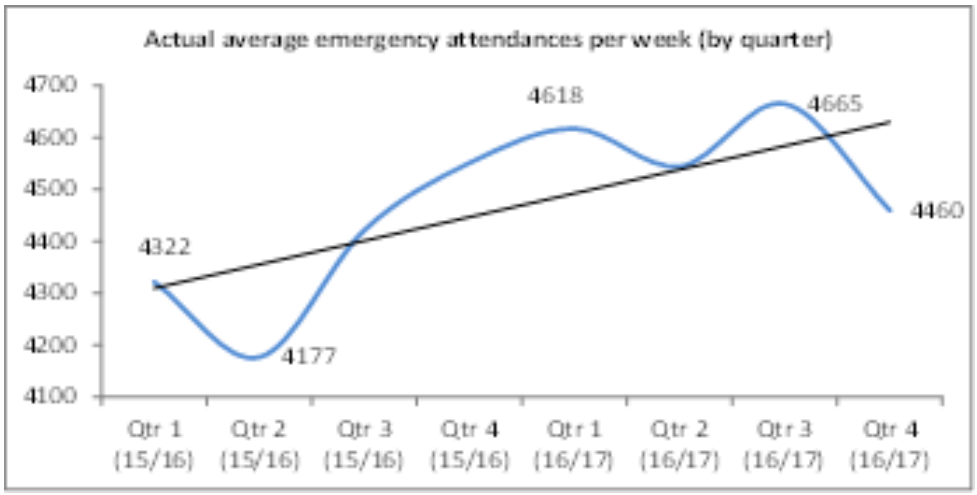
Over the last 12 months, a key success factor in reducing the number of admissions to our hospitals has been the change to the way the GP Assessment Unit (GPAU) works at the Royal Infirmary. Since moving the unit closer to our ED in November, we have seen more ambulatory patients treated and discharged by senior decision-makers on the same day, rather than needing to be admitted to a hospital bed. Even though our length of stay as a Trust has increased from 5.4 days in 15/16 to 6.1 days in 16/17, this is largely due to the impact of GPAU on reducing the overall number of short stay admissions; in other words, the patients who are in our beds are sicker and have more complex needs, and therefore, stay longer.

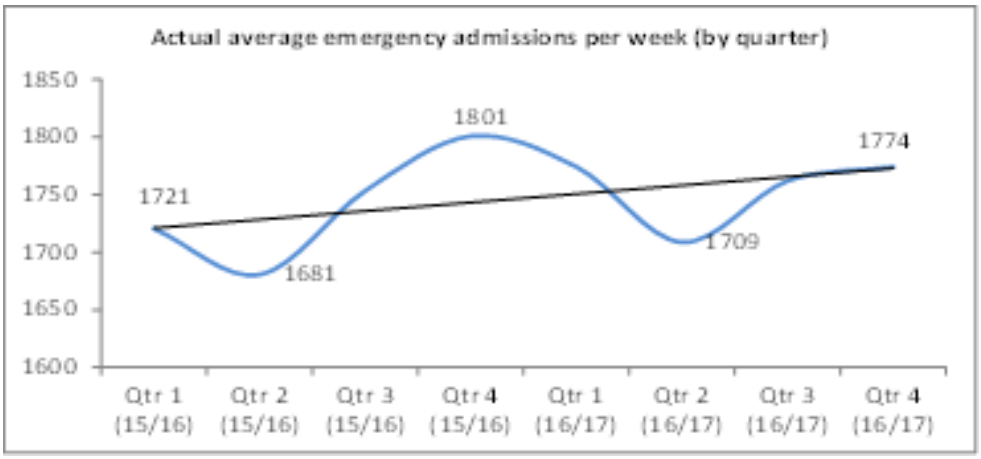
We have also continued to focus efforts on increasing awareness and usage of all the ambulatory services available both within our hospitals and outside in the community, via the Ambulatory Emergency Care Directory, which is a live document available on our intranet and at all GP practices.

We have continued to use the Intensive Community Support (ICS) service to support timely discharge for our patients; this service is provided by Leicestershire Partnership NHS Trust and provides additional support for patients in their own homes, ensuring they are looked after in the right place, and improve flow in our hospitals. The multi-disciplinary team can provide up to four intensive one hour visits a day, and work closely with adult social care and others to ensure patients receive joined up and coordinated care.

Whilst emergency attendances have continued to rise over the past 12 months by five per cent (31 patients a day), there has been a less than one per cent increase in emergency admissions, demonstrating that schemes to avoid admitting a patient are having a positive effect.

Ensuring patients are admitted into the hospital only when absolutely necessary remains a key focus for 2017/18. The way we manage patients at our front door (ED) will change from April as we move into our new ED, and provide a new model of care that will stream and treat all of our patients as they arrive at our doors, ensuring they get the right care, in the right place, first time.





Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps

During 2016/17 we experienced an increased demand of 4.3 per cent in emergency admissions. Our length of stay reduced for patients staying greater than one day by 8.5 per cent, which would have created 44 more beds to meet this demand, but it was not enough to treat the increased numbers of patients we have been seeing. Coupled with this increase in demand, we have also made some reductions in the numbers of beds that we have because of staffing levels and the strategic reconfiguration programme. We have faced some tough decisions this year, as demand on the emergency and surgical pathways has outweighed the number of beds we have for these patients. For the first time in four years, this led us to cancel elective (non-emergency) patients for a number of days in 2016/17, in an attempt to rebalance the system and cope with the pressures we have faced. This is not a good experience for patients, and is not sustainable moving forward.

Overall, the bed capacity (the numbers of beds we have) has not been at the right level to meet the increases in demand we have seen, and the increasing demands that we know will continue in 2017/18. We have developed an initial plan for rebalancing demand and capacity, and this will be a priority area for 2017/18.

The plan includes:

- New actions involving us working more effectively downstream to care for step down patients in a non-acute setting, i.e., in patients own homes, or in the community they live in
- New actions to increase our bed base at the Royal Infirmary and Glenfield (this is in line with the Sustainability and Transformation Plan/our five-year Reconfiguration Plan)
- New actions to transform the hospital pathway for frail, complex patients
- New actions to separate emergency and elective (non-emergency) work.

Diagnose and reduce delays in the in-patient process to increase effective capacity

During this year, we have adopted the national SAFER approach to reduce delays in adult inpatient wards. Known as the SAFER 'patient flow bundle', it blends five elements of best practice, that when all implemented together, brings huge benefits to both patients and staff.

Senior review: All patients will gave a senior review before midday by a clinician who is able to make management and discharge decisions

All patients will have an expected discharge date and clinical criteria for discharge, set up assuming the ideal recovery period and assuming no unnecessary waiting

Flow of patients should start at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the wad by 10am.

Early discharge from wards to home: 33 per cent of patients will be discharged from base inpatient wards before midday

Review - A systematic MDT review of those patients with a length of stay over seven days

Over the year, we have worked with our medical clinical teams to implement aspects of the SAFER approach, alongside Red2Green:

Red2Green: R2G bed days are a visual management system to assist in the identification of wasted time in a patient's journey and are used to reduce internal and external delays. When used in conjunction with the SAFER patient flow bundle and followed consistently, length of hospital stay is reduced and patient flow and safety improves. This was implemented in December 2016 on 14 Emergency and Specialist Medicine wards at the Royal Infirmary and in 2017/18 is rolling out to 13 ward areas at the Glenfield Hospital in RRCV with plans to expand to other clinical management groups across the whole Trust throughout the year.

Work streams have been established to reduce both the internal and external waits in the patients' journey and improvement metrics have been established to measure success.

Setting up an Ambulatory Clinic within our Clinical Decisions Unit at the Glenfield.

Dr Ursula Montgomery has lead a project combining specialist respiratory and cardiac nurses working with GPs to provide a fast track ambulatory service within our Clinical Decisions Unit at the Glenfield Hospital.

This project has delivered a median time of two hours for patients to be seen and discharged, with high patient satisfaction scores and used primary care IT solutions and prescriptions to facilitate patient care.

Plans are in place to extend the project during 2017/18.

Services which consistently meet national access standards

Our priorities for the year were to:

- Maintain 18-week RTT and diagnostic access standard compliance
- Deliver all cancer access standards sustainably

Maintain 18-week RTT and diagnostic access standard compliance

Since the period of very high emergency admissions in winter 2015/16 the referral to treatment (RTT) standard has been more difficult to deliver.

In the early part of 2016/17 this standard was delivered but due to significant referral growth (8 per cent) and the impact of emergency admissions it was not delivered towards the end of 2016 and the start of 2017.

We have a plan to get back to being compliant with this standard in August 2017 and we are working with GPs to support them accessing care other than through a referral to the hospital. This include virtual appointments and advice and guidance. Our work is supported across the whole health system.

Deliver all cancer access standards sustainably

We have seen an increase in the number of patients being referred with suspected cancer this year as GPs work more closely with us to improve the rate of early detection of cancer. We have sustainably achieved the standard of ensuring all patients are seen within 2 weeks of their referral by a specialist.

This year we changed our approach to supporting patients through their cancer pathway by rolling out 'Next Steps' which aims to ensure that every patient leaves the hospital knowing what, when and where their next appointment or investigation on their cancer pathway will be. This has reduced the times patients are waiting and the number of patients who are currently waiting over 62 days for treatment is the lowest it has been in two years. There is more to do this year in embedding this process and ensuring the standard is hit every month.

University Hospitals of Leicester NHS Trust

Performance Against National Standards

Performance Indicator	Target	2016/17	2015/16	2014/15
A&E - Total Time in A&E (4hr wait)	95%	79.6%	86.9%	89.1%
MRSA (All)	0	3	1	6
MRSA (Avoidable)	0	0	0	1
Clostridium Difficile	61	60	60	73
RTT - incomplete 92% in 18 weeks	92%	91.8%	92.6%	96.7%
Diagnostic Test Waiting Times	1.0%	0.9%	1.1%	0.9%
Cancer: 2 week wait from referral to date first seen - all cancers	93%	93.2%	90.5%	92.2%
Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	93.9%	95.1%	94.1%
All Cancers: 31-day wait from diagnosis to first treatment	96%	93.9%	94.8%	94.6%
All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.7%	99.7%	99.4%
All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	86.4%	85.2%	89.0%
All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	93.5%	94.9%	96.1%
All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	78.1%	77.5%	81.4%
All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	88.6%	89.1%	84.5%

Green = target achieved

Red = target failed

Integrated care in partnership with others

Our priorities for the year were to:

- Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the Leicester, Leicestershire and Rutland vision (including formal consultation)
- Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region
- Progress the implementation of the EMPATH strategic outline case

Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the Leicester, Leicestershire and Rutland vision (including formal consultation)

As well as continuing to focus on delivering improvements for our patients through the Better Care Together (BCT) work streams, we also started work on the local Sustainability and Transformation Plan (STP).

The STP describes how the health and social care system within Leicester, Leicestershire and Rutland plans to restore financial balance by 2020/21 through new ways of working, new care models and proposals for reconfiguring our hospital services (subject to formal public consultation) to address long standing issues around the condition of our premises and how these are utilised.

The STP builds on the work developed as part of our BCT programme but with clearer focus on implementing system priorities. Some of the work streams initiated under BCT remain and some have been reshaped to help us focus on biggest issues.

Before we look at the specific work streams and the progress we have made with our partners, the following provides a summary of the five overarching priorities/ solutions within the STP, each designed to help moderate demand on health and social care services (particularly the acute sector) while improving outcomes for patients and financial performance across each partner organisation:

1. **New models of care** focused on prevention, reducing demand on services, including place based integrated teams, a new model for primary care, effective and efficient planned care and an integrated urgent care offer;
2. **Service configuration** to ensure clinical and financial sustainability, including (subject to consultation) consolidating care onto two acute hospital sites, the consolidation of maternity provision onto one site and moving from eight community hospitals with inpatient beds to six;
3. **Redesign pathways** to deliver improved outcomes for patients and deliver core access and quality - including actions to improve long term conditions, improve wellbeing, increase prevention, self-care and harnessing community assets, as well as our work to improve cancer; mental health and learning disabilities;
4. **Operational efficiencies** to reduce variation and waste, provide more efficient interventions and support financial sustainability – this involves delivering on the Carter recommendations, provider cost improvement plans, medicines optimisation and back office efficiencies;
5. **Getting the enablers right** to create the conditions of success, including workforce; IM&T; estates; workforce, engagement and health and social care commissioning integration.

The clinically led work streams that support these priorities build on the work done in 2015/16, bringing partners together to develop shared goals and support the implementation of service improvement plans. During 2016/17, year 3 of our BCT programme (and year 1 of our STP), we have delivered a number of changes that have directly improved patient and service user outcomes.

Key achievements across the five main work streams include:

Work stream	Progress
Urgent and Emergency Care	This remains one of our most challenged areas so the work we are doing with partners is critical to improving urgent and emergency care services for our patients. We have improved patient and professional navigation through our urgent and emergency care services following the introduction of a new (pilot) Clinical Navigation service, incorporating 111 clinical triage, out of hour's telephone advice, East Midlands Ambulance Service NHS Trust (EMAS) Clinical Assessment and Treatment Service (CATS), professional advice line incl. Consultant Connect and Single Points of Access (SPAs). Following the success of the pilot, this model is now being formally rolled out as part of a new Leicester, Leicestershire and Rutland wide procurement that also includes new services like urgent home visiting and urgent care community hubs (providing enhanced primary care, urgent care and diagnostics). We also established the A&E Delivery Board, chaired by our Chief Executive John Adler, which comprises of providers, commissioners and other stakeholders with a view to supporting service delivery, jointly managing risks, reporting progress, and deploying improvement support. We also opened our new emergency floor at the Royal Infirmary with a separate front door for children and adults with an integrated mental health facility so adults and children who are in crisis will be assessed more rapidly, in a safe and suitable environment (as detailed elsewhere in this report).
Home First	This new work stream was fully established this year and has developed robust plans to improve a number of important services, including: • creating a single integrated discharge service within our organisation which acts as a single point of access to social workers, therapists, the complex discharge team, community in reach staff and primary care coordinators; • developing Trusted Assessor arrangements between partner organisations and localities to enable efficient coverage and reduce delay; • Discharge to Assess arrangements, including the support offered to Care Homes.
Integrated Teams	An evolution of some of the BCT work streams, the Integrated Teams work stream has been established to develop and deliver integrated working across Leicester, Leicestershire and Rutland. Multidisciplinary teams of health and social care professionals have been developed with three main priorities: • Risk stratification and case finding –segmenting our population and provide person-centred care to those most in need recognising resource constraints; • Multidisciplinary team working – health and care professionals working together to support people with complex needs that have been identified through risk stratification and case finding; • Personalised care and support planning –the key vehicle by which health and care professionals work together with patients and carers to meet their needs. End of Life (EoL) also features within this work stream where we continue to work with partners to design and deliver integrated end of life care service. This year, we: • Developed a comprehensive baseline of End Of Life provision for our patients o Health Needs Assessment completed July 2016 • Developed a shared vision across 3 CCGs' / LPT /UHL and Voluntary Sector o LLR 5 Year Strategy co-created and clinically led completed January 2017

Work stream	Progress
	• Started to implement the agreed pathway changes to improve care provided to patients ○ Pilot of new pathway for EoL patients commencing in April 2017 We also finalised a new model of care / service specification for an integrated community cardiorespiratory service this year, which will be rolled out during 17/18.
Primary Care	Leicester, Leicestershire and Rutland colleagues have agreed a 'blueprint' for General Practice, which delivers the NHS General Practice Five Year Forward View – this includes a new model for general practice, improved access, a new workforce model, improved infrastructure and targeted investments.
Planned Care	We have worked with our partners in strengthening the governance arrangements with joint commissioner and senior leads from our organisation. We have increased the use of PRISM, a system with links to advice and guidance for GPs and other health professionals and standardised referral pathways for those patients that need a specialist opinion or test. This ensures GPs and patients receive timely advice and information and that only those who will benefit from a specialist service are referred to hospital. We also established a Clinical Priorities Implementation Group to develop evidence based cost effective clinical commissioning policy and pathways to ensure we have robust systems in place to ensure patients are managed and cared for in the most appropriate setting. This involves difficult discussions about what might be considered as low priority treatments. With our partners, we are also reducing the number of outpatient follow up appointments to ensure our specialist capacity is available for new referrals (including cancer).

Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region

The South East Midlands Oncology Centre, our partnership with Northampton and Kettering General Hospitals to provide a single oncology service across Leicestershire, Northamptonshire and Rutland, has seen the appointment of a new Clinical Lead and Project Manager who are leading on alignment of clinical protocols and research to make sure that all patients receive the best possible care. Our staffing and sustainability strategies are taking shape with a new communications plan to keep patients and staff informed.

Our support for the vascular service at the United Lincolnshire Hospitals continues with all patients discussed at our combined MDT. We have reviewed the outcomes and experience of the Boston service and the Lincolnshire team are now able to perform Endovascular Aortic Replacement (EVAR) safely in Boston without our vascular surgeons and interventional radiologists being present for every case.

A consultant surgeon has been appointed under the banner of "East Midlands Urology, a Lincolnshire and Leicestershire Partnership" to join our robotic team. He will see patients locally in Lincolnshire and those requiring complex treatment will only have to travel to Leicester for their surgery. East Midlands Urology will also allow us to increase the choices of treatment location and waiting times offered to patients living to the north of Leicester.

Our Hepatitis C Network, which includes Northampton and Kettering General Hospitals, and supports patients accessing the most up to date treatments for their disease was formalised. Two evening network educational meetings, organised by the Leicester team, have brought together clinicians from multiple organisations, patients and national patient representation groups.

We are now working with University Hospitals of Coventry and Warwick to transition patients with cystic fibrosis, living close to Leicestershire, from their children's to our adults' service. We have new outreach clinics in Coventry to inform and support patients making this move. This additional group of patients will help support the growth of our service in the future.

Progress the implementation of the EMPATH strategic outline case

EMPATH is a pathology partnership between ourselves and Nottingham University Hospital NHS Trust. A Strategic Outline Case to transform pathology services was approved by both Trusts in December 2015 which provided the mandate to develop an Outline Business Case for a fully integrated pathology service.

The Outline Business Case was built around a comprehensive assessment of how and where services could be provided (the Target Operating Model). This assessment concluded there were a range of opportunities to transform pathology services supported by investments in premises, equipment, IT and logistics. The Outline Business Case demonstrated that improvements in the quality of pathology services could be delivered which are financed from the savings from an optimised and consolidated operating model (whilst also making a significant contribution to the financial recovery plans for both Trusts).

The Outline Business Case validated the findings and recommendations within strategic reviews by the Department of Health (the 2008 Lord Carter review of pathology services and the 2015 Dalton review of organisational forms to support delivery of new models of care across traditional organisational boundaries).

A blueprint for developing a fully integrated pathology services has been developed using the findings and recommendations from the Outline Business Case, Carter and Dalton reviews. The blueprint has five elements:

1. Develop a compelling for pathology;
2. Consolidate and optimise business services which are designed around an integrated regional pathology service;
3. Design and implement management arrangements to support a single team running integrated services across multiple organisations;
4. Consolidate and optimise services with each Sustainability & Transformation Plan footprint (STP);
5. Consolidate services across STPs

The blueprint has been well received by a wide group of stakeholders as it focuses on improving the quality and efficiency of local pathology services in the short term without compromising the ambition of the longer term plan for a fully integrated regional pathology service.

The Outline Business Case and blueprint have been endorsed by NHS Improvement who has invited both organisations to be one of five Pathfinders for pathology transformation in the NHS. The Pathfinders will lead the way in developing solutions for pathology transformation which will act as guides for the next phase of the NHS Improvement pathology transformation programme. The Pathfinder programme will support the delivery of the local blueprint and also provide an opportunity to extend the integrated service to include other Trust providers.

Our partnership with the Alliance

The Alliance continues to build on the work started since its inception in April 2014. They continue to provide an extremely positive patient experience (97.2 per cent patient satisfaction compared to 94.5 per cent in 2015/16). In the last year they had no serious incidents, infection control problems and no breaches in Duty of Candour; they managed to see and treat 96.8 per cent of their patients within 18 weeks and have only infrequently cancelled operations on the day (1.2 per cent). Their formal complaints only number 0.01 per cent of overall activity and they continue to get very positive feedback from both patients and staff.

Together with their Patient, Public Participation Group (PPPG) they have developed a comprehensive public, patient and stakeholder engagement programme, and alongside commissioners have been involved with a health and well-being CQUIN for staff which is already providing access to health and well-being activities/ opportunities and improved facilities. Their PPPG carried out PLACE assessments for their hospital facilities and they also recruited volunteers. They have improved their communications using Facebook, Twitter and

YouTube, newsletters, attending partner Annual General Meetings and attended the NHS Innovation Expo in Manchester.

In order to continue their transformational work and move activity closer to patients' homes they have continued to train and develop their staff. Over the last year this includes developing new roles such as the Nursing Associate, Trainee Assistant Practitioners and they have now trained a qualified Nurse Endoscopist. The Alliance has also produced a 5-year workforce development plan which aligns with the local health economy's Sustainability and Transformation Plan (Better Care Together).

Over the last 12 months they have set up and delivered additional services in several community hospitals. They have provided additional gastroenterology outpatient sessions (at the newly opened) St Luke's Treatment Centre in Market Harborough, Hinckley District Hospital, and Loughborough Hospital. They have provided additional endoscopy sessions at all three of these sites and over the last year have increased their provision of colonoscopy by over 100 per cent. In ophthalmology they have provided additional oculoplastics services, YAG laser and glaucoma services at Hinckley District Hospital as well as extra paediatric ophthalmology at Loughborough Hospital. They have set up additional adult and paediatric ophthalmology outpatients, day case oculoplastics and laser therapy at Melton Hospital. They also delivered further urology services in the form of cystoscopy in our endoscopy units and have developed a nurse lead dermatology clinic in Oakham.

In December 2016 they started a pilot to deliver an early pregnancy assessment unit in a primary care setting in the city and they are currently supporting the planning for a single point of access for ophthalmology services. In the last year they have assessed and embedded the Integrated Musculoskeletal (MSK) Triage Hub and are working with ourselves and Leicestershire Partnership NHS Trusts to deliver an Integrated MSK physiotherapy service alongside this.

Over the past year the Alliance has been preparing to deliver over 3,000 dermatology outpatient appointments in a primary care setting and has been working with our Dermatology Department and primary care to develop the workforce and governance arrangements to facilitate this. This work will start soon and similar work is being developed in other specialties'.

They have worked hard with primary and secondary care to develop improved governance for GP's with special interests and have developed a pay structure to reflect these arrangements. They have also carried out a review of diagnostics provision across Leicester, Leicestershire and Rutland with their partners and from April 2017 our ultrasound, plain film and MRI reporting services will be delivered by us from Alliance sites.

They have seen a large number of significant developments in their backroom functions which have improved their efficiency and governance arrangements. Some of these include centralisation of ophthalmology and gastroenterology booking onto one site, outsourcing of audio typing, a review of space utilisation and electronic rostering. The Alliance nursing leadership structure has also been developed to allow career progression and promote retention of staff.

The Alliance continues to improve access to services for local people in line with the Better Care Together strategic objectives. They also continue to develop services within primary care (LLR PCL) and with Leicestershire Partnership NHS Trust by transforming pathways and transferring appropriate activity from us into these settings e.g. EPAU (early pregnancy assessment unit) pilot and Dermatology outpatient appointments.

The Alliance remains committed to developing its workforce and training plan to meet the strategic needs of Leicester, Leicestershire and Rutland in order to deliver sustainable services for the future.

East Midlands Paediatric Critical Care Transport Service

We are the host NHS Trust for a new East Midlands Paediatric Critical Care Transport Service which was commissioned during 2016/17 and we are delivering in partnership with Nottingham University Hospitals NHS Trust.

The service aims to provide an acute transport team operating 24/7 - 52 weeks of the year with capacity to provide advice on how to manage critically ill children, who present to an East Midlands hospital, stabilise

them and transport them to an appropriate paediatric critical care facility, in line with NHS England standards and recognised best practice.

There is a repatriation team which operates weekdays and during daytime hours only, to safely transport patients to or from paediatric critical care facilities, where the level of dependency does not require the full transport service. This will most commonly be transfers back to the hospital that referred them at the end of an episode of critical illness. The purpose of this service is to enable the most efficient use of expensive and pressurised paediatric critical care beds, to deliver care to patients in the most appropriate surroundings, and as close to home as possible.

This new service provides outreach advice and training to East Midlands hospitals in the initial care and stabilisation of acutely ill children, recognising that this improves outcomes and may reduce the need for intensive care admission. This service will be provided in line with NHS England Standards and recognised best practice.

Building on our relationships with GPs

We continue to work closely with colleagues in general practice and Clinical Commissioning Groups (CCGs) strengthening our working relationships and communication links, currently focusing particularly on the transfer of patient care between the Hospitals and GPs. Our GP Services Team act as a conduit to facilitate dialogue and provide representation on interface matters.

A monthly newsletter is produced to update primary care on developments within the Trust; we offer clinical input from Consultants and other professionals at CCG events for primary care staff and we also maintain a website for healthcare professionals to easily access key information.

As part of our on-going engagement we carried out an annual survey of Primary Care staff which achieved a significant increase in overall responses from 2015 and also in GP satisfaction with the Trust as a provider of healthcare. The survey feedback is used to shape our strategy and priorities to further improve our services.

Clinical conversations between GPs and Consultants are being supported through “Consultant Connect” – an acute and immediate telephone access tool and the significant expansion of the NHS e-Referral Service Advice and Guidance facility which enables electronic, written advice from the Consultant Teams.

Armed Forces Engagement

In November 2015 we signed the Armed Forces Covenant and we have continued to develop our relationship with defence units in the area. We are acutely aware that over 5,000 service personnel and their families have recently moved into our area, following the drawdown from Germany, and our services are vitally important to them.

We have agreed honorary contracts for the placement of military personnel within our organisation for training purposes and we have publicly supported our reservists through our internal channels and on social media. We have also supported staff from the Defence and National Rehabilitation Centre regarding their impending move to Stanford Hall, near Loughborough; in order to help their integration with local services.

There have been a number of defence engagement events, over the past year, perhaps most noteworthy were a Trust Board thinking day' at St George's Barracks, North Luffenham in July 2016; courtesy of 2 Medical Regiment; a Nursing Sister from our Emergency Department deployed to Kenya with 2 Medical Regiment as part an employer engagement scheme in August 2016; and our procurement and logistics team attended two, one day training events with 158 Regiment, Royal Logistics Corps, in February and March 2017.

Enhanced delivery in research, innovation and clinical education

Our priorities for the year were to:

- Deliver a successful bid for a Biomedical Research Centre
- Support the development of the Genomic Medical Centre and Precision Medicine Institute
- Develop and exploit the OptiMeD project, scaling this up across the Trust
- Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum
- Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities
- Launch the Leicester Academy for the Study of Ageing (LASA)

Success in Major Bids for Research Infrastructure (including delivering a successful bid for a Biomedical Research Centre)

This has been a busy year in terms of applying for funding to support our research activities. We have recently found that for the first time Leicester has been designated as an NIHR Biomedical Research Centre to support key research in our excellent areas of cardiovascular medicine, respiratory medicine and lifestyle. Also we have for the first time been successfully awarded an NIHR Clinical Research Facility. This will allow us to provide more opportunities for patients to enter early phase clinical trials in multiple speciality areas of the Trust not least in our acute admissions unit and our new emergency department.

We have been successful in our rebid to remain an Experimental Cancer Medicine Centre. This will support the continued clinical research activity of our HOPE clinical trials facility thus offering important opportunities for cancer patients to enter clinical trials.

Furthermore we have also refurbished our clinical research area at the Royal Infirmary to become a joint adult and children's "Research Space".

Support the development of the Genomic Medical Centre and Precision Medicine Institute

This major national project is now in full swing at UHL. The 100,000 genome project team led by Professor Nigel Brunskill have acted as a focus for the enthusiasm of colleagues in multiple specialties to recruit patients with both rare diseases and cancer into this important project in the anticipation that genomics will in the future be fully embedded in routine patient care.

Support the development of the Precision Medicine Institute

A series of regular senior strategy meetings with the University of Leicester have led to the establishment of the Leicester Precision Medicine Institute. This joint enterprise between the University of Leicester and us will ensure that cutting edge research and research findings are directly applied to treatment of individual patients. At the same time more new honorary academic titles for consultants have been given to our consultants by the University of Leicester and a number of academic champions are now embedded within clinical speciality areas to provide a focus for research, education and training excellence.

Develop and exploit the OptiMeD project, scaling this up across the Trust

After the successful conclusion of the pilot on the renal wards at the General Hospital, a business case was taken through our governance committees in year. This has been agreed pending approval from local commissioners, NHS England and sign off by NHS Improvement. We are currently in discussions with these key stakeholders to agree a way forward.

In the next few months we plan to conclude the discussions with stakeholders, we will then begin a two to three year roll out plan. This plan will be integrated within our plans for an Electronic Patient Record as there are a number of co-dependencies and benefits in this.

We will also be continuing to work in year with the East Midlands Academic Health Sciences Network to explore a wider application of the medicines management solution to other East Midlands hospitals, and potentially wider.

Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum:

Postgraduate Medical Education

We were visited by the General Medical Council on 25th October 2016 as part of their East Midlands regional review to assess the quality of undergraduate and postgraduate medical training.

The visiting team identified exceptional and innovative education work in our organisation (highest level of approval as Area of Good Practice):

> *"The Trust is clearly committed to education and training with defined, transparent educational governance systems and structures in place as well as a strong educational team. The Trust displays clear accountability for educational governance at a trust board and directorate level which includes the engagement of the lead Non-Executive director for education and patient partners to improve the quality of education*."

The GMC also identified several additional areas of good practice "Areas that are working well":

> *"The Trust demonstrates a culture that enables doctors in training to learn from mistakes and reflect on incidents/ near misses."*
>
> *"A good, reliable system in place using coloured lanyards to identify the doctors in training at different stages of education and training which helps staff understand their level of capability and competency."*
>
> *"The clinical experience week where doctors in training, particularly core doctors in medical training attend clinics all week works well. This shows the Trust's commitment to education and enables doctors in training to meet the requirements of their curriculum."*
>
> *"The clinical skills unit with high quality simulation facilitators ensures that students and doctors in training get the opportunity to develop their clinical, medical and practical skills through technology enhanced facilities. The team leading the unit were particularly valued by the learners we met."*

There were also areas for improvement identified which we are taking forwards as part of our Education Quality Improvement Plan (departmental induction for on call doctors, password sharing, poor workspace for trainees, some examples of undermining behaviours, need to improve, structure in the delivery of undergraduate education)

Following a Trust Board Away Day September 2016 an educational quality improvement plan was to focus on continuing to improve the quality of the learning experience for our undergraduate and postgraduate medical trainees.

Trust Grade Doctors: we continue to offer doctors in non-training grade posts access to educational supervisors, an e-portfolio and a programme of seminars to support them in their role

EXEL@UHL: this is a reconfiguration project to provide multi-professional educational facilities to create the highest quality built environment to provide excellent education and development facilities for our entire workforce. This will drive the delivery of outstanding patient care, improve the working lives of our staff and support the recruitment, development and retention of staff across all professions.

Undergraduate Medical Education

This year has seen the development of several key initiatives to continue to provide excellent undergraduate education in Leicester and to encourage more of our local graduates to stay and work in the local healthcare economy.

Working with Leicester University a number of our consultants have been awarded Honorary University titles in recognition of their work in education and training

As part of the new Leicester Medical School Curriculum new students were placed with us for Very Early Clinical Experience placements (VECE) which were very successful thanks to commitment of our staff.

The Medical School wrote to thank us for providing the first year students with a valuable experience and reported that feedback received from the students was overwhelmingly positive.

We have also introduced a student mentorship programme which has been well-received.

Other developments include the appointment of three innovative posts: two new Teaching Fellow posts to teach junior students clinical examination skills, and an Education Quality Improvement Fellow working to improve quality of feedback given to students placed in our organisation

Physician Associate Students: We are working with De Montfort University to provide a postgraduate course for Physicians Associates.

This emerging workforce will support doctors in the delivery of safe high quality patient care and the education and training of trainees and medical students. We look forward to receiving students from September 2017 in our organisation.

Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities:

Our Trust Board considered a number of options regarding commercial developments in 2016/17 which include the creation of a wholly owned subsidiary company to operate certain aspects of our pharmacy services.

Launch the Leicester Academy for the Study of Ageing (LASA)

The care of older people is already a major issue for the county, with existing services not geared up to cope with the multiple problems inherent in an ageing population. Leicester Academy for the Study of Ageing (LASA) aims to address the challenge and improve outcomes for older people as well as those who care for them with its holistic, multi-disciplinary approach.

Initially, LASA aims to bring together a community of experts from across all disciplines. Longer term, they want to generate research that can be translated into practice, with all work person – or patient – centred.

The year started with a launch event in April and Jayne Brown, Professor of Nursing (older people) at De Montfort University, and Simon Conroy, Geriatrician, University Hospitals of Leicester and Honorary Professor, University of Leicester were appointed as directors of LASA. A number of other posts are in development, including two professorships in Older Peoples' Health and Integrated Care; Non-Medical clinical academic posts in development (with Leicestershire Partnership NHS Trust); two PhD international students (nursing) all at De Montfort University. There were also two academic clinical fellow post appointed to the University of Leicester to start late in 2017 and up to five others being submitted for 2018.

There was also another event in October 2016 with Age UK, in which additional members of the PPI forum were identified and encouraged to participate in LASA activities.

Four projects have been supported though the consultation forums and a number of research applications submitted. These were:

1. Coping together with the challenges of managing heart failure: can mindfulness help older patients and family carers;
2. An evaluation of the Acute Frailty Network;
3. Development of a Patient Reported outcome Measure for Older People with frailty and urgent care needs; and
4. Urinary tract infections and anti-microbial resistance.

In 2017/18 the plans for LASA to develop further consist of:

1. hosting up to six events at either De Montfort University or the University of Leicester**;**
2. beginning a seminar series, where LASA forum members present recent research or collaborations to academics/clinicians based in Leicester;
3. continuing to apply for funding for MSc and PhD research students;

4. developing Academic Clinical Fellowships that contribute to the on-going success of LASA;
5. implementing an evaluation of the Frail Hospital Intervention.

Develop Relationship with Academic Partners

Collaborative working is essential to obtain maximum quality and value from clinical research activity. We have had regular strategic meetings with colleagues from our academic partners at the University of Leicester, Loughborough University and De Montfort University.

Comply with Key NIHR and CRN Metrics

Currently we remain the highest recruiting Trust in the East Midlands having recruited more than 13,000 patients into national portfolio studies in the last twelve months. Indeed we are the sixth highest recruiting Trust in the whole of England.

A caring, professional and engaged workforce

Our priorities for the year were to:

- Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability
- Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development
- Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders
- Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture
- Developing a more inclusive and diverse workforce to better represent the communities we serve and to provide services that meet the needs of all patients

Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability

A number of new roles have been developed and are supported both within the Trust, but also with key partners in the local health and social care economy.

We have also worked with partners to develop a Leicester, Leicestershire and Rutland wide staff attraction and retention strategy, whole system workforce plans and with clinical leaders, an approach for the leadership of change.

Through the newly established Workforce and Organisational Development Board we are focused on a more integrated approach to workforce and will publish a new People Strategy during 2017/18. The following sections outline some of the achievements during the year.

Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development

We launched the UHL Way in January 2016. IT is the way we manage change in a consistent and sustainable way, but also in a way that engages and empowers the staff involved in, and affected by that change.

The UHL Way is about embedding a culture of continuous improvement across the Trust which in turn improves the quality of care we provide to patients, reduces harm, increases efficiency and effectiveness and supports cost reduction. Over 2016/17, key benefits/ measures of improvement have been set out within individual programmes and overall improvement to staff experience is monitored at quarterly intervals through the Pulse Check and on an annual basis through the National Staff Survey.

The three components to the UHL Way are:

1. Better Engagement: Continuing Listening into Action and completing Year 4 of Implementation
2. Better Teams: Targeted improvement and development
3. Better Change: Adopting the best in change and improvement methodology

These components are supported by the UHL Academy

Better Engagement/ Listening into Action – Classic LiA continues to support Pioneering Teams across the Trust to make changes that benefit our patients and staff and 2016/17 has seen 24 teams using this classic

approach. Nursing into Action saw the last set of wards and departments celebrate their success with improvements such as:

- Nurse led follow up clinics
- Breakfast for parents
- Extended day case ward with side rooms
- Improved single sex compliance and better toilet facilities for patients
- A new pathway for patients in the DVT service

Work also continues with Medics into Action, helping improve support and development for our doctors from students to Heads of Service.

Better Teams

Better team working is important to us as the relationship staff have with their team can make a real difference to their experience at work, and the care patients' experience.

It is important to examine and address staff engagement at a team level as engagement can help staff to develop strong positive feelings and attitudes towards their work and the team. This can really help them to give their best, even when times get tough.

Our first cohort have completed the Better Teams programme and been supported to improve and sustain team working, with guidance and support at each step of the way.

Better Change

Better Change is our improvement methodology and consists of an online toolkit, with supporting guidance and case studies to ensure that both small and large scale change is led and supported in an optimal way.

The Better Change toolkit is based on the national NHS change methodology and has been developed in consultation with both internal and external stakeholders. We are currently working with a number of Exemplar Teams in testing the Better Change approach and toolkit.

UHL Academy

Our Academy is designed to provide learning that will equip leaders with the essential skills and behaviours required to engage with, lead and develop their teams. The programmes and modules align with the core values and tools and are designed to support talent management and succession planning processes. Our first cohort started on our new UHL Way Leadership Development Programme in February 2017.

The Academy is designed to evolve with the needs of our organisation and the wider Leicestershire, Leicester and Rutland system with programmes and modules introduced and flexed to meet the requirements of all learners as they progress through their leadership journey.

Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders

Internally a new Workforce Board will oversee delivery of an integrated People Strategy which will draw together work on education, training, career development, new role development, recruitment and retention and workforce efficiency under a single umbrella to ensure our workforce model supports an overall sustainable workforce plan for Leicester, Leicestershire and Rutland.

In response to recruitment challenges for the trainee medical workforce and the strategy to create new teams around the patient, we have introduced the Physician Associate (PA) role. Four PAs joined us in June 2016 and are proactively promoting the role across both our organisation and the wider East Midlands. This role has made a positive contribution in the respective clinical areas and enabled a level of continuity of care which is benefitting patients. A new PA postgraduate qualification delivered through De Montfort University has been accredited to commence in September 2017. We have supported this development with our existing PAs acting in an ambassadorial capacity. Together with others partners in Leicester, Leicestershire and Rutland, we will support clinical placements. In addition six students from University of Worcester will start placements.

On a Leicester, Leicestershire and Rutland wide basis, we have hosted the clinical lead for Advanced Nurse Practitioners. This ensures a consistent approach to education, training and governance to ensure a

consistency of role across all organisations. To date we have 29 trainees on programme and seven trainees completed in 2016/17 academic year. There are 30 ACPs currently in post. These roles have been identified as critical for local workforce transformation as they provide continuity of high quality clinical care for patients and support the supply gap for medical trainees.

Across the nursing profession, assistant practitioners have been introduced with 41 trainees doing the programme and three having reached completion.

We are part of the Leicestershire Nursing Associate pilot in conjunction with the East Midlands Collaborative and have 50 trainee Nursing Associates working across the whole of the local healthcare community. They are receiving their training at the newly opened 'Centre for Clinical Practice and the Leicestershire School of Nursing Associates' based at Glenfield Hospital and are the only pilot group whose programme is being developed and led by the provider organisations with support from the university.

Nursing have also recruited eight staff with dual registration in both mental health and learning disabilities which provides enhanced patient experience for adult mental health patients and children with such conditions as autism.

The Clinical Coding Team has a long history of under-staffing due to a national shortage of Clinical Coders, with agency coders have been used to make the workload manageable. A funded Coding Strategy was developed in 2016 to plan a team that will become fully resourced and sustainable within three years, and we successfully recruited trainee coders during 2015 and 2016.

Training new coders is a lengthy and resource-intensive process, so the recruitment of ready-trained staff is attempted on a rolling quarterly basis as well. From April 2017 there are two coding trainers in post to provide a structured training programme to support our rolling intake of trainees and to ensure all coders are achieve high coding standards.

Deliver the recommendations of "Freedom to Speak Up" review to further promote a more open and honest reporting culture

In February 2015, Sir Robert Francis published his report 'Freedom to Speak Up' which looked at the culture within the NHS and the confidence of patients, relatives and staff to raise concerns about safety and quality. The review provided independent advice and recommendations to ensure that:

- NHS workers can raise concerns in the public interest with confidence that they will not suffer detriment as a result.
- appropriate action is taken when concerns are raised by NHS workers,
- Where NHS whistleblowers are mistreated, those mistreating them will be held to account.

Since July 2010, we have had a dedicated 'Staff Concerns Reporting Line' (3636). The table below shows the last 3 years of concerns raised through the 'Staff Concerns Reporting Line'.

Number of 3636 Staff concerns received by financial quarter 2014/15 to 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2014/15 Number of concerns received	5	5	5	5	**20**
2015/16 Number of concerns received	3	4	9	7	**23**
2016/17 Number of concerns received	6	15	6	2	**29**

Jo Dawson has been appointed as the newly appointed Freedom to Speak Up Guardian to help raise the profile on how to raise concerns. Jo will work alongside our leadership teams, to support the organisation to review and adapt their processes on how staff raise concerns, and ensure we are a more open and transparent place to work.

We greatly encourage staff to raise concerns around safety and with these adaptions to processes and review on how staff raise concerns we should see significant increase in the figures.

Developing a more inclusive and diverse workforce to better represent the communities we serve and to provide services that meet the needs of all patients

We use the Equality Delivery System (EDS) as our equality delivery framework. The four domains are:

- better health outcomes
- improved patient access and experience
- a representative and supportive workforce
- inclusive leadership

In February 2016 our Trust Board agreed a 'Leading Diversity Action Plan' reflecting best practice (based on research conducted) and staff feedback (using a range of methods). The action plan incorporates five key areas for improvement:

- Strengthen local accountability by developing Clinical Management Group diversity metrics;
- Better align diversity with the our 5-Year Plan;
- To implement Positive Action Interventions (as part of our Recruitment and Retention Strategy);
- Strengthen partnership working across the system around the Diversity Agenda; and
- Develop some targeted talent management strategies for under - represented groups.

We have made good progress against implementing the Leading Diversity Action Plan over 2016/17. In April 2016 the first BME leadership data was reported by Clinical Management Group (CMG) – this level of breakdown was not provided previously. From the data, key thresholds were developed in August 2016 and improvement is monitored at monthly intervals via our Chief Executive Briefings.

Four executive leads (including Board representation) have agreed to act as "mentees" for our BME mentors. This high profile engagement by the senior team adds credibility to this approach and endorses the commitment the Trust want to make to promote career progression for BME staff. Our mentors have been recruited for the programme and with the new reverse mentoring programme commencing in January 2017.

Yvonne Coghill, NHS England Joint Director for Workforce Race Equality Standard (WRES), approached us in November 2016 to work with the Institute of Health Improvement (IHI) and its fellows to use the Quality Improvement Methodology (QIM) to close the gaps in the work place experience of BME and white staff. NHS England would like to study the role of improvement science methodology in assisting the rollout of WRES across the NHS with initial testing restricted to Barts, Royal Free, Sheffield, Leicester and the East London Foundation Trust.

A Trust Board Thinking Day took place on 12 January 2017 facilitated by Roger Kline, NHS England Joint Director of Workforce Race Equality Standard. Essentially in reflecting best practice we will continue to strengthen accountability particularly in areas related to recruitment, focus on inclusive leadership (aligned to the Trust's UHL Way Implementation Plan) and work on the narrative in winning hearts and minds.

Through the Local Workforce Action Board we have developed a comprehensive workforce strategy to support the STP for Leicester, Leicestershire and Rutland. This is supported by six workforce enabling groups which cover strategic workforce planning, capability, organisational development, attraction, staff mobility and Primary Care. The aim is to create an overall Leicester, Leicestershire and Rutland plan for the health and social care workforce. For each of our clinical work streams in the STP, new models of care are being developed which will require new ways of working and people to work across organisational boundaries. Work has been carried out to streamline a number of policies to make this easier and review contracts of employment. As we define new ways of working, each work stream reviews the implications for education and training and employment contracts. This work is supported by a comprehensive organisational development plan looking at induction and leadership across systems to facilitate cross.

Our staff

This chart shows the number of whole time equivalent (wte) staff employed by our organisation:

	2016/17	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11	2009/10
Medical and Dental	1,753	1,680	1,645	1,570	1,551	1,496	1,477	1,496
Administration and Estates	3,806	2,500	2,383	2,095	2,066	2,417	2,534	2,624
Healthcare Assistants and other support staff	2,224	2,042	2,044	1,955	1,811	1,710	1,781	1,882
Registered Nursing and Midwifery	3,548	3,547	3,531	3,345	3,230	3,195	3,168	3,091
Scientific, Therapeutic and Technical	1,378	1,306	1,272	1,201	1,202	1,210	1,210	1,328
TOTAL	**12,709**	**11,075**	**10,874**	**10,167**	**9,860**	**10,029**	**10,171**	**10,421**

Admin and estates includes 1237 wte Facilities Services staff formerly employed by Interserve

Recruiting more nursing staff

We have a dedicated nursing recruitment team to ensure a proactive and rapid response to demand. They monitor vacancies on a monthly basis, and report them to Nursing Executive, share with our commissioners, and report to our Trust Board.

A successful EU recruitment programme has been in place since 2013, with successful recruitment and retention of 300 EU nurses.

However we still have a shortfall in our registered nurse numbers. To address this shortfall we have successfully done some overseas recruitment from India and the Philippines. 200+wte registered nursing staff have been interviewed, and offered positions; however the process of achieving compliance with the NMC to carry out their adaptation programme is extremely slow, therefore the first large cohort of staff to start their adaptation programme are anticipated to arrive June 2017, with a smaller cohort arriving in April 2018.

We are working with Health Education East Midlands (HEEM), to support staff across East Midlands, to return to nursing, or from nursing homes.

Bulk recruitment campaigns have been in place for some years, they involve a collaborative approach to the advertising of and recruitment to nursing posts across the Trust. We are represented at all RCN Jobs Fairs across the country to ensure we are 'on the map' and promote Leicester's as a place to work and live.

Recruitment of newly qualified nurses continues bi-annually, and we remain the main source of employment for De Montfort University (DMU) nursing students. This recruitment process is open to all newly qualified staff from across the country.

Intense focus has been placed on the recruitment processes of newly qualified nurses and we have successfully broadened the recruitment to include Mental Health and Learning Disability nurses, to ensure they can look after the frail, older patient profile on our wards. The Childrens and Midwifery graduate programme has been increased, and we have nurses and midwives graduating bi-annually (previously only annually).

Local employability events in collaboration with DMU are extremely successful and the recruitment timeline for the student nurses has been accelerated, which means we can offer of permanent employment at an earlier stage to the successful graduate. 90 per cent of all students who qualify are retained across Leicestershire, with the majority accepting positions within our organisation.

A creative, innovative, and pioneering recruitment plan to address the vacancies across the Health Care Assistant (HCA) workforce is in place and has been extremely well evaluated. We have held open days followed by recruitment events and interviewing people on the same day to speed up the process, which has been extremely successful.

HCA (clinical) apprentices have been in progress for the past 24 months across the nursing workforce. Once these staff have successfully completed their one year apprenticeship they feed into the HCA recruitment process for substantive HCA posts.

51 trainees from across Leicestershire started the Nursing Associate Pilot Programme in January 2017; this includes 9 trainees for children's services. These trainee Nursing Associates are a diverse group of learners who have extensive clinical experience across all healthcare sectors.

With the role of the Nursing Associate, the Registered Nurse (RN) retains responsibility as the primary assessor, planner and evaluator of patient care; however the Nursing Associate will understand medicines management and will administer medicines safely.

The Nursing Associate role is different to the Assistant Practitioner role. We have continued to recruit to Assistant Practitioner trainee posts but have informed all trainees of the Nursing Associate role and the future opportunity to be 'mapped' over to the new role once all education and training standards have been agreed for Nursing Associates. It may be that we have a mix of both roles or they might prefer to have one role. For example, Nursing Associates maybe the roles involved in direct patient care and the Assistant Practitioner role will be aligned to theatres or laboratories.

National NHS staff survey

The fourteenth National Staff Survey was carried out between September and December 2016. The survey is conducted on behalf of NHS England and the results form a key part of the Care Quality Commission's assessment of NHS Trusts in respect of its regulatory activities such as registration, the monitoring of on-going compliance and reviews.

The survey closed on 2 December with 443 returns, giving a response rate of 36.2 per cent, an increase of 11.2 per cent from the previous year.

In addition to the national staff survey we carry out an independent Pulse Check survey on 25 per cent of all of our staff each quarter. The Pulse Check is carried out by Wrightington, Wigan and Leigh who developed the Pulse Check as a result of extensive research into the drivers of staff engagement. Together these surveys indicate not only measures of engagement but also factors which drive engagement.

The results of the National Staff Survey were generally an improvement on the previous surveys:

		2013	2014	2015	2016	Average (median) for acute trusts
Q21a	"Care of patients / service users is my organisation's top priority"	65%	64%	72%	74%	76%
Q21b	"My organisation acts on concerns raised by patients/service users"	64%	67%	75%	74%	74%
Q21c	"I would recommend my organisation as a place to work"	50%	51%	60%	60%	62%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	57%	56%	64%	65%	70%
KF1	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.53	3.49	3.68	3.74	3.77

Experiments in autonomy, incentivisation and shared governance

We launched our new Autonomous Teams Pilot Programme in February 2016. The aim of the pilot was to explore whether allowing an Autonomous Team to operate with significant decision-making powers and freedoms (as defined within the Terms of Reference) could provide the potential benefits of improved staff engagement and patient experiences and outcomes.

Our pilot programme is based within our Orthopaedics Service for the purpose of operating our Elective Orthopaedics, Trauma and Theatres Team. We have established our Trauma, Orthopaedics and Theatres Leadership Board with membership supported by front-line staff.

Improvements will come from an active involvement of staff in decision-making and therefore having more control over their affairs; creating a virtual sense of ownership.

The next stage will see us supporting the Leadership Team by aligning activity to the UHL Way to ensure that that the team is appropriately equipped to manage change in a consistent and sustainable way, but also in a way that engages and empowers the staff involved in, and affected by that change.

Reducing staff absence

We continue to utilise our in–house '***SMART Absence***' tool which facilitates reporting of absences and ensures structured Return to Work discussions are held.

The system supports managers to take specific actions and also provides on-line guidance from Occupational Health for specific areas and ensures a standard approach is taken with managing sickness absence and supports the reduction of sickness absence rates.

Learning and development

Ensuring all of our staff have access to the right skills and knowledge is crucial if we are to deliver Caring at its Best.

We, through our Learning and Organisational Development Team, are committed to providing learning and development opportunities to all staff. We offer a wide range of courses and by working together with local colleges and private training providers and have in place a robust process for monitoring performance.

We are delighted to retain the National Skills Academy Quality Mark for 'superior' delivery of education and training to the health sector. Retaining this quality benchmark demonstrates our passion and enthusiasm for learning excellence and 'making a difference' across our organisation and the wider health community. This also recognises that we have been innovative in the way we put together our learning programmes and we have sought to reflect that our programmes really do focus on what we, and the NHS needs.

As a training provider and in addition to our own robust monitoring of training provision, we welcome partner organisations to monitor training delivery, including South Leicester College, MATRIX, our local Workforce Development Team, City & Guilds, Pearsons and the National Skills Academy for Health.

Through an annual grant from Health Education East Midlands in 2016/17 we invested £191,700 in learning and development to support employees in Agenda for Change pay bands 1-4 (support staff). It was used to fund appropriate learning and development needs identified through the appraisal process and enabled employees to the gain skills and qualifications that will meet both the needs of the organisation to improve patient care and the delivery of services.

We are responsible for the delivery of Statutory and Mandatory Training. Staff compliance levels have ranged from 73 per cent to 97 per cent across ten core programmes during 2016/17 with action plans in place to sustain/ improve performance against all core programmes. This continues to be supported by training provision and the provision of e-learning programmes aligned to the national Core Skills Training Framework (Skills for Health).

Apprenticeships

We took up the mandate to increase the offer of apprenticeships during 2016/17 we currently have 129 learners following apprenticeship foundation programmes. We have also started 43 intermediate, advanced and higher apprenticeships, some were new recruits and some were existing staff developing new skills in a range of areas. Our new recruits joined our organisation in roles such as Health Care Assistants, Maternity Care Assistants, Physiotherapy Assistants, Pharmacy Assistants, a Communication Administrator, Medical Records Assistants, Clinic Coordinators and Ward Clerks. We have 41 doing the two year Level 5 Assistant

Practitioner Diploma. During 2016/17 38 of our 2015/16 cohort completed their apprenticeships and many have progressed to substantive posts within the Trust.

During 2016/17 we became the provider of choice across the East Midlands, working in partnership with Leicester Partnership Trust to deliver their Apprenticeship and Princes Trust Programmes. We are proud to be the regional provider for the new Public Health England screening qualifications and the national provider for the Level 5 Assistant Practitioner Diploma (Bowel screening).

We anticipate the offer of Apprenticeships will continue to grow aligned to the introduction of the Apprenticeship Levy from 1st April 2017.

Work experience

We currently offer work experience for varying durations for Year 12 and 13 students, degree graduates on clinical programmes and those doing health and social care related courses. In 2016/17 we supported 249 placements, 41 Nursing and Midwifery, 54 Radiography and Theatres, 65 in Physiotherapy and 89 Medical observation sessions in all departments across all three of our hospital sites.

Celebrating achievements

Our annual training awards ceremony allows us to celebrate staff achievements in learning and development. At our annual event in July 2016, 136 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.

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.

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.

Our 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 Steve Amos of Royal Voluntary Service, Rory Palmer Deputy Mayor, Tony Donovan Executive Director of Age UK Leicester Shire & Rutland, David Henson of Healthwatch Leicester, Nicola Junkin and David Morgan Well-being at Work, Nicky Morgan MP, Loughborough, Dr Neluka Weerasooiya of Renal Services UK, Rebecca Evans of Kimal Renal Care, George Oliver Leicester Mercury Editor, Simon Cole Chief Constable, of Leicestershire Police, Jim Davis and Jo Hayward from BBC Radio Leicester, Robert Mason of Asteral, Dr Azhar Farooqi Chair of Leicester City Clinical Commissioning Groups who chose overall “winners” who were presented with a certificate and trophy.

At the annual ceremony we also present an award for our ‘Volunteer of the Year’ in thanks for the support and commitment they give to our organisation.

During November 2016 we launched our new 'Above and Beyond' informal recognition scheme.

Since launch 558 staff have been identified (by staff at all levels from across the Trust) to have gone 'above and beyond' and deserve a special thank you in the form of a badge and card.

Attracting and retaining staff – our benefits scheme

In addition to reward and recognition schemes which enhance staff experience and sense of value, we have responded to themes identified in our exit surveys and pulse check surveys. An overriding theme of health and well-being and work life balance has emerged and in response we launched a Health and Well-being Strategy in January 2017 to promote well-being at work.

The vast majority of our staff are on national NHS pay, terms and conditions which include a comprehensive set of employment policies and procedures. We operate two pension schemes, the NHS Pension Scheme ('**NHSPS**') and the National Employment Savings Trust ('**NEST**') with the vast majority of staff being members.

Our range of six Salary Exchange schemes continue to very popular, including for attracting and retaining staff with over 6,000 staff participating in one or more schemes. Our '***Salary Maxing***' Car Scheme continues to be very popular with staff, as do our cycles and IT schemes. Our unique on-line '***Employee benefits Portal***' continues to develop and facilitate ease of access to our offerings.

NHS Total Reward Statement ('***TRS***') continue to be popular and have been further enhanced with staff viewing a personalised summary of their employment detailing their full employment package throughout the year including basic pay, allowances, Salary Exchange schemes and pension benefits *(for NHS Pension Scheme members only.*

Occupational Health Support

The Occupational Health Service continues to be an integral part of our organisation with 50 per cent of staff having clinical contact with the service each year.

We continue to provide occupational health services across the healthcare community including healthcare students at Leicester and De Montfort Universities.

This year we had our highest uptake of the flu vaccine with 76 per cent of frontline staff having the vaccination. We used peer vaccinators to reach more staff and this enabled us to achieve the CQUIN. The Occupational Health team won the national Flu Fighter award for November for their work with peer vaccinators and have collaborated with the Microbiology medical staff in a research paper for presentation at in international conference in April.

Specialist Registrars in Occupational Health medicine continue to be trained in our vservice. Dr Kaul has been appointed National Training Programme Director for the UK.

Health and Safety

Critical work this year involved the safety challenges around the building and commissioning of the new Emergency Department at the Royal Infirmary as well as other projects around our hospitals.

The overall picture for Health and Safety related issues from the Care Quality Commission report was positive. The work the Team has done on anti-ligature points, window safety and the Safer Sharps initiative has positively impacted on promotion of a safer environment throughout our organisation.

For the seventh year running there has been a reduction of RIDDOR reportable injuries (the most serious category of reported injury).

We have also been able to strengthen the team this year by recruiting an experienced Health and Safety Manager.

Manual Handling

We are pleased that all references to the Practice of Safer Handling in the Care Quality Commission report were very positive. With particular reference to availability of equipment, training and Bariatric arrangements, the report detailed that all actions were in place and suitable.

The rise in bariatric admissions has continued this year and the Manual Handling Advisors have provided expert help, advice, support and equipment to meet the needs of both patient and staff. In last year's report, the process for supply and delivery of specialist bariatric equipment was reported and this has produced;

1) A time efficient delivery of bespoke equipment that reflects the best in bariatric products available.
2) Cost savings of £90,000 for 2016/17 (against the original forecast of £60,000)

Investment has been made in specialist moving equipment for the 250Kgs plus patient. This has greatly aided the care of patients and been a significant factor in promoting safer handling safety for staff.

Manual Handling Advisors, Andrew Lewitt and Paul Ayrton have been recognised for their expertise in this area by authoring a chapter for a specialist text book for Surgeons and Anaesthetists on Bariatric Surgery (Publication date: August 2017)

Security Management

The security agenda has been enhanced by the addition of a Physical Skills trainer. This supports not only training but has allowed the addition of a second Local Security Management Specialist to the team further enforcing management of security issues**.**

We have created a bespoke security management training facility on our premises which allows us to carry out a wide range of security courses for our staff. Feedback from staff attending these courses has been overwhelmingly positive and has led to improved outcomes in conflict situations when they occur.

The team continues to exercise powers of sanction against members of the public due to behaviour issues as part of their commitment to maintaining a safe and secure environment for staff and patients. The partnership between ourselves and Leicestershire Police continues to thrive which has led to the implementation of crime reducing initiatives throughout the organisation.

The Local Security Action Management Plan for NHS Protect standards has been submitted showing steady progress since last year.

This year saw the biggest fall in reported assaults against staff. We compare favourably when benchmarked against the other 152 Acute Trusts. Figures this year show that 10 physical assaults per 1000 members of staff were reported. This puts us in the top 15 per cent of the fewest reported assaults in all acute organisations across England and fourth against Trusts that employ more than 10,000 staff. The actual figure is 5 per 1,000 staff fewer than last year indicating that assaults have fallen by 33 per cent.

Risk management

Effective risk management awareness and practice at all levels is an integral success factor for our organisation. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach as risk is inherent in everything we do. The success of our services requires us to identify risks and ensure that these are adequately managed so that we can achieve our objectives and immediate priorities.

We have a risk management policy is in place to provide a framework with responsibility for the management of all types of enterprise risks. These risks are assessed and reported on our Risk Register, subsequently providing a dynamic risk profile to aid with decision-making.

During 2015/16 we introduced a strengthened risk reporting process to provide greater accountability for risk and to ensure a clear line of sight for reporting risks from 'ward to board'. Increased emphasis continues to ensure that risk treatment plans are regularly reviewed to confirm actions are completed within their specified timeframe. These reviews are performed by local management boards and also at an executive

level; 'Closing the loop' on these actions has brought about a reduction in the number of long-term risks recorded on our Risk Register.

Our internal auditors carried out a review of risk and governance arrangements in place during 2016/17, focusing on how effectively risk management is operating at Clinical Management Group (CMG) level. Their report identified a medium risk to the Trust in terms of control design and operating effectiveness. Actions to address the suggested recommendations will be carried out during 2017/18.

During the year a number of principal risks were identified that may have had the potential to adversely affect the achievement of our strategic objectives and immediate priorities. These have been captured in the Board Assurance Framework (BAF) which provides a level of assurance, using internal and external sources of evidence, to monitor the achievement of our strategic objectives and immediate priorities. Significant areas of concern recorded on the BAF include:

- Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity;
- The demand/capacity gap if unresolved may cause a failure to achieve our deficit control total in 2016/17;
- Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.

Risk Management - Looking ahead to 2017/18:

- Work with CMG leadership teams and the Executive Team to provide specialised support and guidance to help embed enterprise risk management and comply with the recommendations in the CQC report and Internal Audit reviews which took place in 2016/17;
- Review and simplify our risk assessment evaluation framework to ensure it is 'fit for purpose' and continues to reflect best practice;
- Following the completion of training needs analysis, improve risk culture in the Trust by delivering our risk awareness training programme to CMGs;
- Develop a risk assessment toolkit on our internal risk web pages, for all our staff, to improve documentation of risk descriptions, control measures, and treatment plans;
- Explore the feasibility of using a web-based risk register tool to record and report risks;
- Strengthen our arrangements for the identification of 'emerging risks' at all levels in the organisation.

Medical Device Safety Officer - Review of 2016/17:

The Medicines and Healthcare products Regulatory Agency (MHRA), NHS England and NHS Improvement have formed a strategic partnership to develop safety alert broadcasts and guidance to improve the reporting of, and learning from, medical device related incidents and near misses.

A number of local actions have been taken to support compliance with the national framework, including:

- Implementing the role of Medical Device Safety Officer (MDSO);
- Supporting the role of the MDSO through board-level responsibility for medical device safety and governance; and
- Implementing a multidisciplinary medical devices operational group.

Work programmes across the organisation continue to improve data quality in relation to medical device incident reports, subsequently enabling more effective data analysis to provide early indications of prevalent incident trends.

Medical Device Safety Officer - Looking ahead to 2017/18:

- MDSO to carry out a monthly confirm and challenge review of all medical device incidents and near misses reported on Datix;
- Strengthen our governance processes for managing medical device safety notices and alert broadcasts and for escalating recommendations to executive level for appropriate decision making;
- MDSO operational group to develop an audit programme to review ward and department processes for managing medical devices and reporting incidents and near misses.

Central Alerting System - Review of 2016/17:

National patient safety alerts, MHRA medical device alerts, important public health messages and other critical safety information and guidance are issued via the national Central Alerting System (CAS). This is a web-based system that provides a mechanism for healthcare organisations to confirm that actions to comply with national alerts have been taken within specified timescales. We consistently achieve a high level of compliance with deadlines and from 1st January 2016 to 31st December 2016 we received a total of 118 alerts, with only one deadline for compliance breached, which equates to 99 per cent of alerts received being acted upon within their specified due date.

During the year the corporate risk management team carried out an internal review of processes for managing safety alert broadcasts at CMG level. Findings from the review support that robust and effective methods are in place to manage compliance with actions at management and operational level. A small number of recommendations, to strengthen the level of assurance, have been identified and will be applied during 2017/18.

Central Alerting System – Looking ahead to 2017/18:

- Work with CMGs to improve resilience and record keeping processes;
- Deliver our CAS awareness training programme to CMG leaders and local service leads in order to establish a standardised CAS broadcast management process throughout the organisation;
- Carry out another review of CAS management at CMG and local service level to monitor compliance with alert broadcast actions and to review the progress of mitigations recommended in the internal review completed in 2016/17.

A clinically sustainable configuration of services, operating from excellent facilities

Our priorities for the year were to:

- Complete and open Phase 1 of the new Emergency Floor
- Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services)
- Develop and deliver a new model of care that supports our reconfiguration plans
- Develop outline business cases for our integrated Children's Hospital, Women's Services and planned ambulatory care hub

Complete and open Phase 1 of the new Emergency Floor

We have delivered on our commitment to complete Phase 1 of the £43.3m Emergency Floor Project on time. The new Emergency department opened its doors at 4am on Wednesday 26th April 2017. As with many Emergency Departments across the country the sheer volume of patients now attending and being admitted to our hospitals has increased significantly beyond that which was planned for originally. The bigger, purpose built environment, innovations in IT and the new ways in which our staff now works allows us to see and treat patients more quickly.

Our new emergency department has a separate front door for children and adults with an integrated mental health facility so adults and children who are in crisis will be assessed more rapidly, in a safe and suitable environment. We are proud of the frail friendly design features within the adult areas and of how we can now meet the needs of both young children and teenagers, with specially designed waiting areas and a short stay unit. Some rooms will also have parent rooms adjoining to offer more privacy and dignity. Innovations in technology will reduce any duplication and will allow GP's working in the department to access patient's records within primary care to better inform the care they receive.

This new tailored department brings together all emergency care services under one roof, combining the expertise of many teams together into a centre of excellence. The integration of teams lends itself to flexible working and provides a rich environment for teaching, training, research and development.

In 2017 we are now turning our attention to delivering Phase 2 of the project which will bring together all of our acute medical and frailty assessment units, co-located with the Emergency Department. This exciting new development will be completed in spring 2018.

Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services)

Vascular Business Case

The creation of a cutting-edge and comprehensive centre for cardiovascular medicine and research on a single site at the Glenfield Hospital has been an ambition for us for a number of years, and has now become a reality.

Our Vascular Surgery Unit is now one of the UK's premier units providing high-quality care for patients with peripheral vascular diseases. It is staffed by a multidisciplinary team of nurses, occupational therapists,

physiotherapists, radiologists, anaesthetists and surgeons working to achieve excellent outcomes for our patients. This is evidenced by both local patient survey data and national audit outcome data. The team has a strong track-record of innovation and research, and recently was involved in worldwide collaborative research projects that have informed clinical care pathways.

We needed to move the vascular service from the Royal Infirmary to the Glenfield Hospital to bring about the benefits of providing it in the same place as cardiac and cardio-thoracic surgery. The facilities at the Royal Infirmary also did not allow us to provide radiological imaging facilities in-theatre (a hybrid theatre). These two restrictions meant we couldn't carry out complex vascular surgery, which this change now allows us to do.

A hybrid theatre combines an operating theatre with an interventional radiology suite. This means it can flexibly be used as either a conventional operating theatre, or as a radiology imaging facility, but crucially it allows imaging to take place during or immediately after an operation whilst the patient is still in the operating theatre. We are very excited by this development. The hybrid theatre will allow us to improve the patient pathway and give us the opportunity to expand the procedures we can offer, which will improve outcomes for our patients. The hybrid theatre will mean that will the vascular surgery, interventional radiology, cardiology and theatres teams can all work more collaboratively.

Construction work at the Glenfield Hospital was completed in April and included a new state of the art facilities for vascular inpatients: a new ward, vascular studies unit, angiography suite and hybrid theatre. Vascular outpatients, for now, will remain at the Royal Infirmary, but we are starting to develop plans that will allow us to move this service to the Glenfield too; hopefully by the end of the year.

The new facilities at the Glenfield will:

- Transform the scope and quality of the inpatient vascular service for both patients and staff;
- Improve staff recruitment, development and retention;
- Enable a comprehensive programme of clinical management and surgical treatment for patients with aortic pathology; as cardiac, thoracic and vascular surgeons are now all together at the Glenfield site;
- Support our ambition to be recognised as a Level One regional centre for complex endovascular services.

On Friday 28th April, the angiography service completed their move from the Royal Infirmary to their new suite at the Glenfield.

On Friday 5th May, vascular patients who were on ward 21 at the Royal Infirmary were transferred to their new ward at the Glenfield.

On Sunday 7th May, the first vascular surgery took place at the Glenfield.

Level 3 ICU and associated services Business Case

Our 5-year clinical strategy is to consolidate emergency and critical care dependent services onto the Royal Infirmary and Glenfield hospital sites (around right sized Adult Critical Care hubs) and to separate planned and emergency care by 2020/21. We currently provides an adult intensive care service on all three hospital sites. This triplication creates inefficiency and an unsustainable clinical position; the biggest risk being the lack of suitably qualified staff to maintain safe Level 3 Intensive Care Unit services across the three sites. In addition, we also have a lack of Intensive Care Unit beds at our two main emergency sites (the Royal Infirmary and Glenfield Hospital), resulting in cancellations of elective procedures, at a cost of some £4m in 2016/17.

The first step in addressing these issues is the move of Level 3 Intensive Care Unit and associated services dependent on Level 3 Intensive Care Unit from the General Hospital to the Royal Infirmary and Glenfield Hospital. The project includes:

- an increase of six beds in the adult Level 3 Intensive Care Unit at the Royal Infirmary; crucial in allowing us to move clinical services reliant on Intensive Care Unit care from the General Hospital;
- an increase of 11 beds in the adult Level 3 Intensive Care Unit at the Glenfield; crucial in allowing us to move clinical services reliant on intensive care from General Hospital;
- additional wards (some new build and some refurbished) at the Glenfield and the Royal Infirmary, also crucial in allowing us to move clinical services reliant on Adult Level 3 care from the General Hospital;
- more interventional radiology rooms at Glenfield to support the Intensive Care Unit dependant services moving there.

We need to borrow money from the Department of Health in order to carry out the construction work required for this project. We had hoped to get funding in April 2016, but unfortunately we weren't successful. We did manage to find the money from our internal sources in 2015/16 to pay for the six new intensive care beds at the Royal Infirmary, but we haven't been able to start any of the other work.

The 2017 Spring Budget included some money for NHS projects, so we have put in a new application for the funding we need to complete this project and are waiting to hear whether or not we've been successful.

Develop and deliver a new model of care that supports our reconfiguration plans

Integral to our 5 plan is an ambitious estate modernisation programme, which delivers the clinical service co-locations described in our clinical strategy.

To deliver the benefits associated with the reconfiguration of our clinical services, we need to ensure that we push beyond the efficiency and productivity opportunities afforded by any move/s and deliver transformation in our clinical services through the new models of care / new ways of working.

Through a series of clinically led conversations with multi-disciplinary teams, we have started to define clinical visions and think about what we might do differently to ensure we deliver effective, safe and efficient services for our patients. Part of the conversation involves trying to understand the potential implications of any new models of care (or service changes) on our reconfiguration ambitions i.e. what does tomorrow's way of working mean for our patients, our capacity (number of appointments, operations, beds, staff we will need), how we use technology better and so on.

Some of the new ideas discussed as part of this process have already been implemented and/or developed into business cases, in conjunction with partners. For example, we have set up an Ambulatory Clinic at the front of the Clinical Decision Unit (CDU) at the Glenfield Hospital. We have combined specialist respiratory and cardiac nurses with GPs to provide a fast track ambulatory service on CDU. This project has delivered a median time of 2 hours for patients to be seen and discharged, with high patient satisfaction scores. This is complemented by work developed as part of our Better Care Together Programme, which will involve the provision of specialist-led, integrated cardiorespiratory service in the community, providing a more convenient service to patients and helping to relieve the pressure on hospital services, which can maintain focus on diagnosis and management of more complex problems.

Develop outline business cases for our integrated Children's Hospital, Women's Services and planned ambulatory care hub

This year we have focused on developing our service models and patient pathways for Women's services, Children's services and the Planned Ambulatory Care Hub (outpatients and day-case procedures). This has involved working with our stakeholders internally, including doctors and nurses, as well as those outside of our hospitals, for example: our local commissioners, GPs, patients and the public.

We are not able to complete our business cases and get them approved by the Trust Board until we have carried out formal public consultation, which is a structured process for us to talk to the public about our plans for the future and make sure their views are taken into account. Unfortunately, public consultation has been delayed whilst the national process for developing and validating Sustainability and Transformation Plans has been taking place. There has also been a lack of capital funding, which we need to get architects etc. on board in order to come up with designs for our projects.

East Midlands Congenital Heart Service

Despite NHS England's announcement in June that they were *'minded to cease commissioning Level 1 CHD services from the EMCHC at Glenfield'* the service has continued to go from strength to strength.

The key objective has been to maintain high quality services for all of our patients whilst we respond to the requirements of the consultation process associated with NHS England's proposals. Our survival rates are better than national average, we have lower cancellation rates and waiting lists than other Level 1 centres, and 99 per cent of our friends and families would recommend us to a loved one.

The areas where NHS England assessed the service as not meeting the required standards focussed primarily on:

- Co – location – the standard requires Congenital Heart Disease services to be co-located with all other paediatric services by April 2019. Our unit is currently located at the Glenfield Hospital which means we do not meet this standard. We have responded to this with a clear plan to co-locate with other paediatric services within the designated time period, and EMCHC will be the first phase of the Childrens Hospital Project and will move across to the Royal Infirmary before the summer of 2019. NHS England has now accepted this as an appropriate plan.
- Surgical numbers - the standards require the service to have three surgeons all performing an average of 125 surgical cases over three years from April 2016 when the standards were approved, and then for four surgeons to be performing 500 cases total by 2020/21. We have submitted a robust growth plan that has gained support from all of our network hospitals that clearly demonstrates this is achievable. At time of writing this report we are awaiting feedback from NHS England in respect to this plan.

The consultation process has generated superb support from stakeholders, patients, staff and friends of EMCHC with the highlights being the two marches through Leicester with numbers reaching over 1500 people, a petition of over 130,0000 signatures being delivered to No 10 Downing Street, very informed and passionate consultation meetings with staff and stakeholders, and appropriate challenge from the Health Overview and Scrutiny Committees, and political representatives across the East Midlands. Currently the consultation has achieved 2,500 responses across England of which 1,800 are from the East Midlands – there can be no doubt of the strength of feeling regarding the need to keep the service in the 'Heart in the East Midlands', for all patients within the East Midlands.

We will be responding formally to the NHS England consultation, but hope that the evidence provided in the Growth plan recently submitted will be the reassurance needed for the service to be allowed to continue to grow and deliver excellent care for all the CHD patients in the East Midlands region.

A financially sustainable NHS organisation

Our priorities for the year were to:

- Deliver our CIP target in full
- Reduce our deficit in line with our 5-Year Plan
- Reduce our agency spend to the national cash target
- Implement service line reporting through the programme of service reviews to ensure the ongoing viability of our clinical services
- Deliver operational productivity and efficiency improvements in line with the Carter Report

Deliver our CIP target in full

We over-achieved our cost improvement target of £35m, by doing the following:

- Treating more patients via more productive Theatres, outpatients and beds capacity;
- Reduce the price we pay for goods/services;
- Remove waste and eliminate unnecessary variation in our patient pathways;
- Ensuring the actions taken above did not adversely impact on the quality of care delivered to our patients.

Reduce our deficit in line with our 5-Year Plan

Our 5-year financial strategy has been revised and has been integrated within the wider health economy STP financial plan. The strategy continues to be reviewed and will be refreshed on a bi-annual basis.

Reduce our agency spend to the national cash target

We were set a challenging target to achieve a reduction in agency expenditure to £20.6m during 2016/17. This has not been achieved, although spend on agency staff has reduced from £33m to £25m. This has been the result of targeted action to reduce vacancies which have reduced from 9.49 per cent in April 2016 to 6.5 per cent in March 2017.

Nursing vacancies have remained high but significant work has been done to increase the use of our bank and reduce the net cost per unit of agency. Medical vacancies have reduced considerably during the year.

Targeted recruitment campaigns have also seen the number of radiography and sonography vacancies fall.

Implement service line reporting through the programme of service reviews to ensure the on-going viability of our clinical services

Service Line Reporting and the use of Patient Level Information and Costing Systems (PLICS) continues to support the financial appraisal elements of the on-going reviews of our clinical services. This will be strengthened within 2017/18 through the rollout of an organisational wide PLICS engagement programme.

Deliver operational productivity and efficiency improvements in line with the Carter Report

We have been a leader in the participation of the Carter programme including support the procurement programme nationally. It has delivered the following:

- Significant reductions in the prices paid for goods and services by £8m;
- A transformation plan for our Pharmacy services for the coming years;
- Significant savings with regard to energy consumption, supporting financial improvement, but also the environment;
- Reduction in costs of corporate services and overheads.

Enabled by excellent IM&T

Our priorities for the year were to:

- Improve access to and integration of our IT systems (John Clarke)
- Conclude the EPR business case and start implementation (John Clarke)

Improve access to and integration of our IT systems

It has been a year of transition for our Information, Management and Technology Team.

After a long process, we were not able to secure approval for our Cerner Electronic Patient Record system so we have had to review our strategic approach. However, this has not meant that we have stood still; we have worked with our key partners to upgrade many of our key systems and provide new clinical functionality such as electronic observations and a brand new approach to IT within the new Emergency Department.

Conclude the EPR business case and start implementation

We have started our first step on our vision for the 2020 Paperless Hospital and in 2017/18 we will see an acceleration in improvements in both the software and hardware to support our clinical and administrative staff in providing excellent care to our patients.

Sustainability Report

Our Estates and Facilities Teams are fully committed to supporting and implementing sustainability across a wide and diverse range of services and procurement initiatives and this was reinforced within the revised Estates and Facilities 5-Year Plan. The plan outlines the main projects that have been designed to provide the necessary deliverables required to implement an effective sustainable environment and foundation for our future, ensuring our quality commitment to "providing a sustainable, safe and welcoming environment from where clinical care of the highest standard can be delivered".

We have Chair representation of the Energy and Sustainability Groups which has been established by the Estates and Facilities Technical Compliance Team and this forum will provide technical and statutory compliance guidance in support of our sustainability Strategy.

The Technical Compliance Team have advised and promoted elements of sustainability, to ensure that all new projects, new works and refurbishments incorporate the most effective "Low Carbon Technology" available within limited resources.

We completed the various statutory annual reports as listed below at the required time and are on target for the 2017 deadline for submitting the next set of returns.

a) Estates Return Information Collection (ERIC)
b) Property Assurance Model Report (PAM)
c) European Union Emissions Trading Scheme (EUETS)
d) Carbon Reduction Commitment (CRC)
e) Combined Heat & Power Quality Assurance (CHPQA)

Energy and Sustainability Projects

During 2016/17 the Estates and Facilities have successfully built/refurbished and commissioned the following which have all included the use of "Low Carbon Technology" and the incorporation energy efficient management strategies, inclusive of LED, Variable Speed drives, High efficiency Pumps and Motors, Building Management Systems, insulation, boilers and general application of good working practices and good housekeeping.

f) New Emergency Department Floor (A&E) - (LRI)
g) Refurbishment of Theatre Recovery with additional bed bays to enhance activity performance (LRI) & (GH)
h) New Hybrid Theatre (GH) and General Refurbishment/ upgrade to the Theatres (LRI)
i) Remodel of Ward 23 to a new stage of the art Vascular Investigation and treatment Unit (GH)
j) Remodel of an area to provide another state of the art Angiology Unit (GH)
k) Various LED Lighting schemes (LGH)

Heating and Power

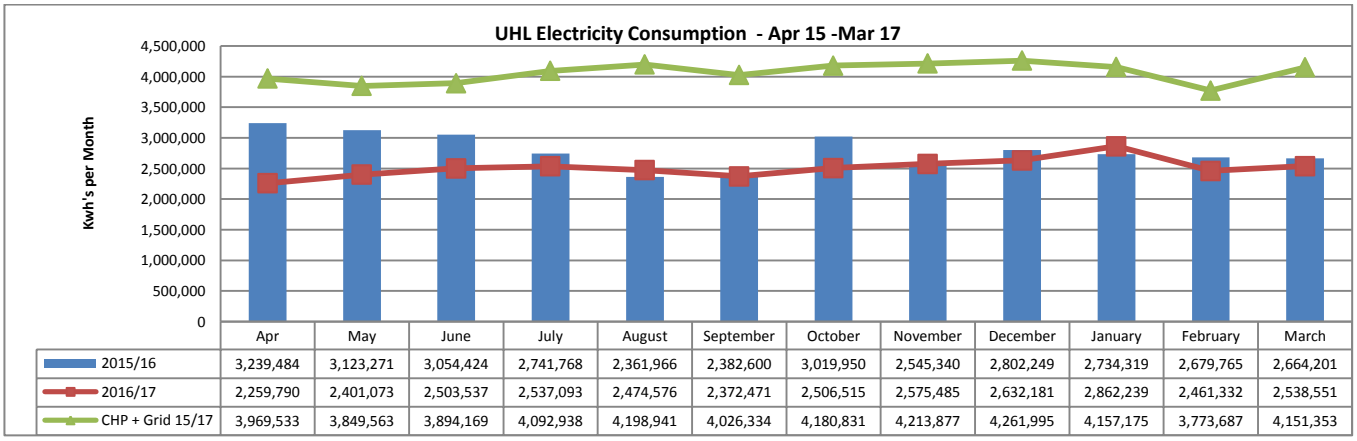
This period the new CHP units have improved their availability as they have been fine tuned to the sites demand.

Feb 16 - Jan 17 12 months	Royal Infirmary	Glenfield Hospital	Total
CHP gas used	28,277,817	14,805,964	43,083,781
CHP Elec Generated	12,592,641	5,670,067	18,262,708
CHP Heat Generated	7,658,900	5,846,100	13,505,000
Est. CO2 Saving	**2,721**	**1,394**	**4,116**
hours run	7,855	7,426	15,281
Est. Cost Saving	**£472,193**	**£228,433**	**£700,626**

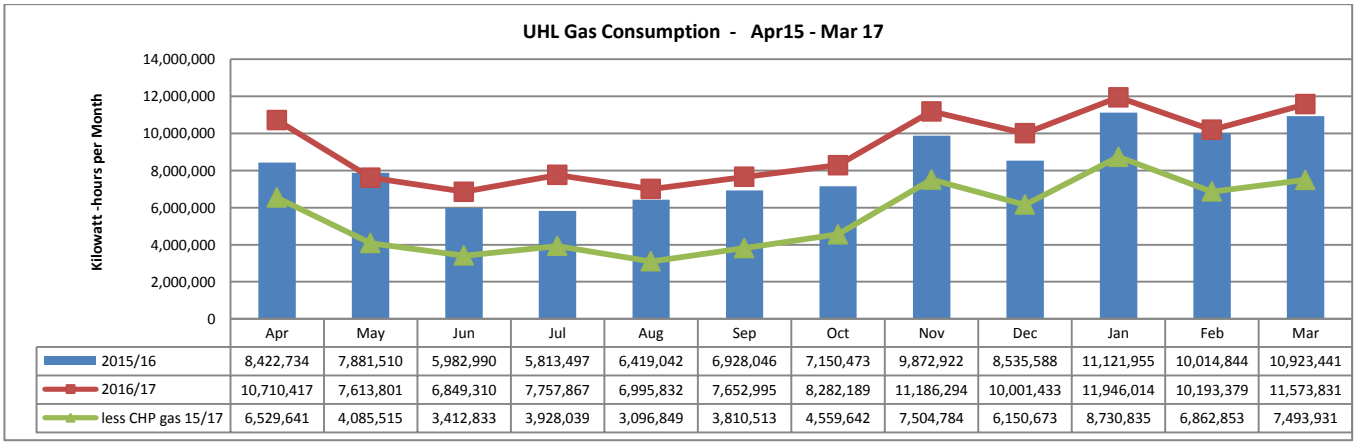
Description	Gas	Grid Electricity	Totals	Cost	CO2 Emissions	CO2 Emissions
Year	Usage (KWh)	Usage (KWh)	(KWh)	Costs (£)	(Tonnes)	(CRC Cost)
2006/07	116,873,611	29,357,222	146,230,833	£5,252,319	37,531	N/A
2007/08	99,831,667	30,681,111	130,512,778	£4,403,428	35,090	N/A
2008/09	109,781,944	33,822,222	143,604,167	£7,320,137	38,633	N/A
2009/10	93,697,272	36,426,819	130,124,091	£5,136,734	36,910	N/A
2010/11	96,694,476	39,489,130	136,183,606	£5,282,765	39,236	N/A
2011/12	85,673,210	42,535,080	128,208,289	£6,479,603	38,881	£376,571
2012/13	86,601,762	46,390,022	132,991,784	£7,223,638	41,334	£404,539
2013/14	83,164,032	48,522,097	131,686,129	£7,995,022	40,724	£400,777
2014/15	92,086,201	38,205,678	130,291,879	£7,072,683	36,950	£281,979
2015/16	101,496,587	32,832,008	134,328,594	£6,390,731	36,138	£291,598
2016/17	109,998,486	30,472,348	140,470,834	£5,624,988	36,441	£300,575
2017/18 6%	103,398,577	28,644,007	132,042,584	TBA	34,254	TBA
2018/19 6%	97,194,662	26,925,367	124,120,029	TBA	32,199	TBA
2019/20 6%	91,362,983	25,309,845	116,672,827	TBA	30,267	TBA
Annual Change	-8,501,900	2,359,660	-6,142,240	£765,743	-303	-£8,977
% age change	-8.38%	7.19%	-4.57%	11.98%	-0.84%	-3.08%
2012/13 Change	-23,396,724	15,917,674	-7,479,050	£1,598,650	4,893	N/A
% age change	-20%	54%	-5%	30%	13%	N/A

Note: TBA is for future costs which have a large reliance on many variables, but predominantly

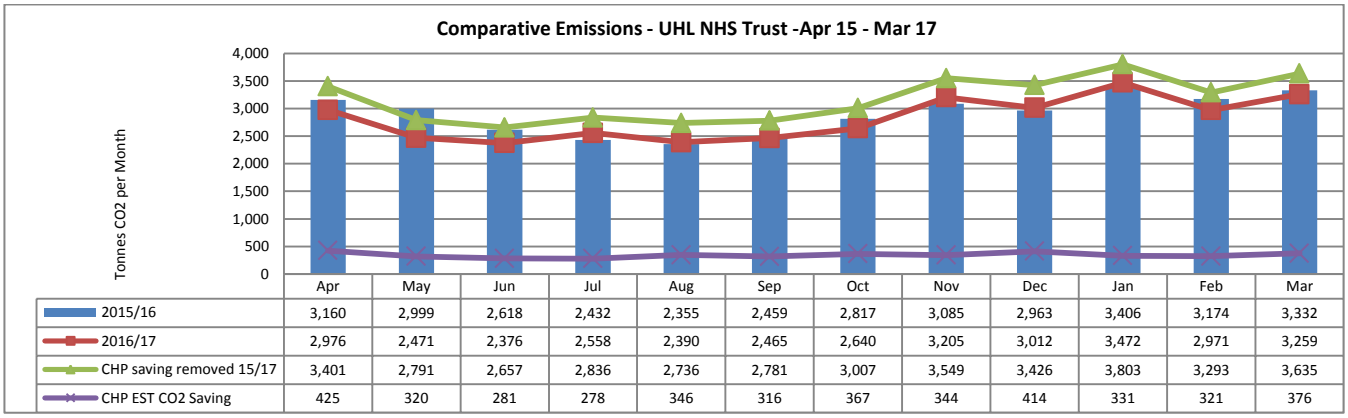
1. Consumption of power and or gas depend on activity, weather and the CHP units – just for volume
2. Cost of the utilities as commodity and non-commodity which is made up of several components plus the activity on the site and the CHP units availability.



	Apr	May	June	July	August	September	October	November	December	January	February	March
2015/16	3,239,484	3,123,271	3,054,424	2,741,768	2,361,966	2,382,600	3,019,950	2,545,340	2,802,249	2,734,319	2,679,765	2,664,201
2016/17	2,259,790	2,401,073	2,503,537	2,537,093	2,474,576	2,372,471	2,506,515	2,575,485	2,632,181	2,862,239	2,461,332	2,538,551
CHP + Grid 15/17	3,969,533	3,849,563	3,894,169	4,092,938	4,198,941	4,026,334	4,180,831	4,213,877	4,261,995	4,157,175	3,773,687	4,151,353



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	8,422,734	7,881,510	5,982,990	5,813,497	6,419,042	6,928,046	7,150,473	9,872,922	8,535,588	11,121,955	10,014,844	10,923,441
2016/17	10,710,417	7,613,801	6,849,310	7,757,867	6,995,832	7,652,995	8,282,189	11,186,294	10,001,433	11,946,014	10,193,379	11,573,831
less CHP gas 15/17	6,529,641	4,085,515	3,412,833	3,928,039	3,096,849	3,810,513	4,559,642	7,504,784	6,150,673	8,730,835	6,862,853	7,493,931



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	3,160	2,999	2,618	2,432	2,355	2,459	2,817	3,085	2,963	3,406	3,174	3,332
2016/17	2,976	2,471	2,376	2,558	2,390	2,465	2,640	3,205	3,012	3,472	2,971	3,259
CHP saving removed 15/17	3,401	2,791	2,657	2,836	2,736	2,781	3,007	3,549	3,426	3,803	3,293	3,635
CHP EST CO2 Saving	425	320	281	278	346	316	367	344	414	331	321	376

Travel Management

Our approach to transport is to provide a mixture of sustainable travel options along with parking facilities for those that need. The following list provides some of the main initiatives:

- Our Travel Plan incorporates environmental initiatives, which is being used and acted upon during all estates developments at the Trust;
- All alternative travel modes are promoted throughout the Trust including Park and Ride Services;
- We opened a new patient and visitor multi-storey car park on 1st February 2016, this includes over 430 additional spaces which incorporate 21 new disabled bays;
- Work has just started on a new drop off area within the surface level section of the main patient/visitor car park;
- A new tariff has been introduced (applicable across all sites). The prime carer of a patient that has been in hospital for more than six weeks will be provided with free parking from the beginning of the seventh week. The prime carer needs to provide proof of parking for the six weeks;
- We are working with the police to promote security of cycles;
- We are working with the city council and Sustrans to promote cycling at the Glenfield hospital (this hospital falls into the catchment area for the particular project, the other 2 hospitals currently do not);
- We have set up a Bicycle User Group;
- We continue to promote the Cycle to Work scheme i.e. purchasing a bike through salary sacrifice;
- We have reviewed staff parking arrangements reissuing permits based upon a new criteria that focuses on work related travel;
- We continue to look at the issuing of parking permits with a view to gradually asking staff to reapply on renewal;
- Our Hospital Hopper service was re- launched in January 2017, Centrebus have been awarded the contract for at least another three years;

Information Governance

We recognise the importance of robust information governance. During the year the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

All NHS Trusts are required to carry out an information governance self-assessment every year using the NHS Information Governance Toolkit. This contains 45 standards of good practice, spread across the domains of:

- information governance management;
- confidentiality and data protection assurance;
- information security assurance;
- clinical information assurance;

- secondary use assurance; and
- corporate information assurance.

We achieved a minimum level 2 standard across all of the 45 standards submitting a score of 80 per cent satisfactory standard on the 31st March 2017.

During the year we reported to the Information Commissioner's Office two serious untoward incidents involving a lapse of data security. Patient care was not put at risk.

In respect of other personal data related incidents experienced during the year, we have carried out investigations to ensure that the root causes are properly understood and addressed; in addition, where necessary patients have been contacted to inform them of the lapses and to provide them with assurance about the actions we have taken to prevent recurrence.

Procurement and supplies

During the year, the Procurement and Supplies team have been working closely with both colleagues and suppliers to deliver on our Procurement Strategy 2015-2018 (Procurement & Supplies Strategy).

In line with this we have made significant progress towards delivering our annual improvement plan.

Some particular highlights include …

- Enabling the Trust to reduce its deficit through our work with both colleagues and suppliers. We have enabled over £8m of cost improvement plan (CIP) savings during the financial year. This is a substantial increase from the £4m delivered in 2015/16
- Continuing to play a key role in the national NHS procurement agenda and in particular supporting delivery of the Carter report (see Lord Carter Report)
- Successful delivery of the national Carter metrics and production of our Procurement Transformation Plan
- Achievement of Level 1 on the NHS Commercial and Procurement Standards – we were the first Trust in the East Midlands to achieve this and are now supporting other Trusts in the area with their assessments
- Improving our collaboration with NHS Supply Chain and becoming one of 24 Trusts advising on their national procurement strategies.
- Supporting the delivery of the Trust re-configuration programme and the new facilities management model for UHL.
- Non Clinical Team of the year award for the East Midlands and regional Innovation award from the East Midlands Healthcare Financial Management Association (HFMA).

Our plans for 2017/18 include…

- Continuing to improve the procurement and supplies processes in line with our three year Procurement Strategy.
- Delivering a further £8m or more of cash savings to the Trust (CIP)
- Achieving Level 2 on the NHS Standards of Procurement by the end of the year.
- Continuing to lead and support delivery of the national procurement agenda in the NHS.

Emergency Planning

The Emergency Planning and Business Continuity Team have continued to make vast improvements to the overall resilience of the Trust during 2016/17, which has been a particularly busy year.

The team redeveloped the way in which staff are notified of an incident. Previously we relied on manual call cascades that were very time consuming and outdated. Now we have an automated system that can notify our staff quickly in the event of an incident. We have successfully tested it a number of times to over 1000

members of staff, and we have received some very positive feedback. We will continue to develop this throughout 2017 to ensure that we can respond to a wide range of incidents.

The team have been heavily involved in the new Emergency Department build which has purpose built facilities for dealing with contaminated casualties. This means that for incidents which involve hazardous materials so that we do not have to rely on temporary structures to be erected to carry out decontamination. This will help us to respond more quickly to an incident whilst protecting our staff and patients from further contamination.

The team continue to work closely with all the services within the Trust, most notably this year we have seen some vast improvements in our downtime arrangements for loss of IT systems. The most significant projects have included 12-hour downtime of our central patient record system and implementation and expansion of Nerve Centre within the Emergency Department and the wider hospital. Having robust and tested downtime arrangements ensures that we can keep our patients safe in the unlikely event of a loss of our critical IT systems.

Each year NHS England assesses us on a number of core standards relating to Emergency Planning. At the time of the review in October 2016, we were 92 per cent compliant with the standards, which is a slight slip from the previous year of 98 per cent, and 8 per cent partially compliant. The two main reasons for the slight slip in compliance are due to some changes to the assessment process and some documents that were going through their review cycles at the time of the assessment. Our rating for this year is “substantial” compliance and we have agreed a number of actions with NHS England to improve our rating.

The team continue to work closely with other agencies to mitigate the impact of an incident to the population of Leicester, Leicestershire and Rutland and beyond. The team have been heavily involved in a number of regional events that have helped to shape the responses to a number of incidents. Working with other partners ensures that we continue to share our experiences for the benefit of everyone and ensure that we can all respond collectively.

The next year looks to be as busy as ever with the team working on exercises to test hospital evacuation and responding to a Major Incident as well as working on how we can improve our resilience around cyber security whilst assuring NHS England and the public of our continued commitment and development of resilience arrangements.

Our priorities for 2017/18

For 2017/18 we have reduced the number of things that we are focusing on to make it more manageable and achievable. This is what we will be focusing on for the coming year:

Our People

We will have the right people with the right skills in the right numbers in order to deliver the most effective care

In 2017/18:

- We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care
- We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget
- We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'.

Education & Research

We will deliver high quality, relevant, education and research

In 2017/18:

- We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education
- We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates
- We will develop a new 5 Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership.

Partnerships & Integration

We will develop more integrated care in partnership with others

In 2017/18:

- We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty
- We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals
- We will form new relationships with primary care in order to enhance our joint working and improve its sustainability.

Key Strategic Enablers

We will progress our key strategic enablers:

In 2017/18:

- We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work
- We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care
- We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services
- We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities
- We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust
- We will deliver financial stability as a consequence of the priorities described here in order to make the Trust clinically and financially sustainable in the long term.

Quality Commitment for 2017/18

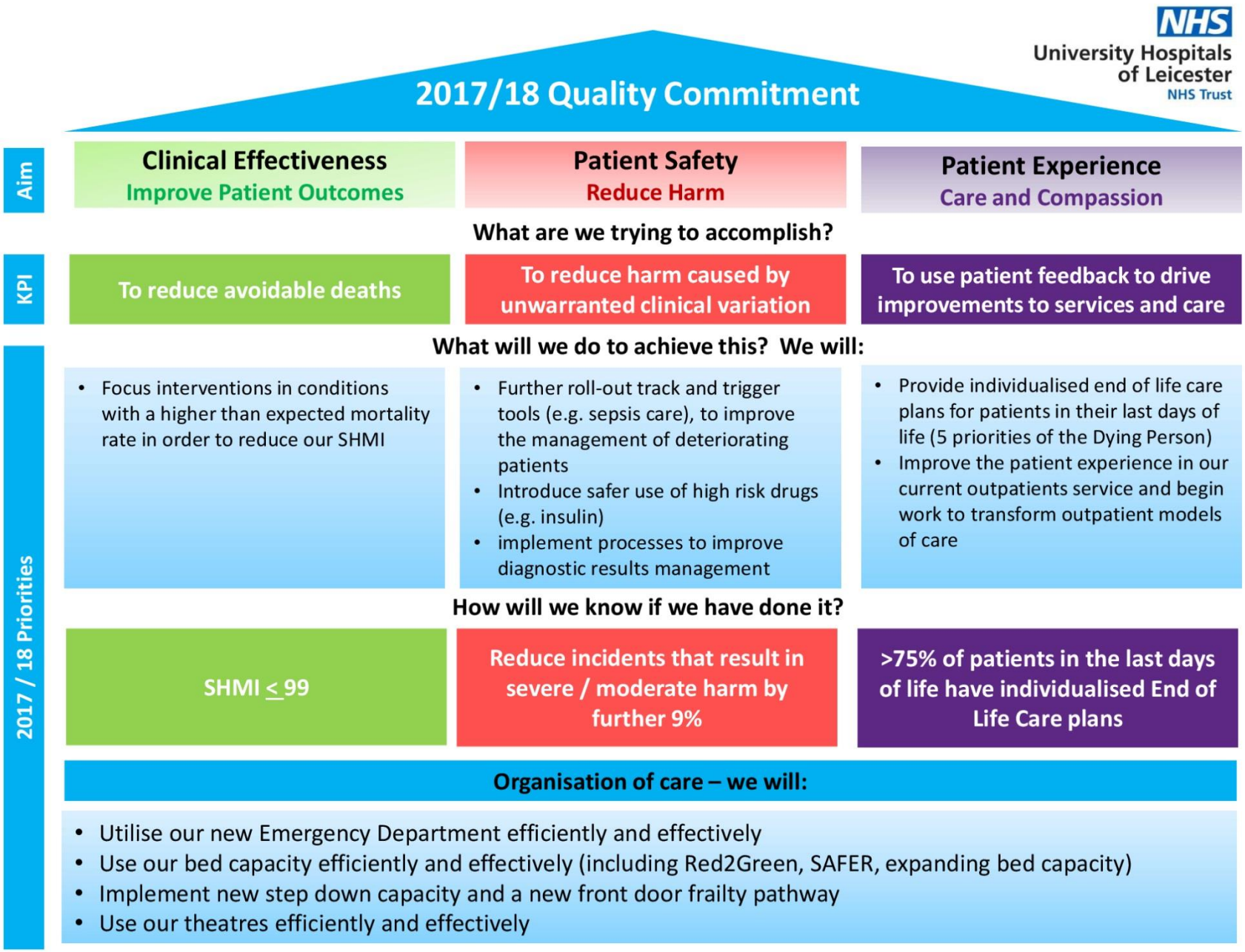
Our **Quality Commitment** has proven very successful so will remain, updated for 2017/18.

We continue with the three pillars, focussed on continuing to improve effectiveness, safety and patient experience.

One of the particular areas that we want to do better on this year is diagnostic results management, aka "acting on results".

The newest element of the Quality Commitment is **'Organisation of Care'**. This brings together several aspects of operational improvement including maximising the potential of our new Emergency Department and balancing demand and capacity.

You can find updated our Quality Commitment for 2017/18 overleaf.


NHS
University Hospitals of Leicester
NHS Trust
2017/18 Quality Commitment
Aim
Clinical Effectiveness
Improve Patient Outcomes
Patient Safety
Reduce Harm
Patient Experience
Care and Compassion
What are we trying to accomplish?
KPI
To reduce avoidable deaths
To reduce harm caused by unwarranted clinical variation
To use patient feedback to drive improvements to services and care
What will we do to achieve this? We will:
2017 / 18 Priorities
• Focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI
• Further roll-out track and trigger tools (e.g. sepsis care), to improve the management of deteriorating patients
• Introduce safer use of high risk drugs (e.g. insulin)
• implement processes to improve diagnostic results management
• Provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person)
• Improve the patient experience in our current outpatients service and begin work to transform outpatient models of care
How will we know if we have done it?
SHMI ≤ 99
Reduce incidents that result in severe / moderate harm by further 9%
>75% of patients in the last days of life have individualised End of Life Care plans
Organisation of care – we will:
• Utilise our new Emergency Department efficiently and effectively
• Use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity)
• Implement new step down capacity and a new front door frailty pathway
• Use our theatres efficiently and effectively

Operating and financial review

Overview of 2016/17 Financial Position

We planned to deliver an income and expenditure deficit of £8.3m in 2016/17, including Sustainability and Transformation Funding (STF) of £23.4m. This was a deficit of £31.7m net of STF funding which was an improvement over the equivalent deficit of £34.1m in the prior year. This was predicated on the delivery of a Cost Improvement Programme (CIP) of £35.0m.

In order to receive the STF funding we have to achieve targets in four areas. Primarily we need to achieve our planned financial performance as well as achieving access standards in A&E, Cancer and Referral to Treatment (RTT).

However, in month 9 and in response to the worsening of the national financial position of the provider sector, we were asked to develop a plan for a deficit of £27.2m, including a reduced level of STF funding of £11.4m. Our planned deficit net of STF was amended to £38.8m from the original £31.7m.

At the same time, we had to carry out a review of the ambitious capital programme that had been originally planned at £81.7m, supported by internally generated funds of £44.2m and £37.7m capital loans from the Department of Health. The key elements of the original capital programme were:

- Addressing backlog maintenance and investment within critical infrastructure;
- Building our new Emergency Floor;
- Redevelopments and investments to support the longer term estate reconfiguration plans and;
- Investment in IT and new equipment.

We achieved the revised deficit of £27.2m at the year end, including delivery of £36.2m CIP, and delivered our other statutory duties.

Following a strategic review and recognising the limitations around external capital funds, the final capital expenditure plans were set at £62.6m, supported by £21.1m of capital loans from the Department of Health.

The above means that we enter 2017/18 in a different place financially than was anticipated within our five year strategic plan. It was not possible for us to sign up to the proposed control total for 2017/18 which will mean that we are not eligible for STF funding in that year.

We will deliver a £26.7m deficit which includes the delivery of a £33.0m Cost Improvement Programme.

Financial review for the year ended 31st March 2017

We did not meet all of our financial and performance duties for 2016/17:

• Balancing the books	We delivered an income and expenditure deficit of £27.2m
• Managing cash	We delivered both the External Financing Limit (EFL) and Capital Resource Limits (CRL)
• Investment in buildings equipment and technology	We invested £62.6 million in capital developments

Performance against our Financial Plan

We delivered a £27.2m deficit for the year against the planned deficit of £8.3m. This was £18.9m adverse variance to plan, including £12m relating to STF funding.

Our final year end position included the following (excluding the impact of donated assets):

Total income	£924.3m actual; which was £9.1m under plan relating to favourable settlements with commissioners and additional RTT work.
Total expenditure	£966.3m actual; which was £15.4m over plan and includes overspends of £5.2m on pay and overspends of £5.9m on non-pay.
Impairment	£24.8m impairment was incurred which was not planned at the beginning of the year. This is adjusted out of the adjusted deficit for the year of £27.1m.
Capital expenditure	£62.6m against a revised capital resource limit of £53.8m.
Cash balance	£1.2m closing cash balance against a plan of £1.0m.
Cost Improvement Programme (CIP)	Delivered £36.2m against a £35.0m target.

Balance Sheet

Cash: We ended the year with a cash balance of £1.2m and secured external financing of £79.1m, which included:

- £27.2m to fund our deficit;
- £29.0m for working capital support: and
- £21.1m for capital financing in relation to our emergency floor project.

The total balance of our external financing at the year-end was £134.1m.

Non-current assets: The value of our non-current assets (including property, plant and equipment and intangible assets) increased by £7.9m mainly as a result of:

- £62.6m total net additions; less
- £28.2m downward revaluation; less
- £26.5m depreciation.

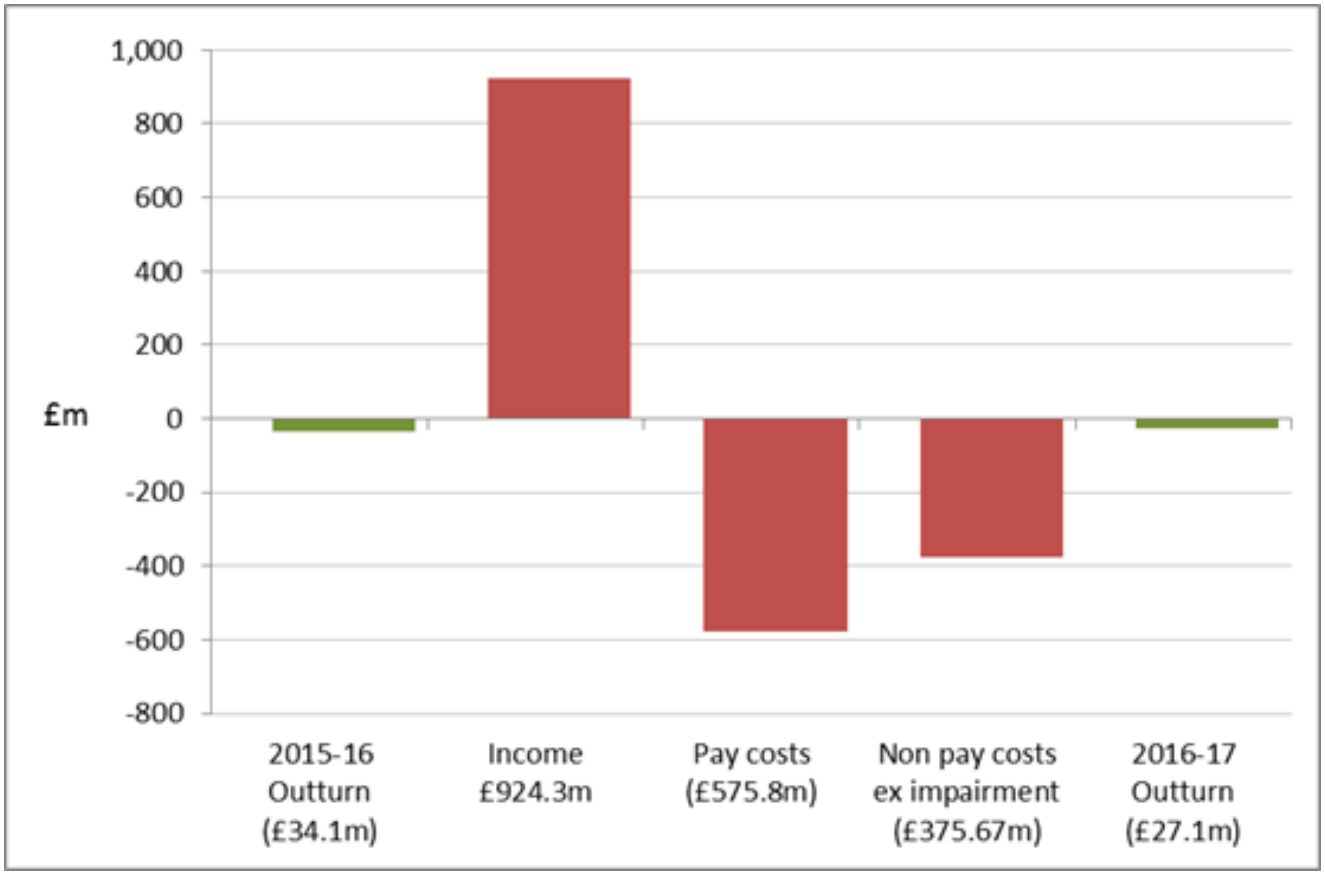
Working capital: Our receivables have increased by £10.8 mainly due to an £11.8m increase in NHS debtors as a result of an increased level of invoicing for year-end activity and income generation at the year end.

Our payables have decreased by £10.3m during the year mainly due to due to the impact of the additional external financing received in year.

Taxpayers equity: This represents the methods of funding our assets and liabilities. The main component of our taxpayers equity is Public Dividend Capital (PDC) which increased by £2.1m in the year following receipt of additional funding for a Linear Accelerator; IT equipment for the National Genome Project; and a Fibro scanner.

Our retained earnings reduced by £52.0m due to our financial deficit and impairment following an asset revaluation. Our revaluation reserve balance also reduced by £3.7m due to the asset revaluation.

Key Financial Indicators:



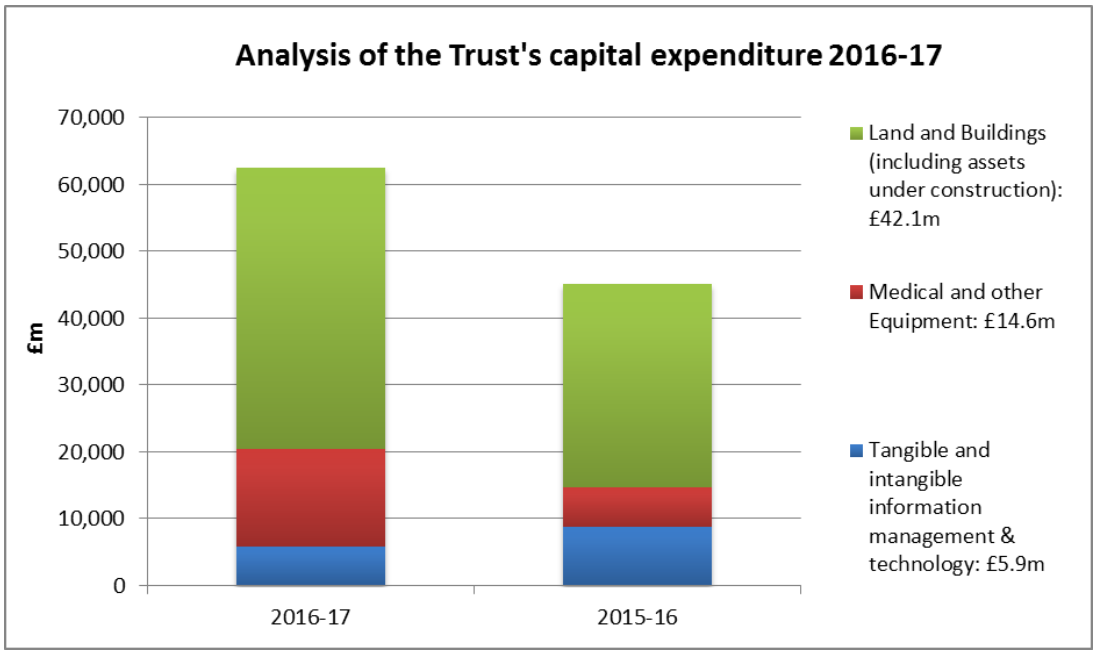
Income: We received £924.3m of income (excluding donated assets) which is a £58.3m (6.7 per cent) increase from the £866.0m we received in 2015/16.

Pay expenditure by staff group: We spent £575.8m on staff costs, which is a £57.4m (11.1 per cent) increase over the 2015/16 total of £518.4m. £23.4m of this increase is due to the impact of Estates and Facilities transfer where costs were previously reflected in non-pay. £16m of this increase is due to increased social security and pension costs.

Non-pay expenditure: We incurred £375.6m of non-pay expenditure which was a £6.1m (1.6 per cent) decrease over the 2015/16 total of £390.4m. £11.6m of this reduction relates to a decrease in general supplies and services costs, including insourcing services previously provided by Interserve (£18.05m). This is offset by other increased spend on general supplies and services, and general price increases.

We also had an impairment of our property, plant and equipment of £24.8m following a revaluation of its estate.

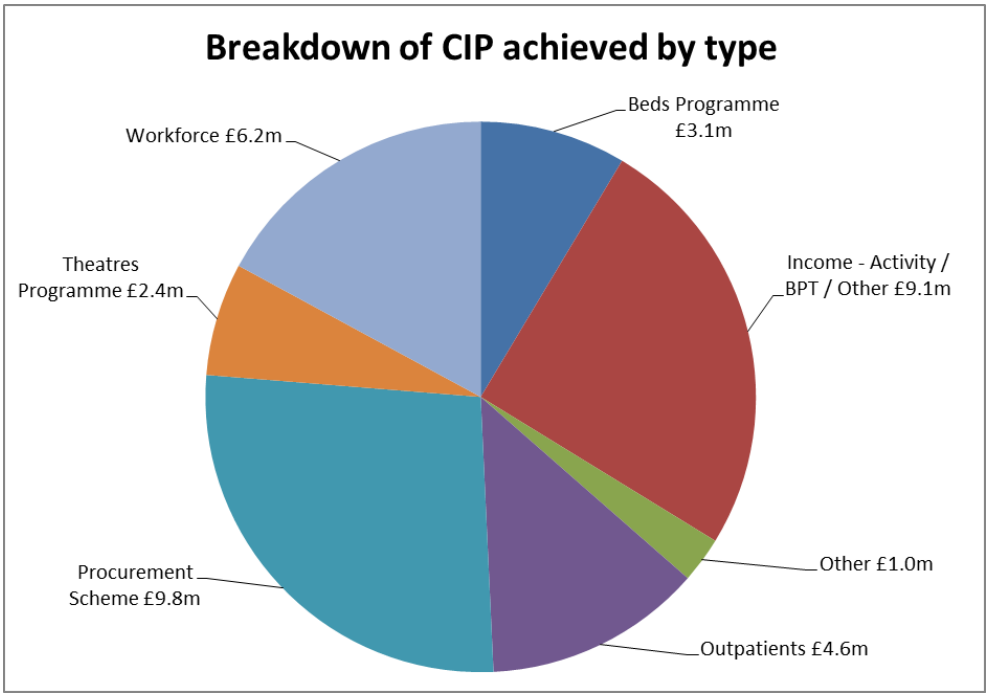
Capital expenditure: Our capital expenditure (excluding adjustments for donated assets) was £62.6m, a £17.4m (38.5 per cent) increase over the 2015/16 total of £45.2m. A breakdown of the spend is shown in the graph below.



Capital expenditure for 2016/17 consisted of:

- £30.1m on reconfiguration schemes including £19.8m relating to our new Emergency Floor; and £7.6m on relocation of vascular services;
- £9.9m on estates and facilities critical infrastructure works;
- £4.1m on various IM&T schemes;
- £5.7m on medical equipment; and

Our efficiency programme: We delivered £36.1m against our £35.0m cost improvement programme in 2016/17. The programme focused on productivity whilst maintaining high quality patient services. £6.2m of improvements in the way workforce; £9.2m of savings came from income activity; and £9.8m from procurement schemes. A breakdown of the CIP achieved is shown in the chart below.



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 2016/17, 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

Financial planning: We have submitted its 2017/18 plan to the NHS Improvement. The key details relating to the plan for 2017/18 are as follows:

- Planned I&E deficit of £26.7m;
- A major CIP plan of £33.0m;
- A capital expenditure plan of £54.4m, including the Emergency Floor development and the EPR Programme;
- External funding of £48.5m to fund the capital programme;
- An external Financing Limit (EFL) of £43.5m;
- A Financial Risk Rating (FRR) of 3 (calculated in accordance with the NHS Improvement planning submission guidelines).

Our financial plan and resulting deficit position is driven by our activity and income assumptions, workforce implications and CIP. We have a clear process for delivering against these areas, and to ensure a realistic monthly profile of income and expenditure.

Cash management: We will require both capital and revenue financing in 2017/18 as follows:

- £7.0m capital funding for the phase two of the Emergency Floor project;
- £26.7m to fund the 2017/18 deficit; and
- £58.0m to repay the brought forward revolving working capital facility.

Net overdue payables brought forward totalled £17.5m (overdue receivables of £14.7m and overdue payables of £32.3m).

We are producing an action plan to reduce the level of overdue receivables and payables and this will involve an application for further external working capital funding.

We will further improve our performance against the Better Payment Practice Code (BPPC) in 2017/18 as a result of the financing outlined above. Sufficient liquidity therefore will exist or can be made available to support our operations in the coming twelve months from the date of annual accounts.

Efficiency programme for 2017/18: In 2017/18, we have set a challenging efficiency target of £33.0m. Delivery of this total will be challenging and our processes will continue to give assurance over the schemes and their quality impact. These processes have proved effective in 2016/17 and include CIP reporting through the Chief Operating Officer with weekly updates to the NHS Improvement. All CIP schemes are quality and risk assessed and there is regular reporting to the Executive Performance Board; Integrated Finance, Performance & Investment Committee; and Trust Board.

Capital programme: We are continuing to invest in our buildings and equipment. We have a major capital agenda over the medium term, including the Emergency Floor project which has entered phase two, and our reconfiguration scheme, both of which started in 2014/15.

Our capital programme for 2017/18 involves up to £54.4m of investment. Major schemes include:

- £7.0m for the Phase 2 Emergency Floor;
- £4.2m for Glenfield Intensive Care; and

- £2.8m for the relocation of the East Midlands Congenital Heart Service.

Directors Report: The Directors are not aware of any information of which the auditors are not aware. Each Director has taken all of the steps that they ought to have taken as a Director in order to make sure they are aware of any relevant audit information and to establish that the auditors are aware of that information.

Statement of Accounting Officer's responsibilities: The Accounting Officer is responsible for the preparation of the financial statements and can confirm that the annual report and accounts as a whole is fair, balanced and understandable and that he or she takes personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

The Accounting Officer can confirm that, as far as he is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Accounting Officer has taken all the steps that he or she ought to have taken to make himself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

Signed 

Chief Executive (on behalf of the Trust Board)

Date: 1 June 2017

Remuneration Reports

Salary and pension entitlements of senior managers – salary 2016/17

	2016-17					
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
BOARD MEMBERS						
K Singh, Chairman	40-45.	11	0	0	0	40-45.
J Adler, Chief Executive	205-210	152	0	0	100-102.5	320-325
R Mitchell, Chief Operating Officer	145-150	0	0	0	32.5-35.0	180-185
P Traynor, Chief Finance Officer	185-190	0	0	0	0	185-190
J Smith,Chief Nurse	140-145	0	0	0	0	140-145
A Furlong, Medical Director	180-185	0	0	0	42.5-45.0	225-230
NON EXECUTIVE DIRECTORS						
M Traynor, Non-Executive Director	5-10.	0	0	0	0	5-10.
Colonel (retired) I Crowe, Non-Executive Director	5-10.	0	0	0	0	5-10.
Dr S Dauncey, Non-Executive Director (until 31 July 2016)	0-5	0	0	0	0	0-5
R Moore, Non-Executive Director	5-10.	0	0	0	0	5-10.
Professor A Goodall, Non-Executive Director (until 30 June 2016)	0-5	0	0	0	0	0-5
A Johnson, Non-Executive Director	5-10.	0	0	0	0	5-10.
B Patel, Non-Executive Director (from 1 August 2016)	0-5	0	0	0	0	0-5
Professor P Baker, Non-Executive Director (from 1 July 2016)	5-10.	0	0	0	0	5-10.
Dr S Crawshaw, Non-Executive Director (from 3 January 2017)	0-5	0	0	0	0	0-5
SENIOR MANAGERS						
S Ward, Director of Corporate & Legal Affairs	105-110	0	0	0	15.0-17.5	125-130
M Wightman, Director of Marketing and Communications	120-125	0	0	0	25.0-27.5	150-155
L Tibbert, Director of Workforce and Organisational Development	120-125	0	0	0	27.5-30.0	145-150.

The Executive Medical Director – Andrew Furlong receives remuneration in his other capacity as a Consultant Trauma and Children's Orthopaedic Surgeon banding (in £000) of 60-65 included in the figure above.

Salary and Pension entitlements of senior managers – Salary 2015/16

	2015-16					
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
BOARD MEMBERS						
K Singh, Chairman	40 - 45	18	0	0	0	40 - 45
J Adler, Chief Executive	195 - 200	130	0	0	95-97.5	300-305
R Mitchell, Chief Operating Officer	145 - 150	0	0	0	55-57.5	200-205
P Traynor, Chief Finance Officer	165 - 170	0	0	0	95-97.5	260-265
C Ribbins, Acting Chief Nurse (until 2 August 2015)	35 - 40	0	0	0	0	35-40
J Smith,Chief Nurse (from 3 August 2015)	90 - 95	0	0	0	0	90 - 95
A Furlong, Medical Director (from 1st April 2015)	180-185	0	0	0	0	180-185
NON EXECUTIVE DIRECTORS						
M Traynor, Non-Executive Director	5 -10	0	0	0	0	5 - 10
Colonel (retired) I Crowe, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
Dr S Dauncey, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
J E Wilson, Non-Executive Director (until 31 December 2015)	0 - 5	0	0	0	0	0 - 5
R Moore, Non-Executive Director (from 1 April 2015)	5 - 10	0	0	0	0	5 - 10
Professor A Goodall, Non-Executive Director (from 1 July 2015)	0 - 5	0	0	0	0	0 - 5
A Johnson, Non-Executive Director (from 1st November 2015)	0 - 5	0	0	0	0	0 - 5
SENIOR MANAGERS						
K Shields, Director of Strategy (until 14th February 2016)	115-120	0	0	0	35-37.5	150-155
S Ward, Director of Corporate & Legal Affairs	105 - 110	0	0	0	40-42.5	150-155
M Wightman, Director of Marketing and Communications	105-110	0	0	0	35-37.5	145-150
E Stevens, Acting Director of Human Resources (until 13 September 2015)	45-50	0	0	0	370-372.5	415-420
L Tibbert, Director of Workforce and Organisational Development (from 3 August 2015)	75 - 80	0	0	0	17.5-20.0	95-100

Salary and Pension entitlements of senior managers - Pension Benefits

Name and title	Real increase in pension at state pension age (bands of £2500) £000	Real increase in lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2017 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2016 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Employers Contribution to Stakeholder Pension £000
BOARD MEMBERS								
J Adler, Chief Executive	5.0-7.5	15.0-17.5	80.0-85.0	240.0-245.0	1,493	158	1,651	0
R Mitchell, Chief Operating Officer	2.5-5.0	0	25.0-30.0	60.0-65.0	260	26	286	0
P Traynor, Director of Finance	0	0	0	0	732	0	732	0
J Smith Chief Nurse	0	0	0	0	522	0	522	0
A Furlong Medical Director	2.5-5.0	0.0-2.5	35.0-40.0	100.0-105.0	597	57	654	0
SENIOR MANAGERS								
S Ward, Director of Corporate & Legal Affairs	0.0-2.5	2.5-5.0	45.0-50.0	135.0-140.0	894	53	947	0
M Wightman, Director of Communications	0.0-2.5	0	30.0-35.0	75.0-80.0	442	33	475	0
L Tibbert, Director of Workforce and Organisational Development	0.0-2.5	0	0.0-5.0	0	16	25	41	0

J Smith and P Traynor are not members of the NHS Pension Scheme.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures 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. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfers Values) Regulation 2008. Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued

pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Directors and Senior Managers Remuneration

We classify our Directors and Senior Managers as Very Senior Managers (VSM) these members of staff are deemed to be on a VSM payscale which is non agenda for change. The remuneration of these individuals is set by our remuneration committee. On an annual basis the remuneration committee decides on any pay uplift or pay award for VSM for the forthcoming year.

Analysis of Staff Number

The table below shows the staff composition by group.

Staff Group	Gender		
	Female *Number*	**Male** *Number*	**Total** *Number*
Scientific and Technical	294	91	385
Clinical	1,900	321	2,221
Administrative and Clerical	1,983	473	2,456
Allied Health Professionals	436	133	569
Estates and Ancillary	809	535	1,344
Healthcare Scientists	248	176	424
Medical and Dental	700	1,053	1,753
Nursing and Midwifery Registered	3,192	355	3,547
Board Members	1	5	6
Senior Managers	1	3	4
Grand Total	**9,564**	**3,145**	**12,709**

Exit Packages

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	2016-17							
	Number	£'s	Number	Number	Number	£'s	Number	£'s
Less than £10,000	1	8,050	0	0	1	8,050	0	0
Totals	1	8,050	0	0	1	8,050	0	0

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	2015-16							
	Number	£'s	Number	Number	Number	£'s	Number	£'s
£25,001-£50,000	1	43,710	0	0	1	43,710	0	0
Totals	2	43,710	0	0	2	43,710	0	0

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 pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table. This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Off payroll payments

We have 24 relevant off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months. All off-payroll engagements have been subject to a risk based assessment and assurance has been sought as to whether the individual is paying the right amount of tax.

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	24
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	17
for between 2 and 3 years at the time of reporting	2

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016; of which the number for whom:	5
assurance has been requested	5
assurance has been received	5

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	9

Expenditure on consultancy

We incurred £2.2m on consultancy services.

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 our highest paid director in the financial year 2016/17 was £220k-£225k (2015/16 £210-215k). This was 8.30 times (7.41 times in 2015/16) the median remuneration of the workforce, which was in the banding £25k-£30k (2015/16 £25k-£30k). The salary of the highest paid director has increased by £8.6k and the median remuneration of the workforce has reduced by £1.5k, partly due to the transfer of staff from Interserve in the year.

In 2016/17, two employees received remuneration in excess of the highest-paid director (four employees in 2015/16). Remuneration across the Trust ranged from £1k-£252k (2015/16 £1k-£250k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. For the purposes of this disclosure the remuneration of each employee is stated on an annualised, full time equivalent basis.

Signed 

Chief Executive (on behalf of the Trust Board)

Date: 1 June 2017

Annual Governance Statement 2016/17

Executive Summary

The annual governance review confirms that we, the University Hospitals of Leicester NHS Trust, have a generally sound system of internal control that supports the achievement of its policies, aims and objectives. We recognise that the internal control environment can always be strengthened and this work will continue in 2017/18, as described below.

We have identified below a number of significant control issues which have impacted on our performance in 2016/17. This Statement gives an account of remedial action which has been, and is being, taken.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports adherence to our policies and achievement of our 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 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.

In undertaking this role I, and my team, have developed strong links with the NHS Trust Development Authority (now NHS Improvement), local Clinical Commissioning Groups and other partner organisations.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide a reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an on-going process designed to:

- identify and prioritise the risks to the achievement of policies, aims and objectives of the Trust; and
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place at the University Hospitals of Leicester NHS Trust for the financial year ended 31 March 2017 and up to the date of the approval of the annual accounts.

The Governance Framework of the Organisation

Trust Board composition and membership

Our Trust Board comprises of 13 members: a Chairman, seven Non-Executive Directors and five Executive Directors.

There have been a number of changes in the composition of the Board during 2016/17.

Professor Alison Goodall, nominated by the University of Leicester, stood down from her role as a Non-Executive Director on 30 June 2016 and was succeeded by Professor Philip Baker, Head of the College of Medicine, Biological Sciences and Psychology. Mr Ballu Patel took up the position of Non-Executive Director on 1st August 2016. Dr Sarah Dauncey resigned from her Non-Executive Director role in July 2016 and Dr Shirley Crawshaw took up the position of Non-Executive Director on 1st January 2017.

On an interim basis, the responsibilities of the post of Director of Strategy have been assigned to the Chief Financial Officer, Mr Paul Traynor, and Director of Communications, Integration and Engagement, Mr Mark Wightman. Consideration will be given to making a substantive appointment to the post of Director of Strategy during 2017/18.

The Board is supported in its work by the Director of Workforce and Organisational Development and Director of Corporate and Legal Affairs who each have a standing invitation to attend all meetings, but not in a voting capacity.

In summary, although there has been turnover in Non-Executive Director posts at Board level in 2016/17, the process of making substantive appointments is now complete, creating a well-balanced Board to provide continuity of leadership going forward.

Performance Management Reporting Framework

The Chief Executive reports on key issues to each public Board meeting and a Quality and Performance Dashboard forms part of this report.

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 meeting of the Board's Integrated Finance, Performance and Investment Committee (IFPIC) and Quality Assurance Committee (QAC). This report is also published as part of our Trust Board papers.

The monthly report:

- is structured across several domains: 'safe'; 'caring'; 'well-led'; 'effective'; 'responsive'; and 'research';
- includes information on our performance against the NHS Improvement's Single Oversight Framework;
- includes performance indicators rated red, amber or green;
- is complemented by exception reports and commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

Importantly, the quality and performance report includes information on 'never events'. Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.

During 2016/17, four such incidents were reported at the Trust which met the definition of a never event. These related to a medication incident; an item left in situ following a procedure; and two cases of incorrect tooth extraction.

In each case, we informed the patients and their relatives of the errors and we apologised for our failings.

Thorough root cause analysis of each incident is undertaken to identify key actions to prevent recurrence. Implementation of these actions is tracked by the Quality Assurance Committee on behalf of the Trust Board.

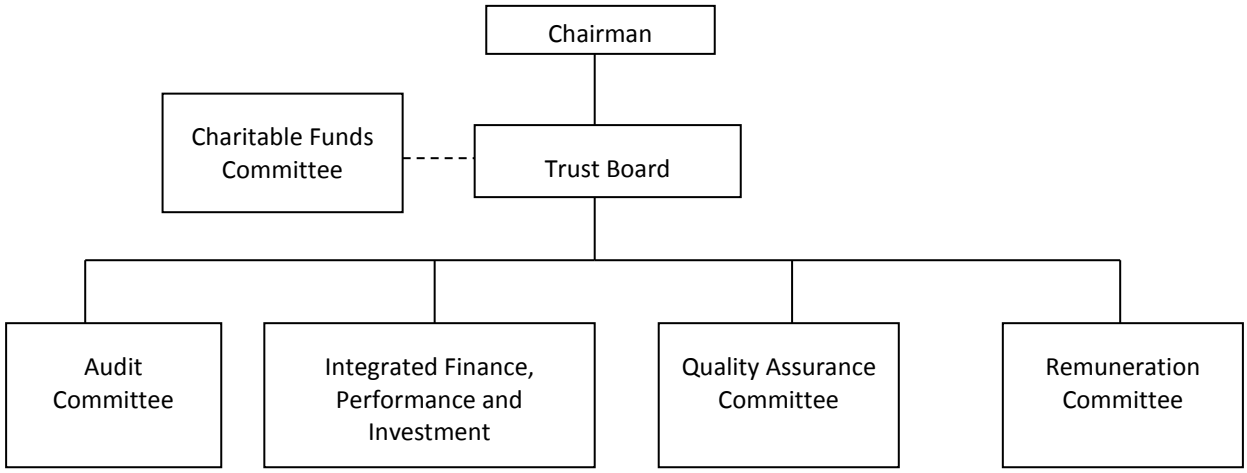
The formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- staff and patient stories, which are presented in public at each Board meeting. These shine a light on staff experiences and individual experiences of patient care provided by our organisation, and act as a catalyst for improvement; and
- Board members carry out regular patient safety walkabouts.

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

Committee Structure

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



All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Remuneration Committee, which (in accordance with NHS guidance) comprise Non-Executive Directors exclusively. All Non-Executive Directors are encouraged by our Chairman to attend all Board level committee meetings, even if they are not voting members of those committees.

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 has met on six occasions throughout the 2016/17 financial year. It has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of our organisation's business. The Audit Committee receives reports at each of its meetings from the External Auditor, Internal Auditor and the Local Counter-Fraud Specialist, the latter providing the Committee with assurance on our work programme to deter fraud.

The Integrated Finance, Performance and Investment Committee meets monthly to oversee the effective management of our financial resources and operational performance across a range of measures. The Quality Assurance Committee also meets monthly and seeks assurances that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients.

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

Every meeting of the Trust Board and each Board committee meeting was quorate during 2016/17.

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 2016/17 is set out in an appendix to this Statement. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attendees as detailed in the terms of reference for each committee.

Board Effectiveness

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

Our Board recognises the importance of effectively gauging its own performance so that it can draw conclusions about its strengths and weaknesses, and take necessary steps to improve. The Board is keen to ensure that it is:

- operating at maximum efficiency and effectiveness;

- adding value; and
- providing a yardstick by which it can both measure its own effectiveness and prioritise its activities for the future.

Building on the findings of a third party external adviser carried out in 2014/15, during the year the Trust Board continued to implement a programme of work to improve Board and Board committee reporting. This work has helped us to:

- align the Board agenda to our priorities and the things that matter most;
- stimulate more forward-looking and strategic conversations in the boardroom;
- reduce duplication and size of the Board pack whilst increasing visibility and insight;
- embed the tools, skills and capability to deliver high quality reports and executive summaries that meet the Board's information needs.

Now that its membership is complete, the Trust Board is to embark on an externally facilitated Board development programme, led by NHS Providers and commissioned by NHS Improvement. Workshops will take place in June and July 2017 on (a) developing an effective and compassionate unitary Board and (b), recovering and maintaining performance. Content will be tailored specifically to the Trust, encouraging consistency throughout the organisation and developing team work.

Outside of its formal meetings, the Board has held development sessions ('Thinking Days') each month throughout the year. Amongst the topics considered were our reconfiguration programme; risk management; workforce equality and diversity; workforce planning and organisational development; and stakeholder engagement.

Our Chairman set objectives for the Chief Executive and Non-Executive Directors for 2016/17. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2016/17. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively, and the results reported to the Remuneration Committee for consideration.

Corporate Governance

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

We have in place a suite of corporate governance policies which are reviewed annually and updated as required. These include standing orders, standing financial instructions, a scheme of delegation, policy on fraud and code of business conduct.

The Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'. We have also adopted the 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).

In line with national guidance issued by NHS England and NHS Improvement in February 2017, we will implement new rules for managing conflicts of interest from 1 June 2017.

Information Governance

We recognise the importance of robust information governance. During 2016/17, the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Information Governance Toolkit. This contains 45 standards of good practice, spread across the domains of:

- information governance management;
- confidentiality and data protection assurance;
- information security assurance;
- clinical information assurance;
- secondary use assurance; and

- corporate information assurance.

We achieved a minimum level 2 standard across all of the 45 standards. Expressed as a score, we achieved 80 per cent, an improvement on our 2015/16 score of 65 per cent.

During the year we reported to the Information Commissioner's Office two serious untoward incidents involving a lapse of data security. Patient care was not put at risk.

In respect of other personal data related incidents experienced during the year, we have carried out investigations to ensure that the root causes are properly understood and addressed; in addition, where necessary patients have been contacted to inform them of the lapses and to provide them with assurance about the actions we have taken to prevent recurrence.

The Risk and Control Framework

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

All 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 reviews the Framework on a monthly basis to identify and review our principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, the controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed. The Chief Executive highlights key issues in his monthly report to the public meeting of the Trust Board, appended to which are the Board Assurance Framework Dashboard and Organisational Risk Register Dashboard, respectively. A copy of the full Framework is also published monthly with the Board papers.

During 2016/17, the Trust Board has considered how best to strengthen our risk management arrangements at two development sessions ('Thinking Days').

Agreement has been reached to implement a revised approach in quarter one 2017/18, the principal aims of which are to ensure:

(a) firstly, within the Board itself, that an informed consideration of risk and risk tolerance underpins organisational strategy, decision-making and the allocation of resources; and

(b) secondly, that the organisation has appropriate risk identification and risk management processes in place to deliver the Annual Operational Plan and comply with the registration and licensing requirements of key regulators.

Our Annual Operational Plan 2017/18 responds to and addresses the strategic risks we face. The current Board Assurance Framework is to be updated to reflect risks in the 2017/18 plan and will continue to be reviewed at regular intervals by both the Executive Team and Trust Board.

Risk Assessment

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

We use a common risk-scoring matrix 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 that appropriate management arrangements are in place.

Annual Quality Account

We are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Account 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 our Annual Quality Account. This is reviewed in draft form by our Quality Assurance Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2016/17, the Quality Assurance Committee has noted our internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – the Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 1 June 2017.

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 2016/17 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 note that, in their Annual Audit Letter issued in June 2016, External Audit:

- noted that they had issued an unqualified opinion on the Trust's accounts on 3rd June 2016. This meant that External Audit believed that the accounts gave a true and fair view of our financial affairs and of the income and expenditure received during the year;
- noted that there were no significant matters which they were required to report to those charged with governance;
- noted that we have prepared our accounts on a going concern basis as there was no evidence of a prospect of services ceasing altogether at the Trust, however given our cumulative financial deficit of £114.4 million incurred over the last three financial years, issued a qualified ('except for') conclusion on our Use of Resources conclusions and (as required) wrote to the Secretary of State for Health confirming this position (referred to as a 'Section 30 letter').

External Audit raised one medium risk recommendation as a result of their 2015/16 audit work relating to valuation assumptions and methodology. We accepted this recommendation and have acted upon it in 2016/17; and have similarly acted upon a recommendation carried forward from the 2014/15 audit to strengthen the quality assurance procedures in relation to the valuation of land and assets.

I have also 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, Integrated Finance, Performance and Investment Committee and Quality Assurance Committee. During 2016/17, 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 2016/17, the Head of Internal Audit notes that Internal Audit have carried out 12 reviews during the year. None of the individual assignment reports had an overall classification of critical or high risk.

We have taken, and are taking action to address the findings of Internal Audit and implementation of the actions in question will be reviewed by the Audit Committee during 2017/18.

The Head of Internal Audit is satisfied that sufficient internal audit work has been carried out in 2016/17 to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, the Head of Internal Audit notes that assurance can never be absolute – the most the Internal Audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

The Head of Internal Audit Opinion for 2016/17 is that governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the control framework. I accept this finding and am committed to strengthening the internal control environment, as detailed in this Statement.

Using our Board Assurance Framework, the Trust Board has also identified actions to mitigate other risks in the year in relation to:

a. implementing our Quality Commitment;
b. providing an appropriate environment for staff/patients;
c. an increase in emergency attendances/admissions without a corresponding improvement in process and /or capacity;
d. delivering the national access standards;
e. tertiary referrals flows from partner organisations;
f. progressing the Better Care Together programme at sufficient pace and scale;
g. delivering an effective learning culture and providing consistently high standards of medical education;
h. delivering the Genomic Medicine Centre project;
i. ensuring the supply and retention of the right staff, at the right time, in the right place and with the right skills that operate across traditional organisational boundaries;
j. system wide consistency and sustainability in the way we manage change and improvement, impacting on the way we deliver the capacity and capability shifts required for new models of care;
k. delivering the recommendations of the national 'freedom to speak up review';
l. estates infrastructure capacity;
m. capital resources to deliver the reconfigured estate which is required to meet our revenue obligations;
n. delivering a clinically sustainable configuration of services;
o. delivering the 2016/17 programme of services reviews, a key component of service-line management;
p. balancing the demand/capacity equation;
q. achieving a revised and approved 5-year financial strategy;
r. progressing the Electronic Patient Record programme;
s. aligning Information Management and Technology priorities to our overall priorities.

Any changes in the current or target risk scores are highlighted to the Trust Board, and the Board also reviews and seeks assurances on the management actions in place to mitigate the identified risks.

Significant Control Issues

Care Quality Commission (CQC) Inspection

In January 2017, the CQC published the findings of their inspection of our hospitals undertaken in June and July 2016. The CQC rated the Trust overall as 'Requires Improvement', and also rated each hospital individually as 'Requires Improvement'. The CQC rated 'Caring' as 'Good' across all three hospital sites.

The Trust Board has approved a formal action plan to address the findings of the CQC and progress against this plan will be monitored by the Quality Assurance Committee on behalf of the Trust Board during 2017/18.

At the time of the CQC inspection, conditions imposed by the CQC in December 2015 on our registration as a service provider (following an unannounced inspection in November 2015 at our adult Emergency Department) remained in place. On 15 November 2016, the CQC lifted the conditions as the CQC was assured that we had satisfactorily addressed areas of poor practice and potential risks to patient safety.

Key Financial Duties

In respect of performance in 2016/17 against the key financial duties, we have:

a. not delivered the planned deficit of £8.3m ;

b. achieved the External Financing Limit (the limit placed on net borrowing) of £87,578k, with a permitted underspend of £5,204k;
c. achieved the Capital Resource Limit (the limit placed on net capital expenditure) of £62,419k, with a permitted underspend of £21,000.

At its meeting in May 2016, the Audit Committee assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by consideration of a 2016/17 going concern statement, prepared by the Chief Financial Officer.

The Committee endorsed the going concern statement, underpinned by a working capital strategy the key objectives of which were to:

a) maintain the cash balance as planned during 2016/17, including drawing down temporary and permanent borrowing and managing our other working capital balances;
b) improve performance against the 'Better Payment Practice Code';
c) achieve the External Financing Limit and Capital Resource Limit; and
d) further develop monitoring and reporting processes to ensure that there were robust linkages between cash balances; revenue income and expenditure; and capital expenditure.

The Trust Board subsequently accepted the 2016/17 'going concern' position statement at its meeting in June 2016, on the recommendation of the Audit Committee.

Throughout the 2016/17 financial year, we have failed to meet our obligations under the Better Payment Practice Code and have experienced considerable pressures in managing the day to day cash position. This situation has arisen as a result of historic financial deficits; delays in accessing cash within year; and sub-optimal cash management and forecasting processes. In response to these pressures, we commissioned PricewaterhouseCoopers (PwC) to review our approach to cash management, cash forecasting and the associated reporting of the cash position to the Integrated Finance, Performance and Investment Committee. This piece of work has concluded and we have accepted PwC's final report with their recommendations having been adopted and implemented. Performance is reviewed at each meeting of the Integrated Finance, Performance and Investment Committee and scrutinised further on a periodic basis by the Audit Committee.

The Board has agreed plans to deliver the agreed 2017/18 financial plan – a £26.7m deficit - which includes the delivery of a £33m Cost Improvement Programme.

Emergency Care

Unfortunately, we failed to meet the A&E 4-hour standard in 2016/17, achieving a performance of 79.6 per cent (86.9 per cent 2015/16) against a target of 95 per cent.

As a member of the Leicester, Leicestershire and Rutland Urgent Care Board, we are fully committed to working with our partners across the health and social care sectors to improve emergency care performance in 2017/18.

Waiting list management arrangements

We recognise the importance of ensuring that we have in place appropriate arrangements to ensure the effective management and delivery of 'referral to treatment' pathways, and this includes being assured of the quality and accuracy of elective waiting time data. During the course of 2016/17, we have carried out a comprehensive review of the elective pathway from referral through to treatment and discharge of patients. This has included the cancer pathway process and associated diagnostic processes.

The review has identified points at which there is potential for error or failure of our processes. These have then been risk assessed and actions agreed to mitigate the identified risks, with target dates and risk owners. The resulting action plan has been agreed by the Executive Performance Board, and reviewed by the Audit Committee. Implementation of the action plan will be tracked at meetings of both bodies during 2017/18.

We have agreed that External Audit will agree a testing approach with us which will provide assurance that the controls identified are designed and operating effectively. External Audit's work will focus on those areas identified as higher risk. The results of this review, and the response of the Executive Team to those results, will be reported to the Audit Committee in 2017/18.

Alongside these actions, we commissioned Internal Audit during 2016/17 to carry out a review of the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of the data. Internal

Audit's review has identified opportunities to make improvements in our processes, and actions have been agreed to implement Internal Audit's recommendations during 2017/18.

Conclusion

My review confirms that the University Hospitals of Leicester NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. We recognise that the internal control environment can always be strengthened and this work will continue in 2017/18, as described above.

In addition to the specific issues identified above, further work will also be carried out in 2017/18 to review and strengthen our governance, risk management and internal control systems, policies and procedures as part of our commitment to continuous improvement.

Signed 

Chief Executive (on behalf of the Trust Board)

Date: 1 June 2017

Trust Board and Committee attendance 2016/17

Name	**Trust Board** maximum – 18	**Audit Committee** maximum – 6	**Integrated Finance, Performance and Investment Committee** maximum – 12	**Quality Assurance Committee** maximum – 12	**Remuneration Committee** maximum – 3	**Charitable Funds Committee** Maximum – 5
Karamjit Singh – Chairman	16/18	N/A	10/12	10/12	3/3	3/4
Professor Philip Baker – Non-Executive Director **(1)**	13/15	N/A	N/A	N/A	1/2	N/A
Dr Shirley Crawshaw – Non-Executive Director **(2)**	4/4	2/2	3/3	3/3	1/1	1/1
Ian Crowe – Non-Executive Director	17/18	5/6	11/12	11/12	2/3	4/5
Dr Sarah Dauncey – Non-Executive Director **(3)**	3/4	0/2	3/3	3/3	1/1	1/1
Alison Goodall – Non-Executive Director **(4)**	2/3	N/A	N/A	N/A	0/1	N/A
Andrew Johnson – Non-Executive Director	18/18	6/6	11/12	11/12	3/3	4/4
Richard Moore – Non-Executive Director	17/18	6/6	9/12	9/12	3/3	4/4
Ballu Patel – Non-Executive Director **(5)**	12/14	4/4	8/9	8/9	2/2	4/4
Martin Traynor – Non-Executive Director	18/18	4/6	11/12	11/12	2/3	5/5
John Adler – Chief Executive	18/18	1/1	10/12	9/12	3/3	N/A
Mr Andrew Furlong – Medical Director	15/18	N/A	N/A	9/12	N/A	N/A
Richard Mitchell – Chief Operating Officer	14/18	N/A	11/12	N/A	N/A	N/A
Julie Smith – Chief Nurse	17/18	N/A	N/A	8/12	N/A	N/A
Louise Tibbert – Director of Workforce and OD	17/18	N/A	11/12	N/A	2/3	N/A
Paul Traynor – Chief Financial Officer	18/18	6/6	11/12	N/A	N/A	5/5
Stephen Ward – Director of Corporate and Legal Affairs	17/18	6/6	N/A	N/A	3/3	5/5
Mark Wightman – Director of Marketing and Communications	15/18	N/A	N/A	N/A	N/A	4/5

Notes:

(1) Non-Executive Director from 1 July 2016
(2) Non-Executive Director from 3 January 2017
(3) Non-Executive Director until 14 July 2016
(4) Non-Executive Director until 30 June 2016
(5) Non-Executive Director from 1 August 2016

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

We have audited the financial statements of University Hospitals of Leicester NHS Trust for the year ended 31 March 2017 on pages 2 to 35 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Board of Directors of University Hospitals of Leicester NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2017 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the Department of Health Group Accounting Manual 2016/17; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of the above responsibilities.

Other matters on which we report by exception – referral to Secretary of State

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 1 June 2017 a referral was made to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in respect of the Trust's failure to achieve its statutory break even duty.

Other matters on which we report by exception - adequacy of arrangements to secure value for money

We are required to report by exception if we conclude that we are not satisfied that the Trust has made proper arrangements to secure economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2017.

In considering the Trust's arrangements for securing sustainable resource deployment, we identified the following matters:

- The Trust incurred a deficit of £27.2 million in 2016/17. This was £18.9 million adverse to plan, including £6.9 million relating to underlying performance and £12 million in respect of planned for Sustainability and Transformation Funding (STF) not received.
- NHSI requires the Trust to deliver an £8.4 million surplus in 2017/18, inclusive of £21.8 million STF, effectively an underlying deficit plan of £13.4 million. The Trust is not planning to meet the control total but recognises that financial improvement is required. As such, STF income is not factored into planned outturn, and the overall plan to deliver a £26.7 million deficit in 2017/18 carries with it significant risk.
- The Trust did not consistently meet a number of operational targets during 2016/17, particularly A&E Waiting Times, Cancer 62 day Pathway, and Diagnostics 6 Week Wait.
- The latest report from the Care Quality Commission dated 26 January 2017 provided an overall rating of 'requires improvement' to the Trust following an inspection undertaken in June 2016. The report rated 'requires improvement' in the four sub-categories of safe, effective, responsive and well-led services.

These issues are evidence of significant weaknesses in the Trust's arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2016, we are not satisfied that, in all significant respects, University Hospitals of Leicester NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Certificate

We certify that we have completed the audit of the accounts of University Hospitals of Leicester NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Jonathan Brown.

Jonathan Brown
For and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
One Waterloo Way
Leicester
LE1 6LP

1 June 2017

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.

Acuity The measurement of the intensity of care required for a patient delivered by a registered nurse. There are six categories ranging from minimal care to intensive care.

Ambulatory care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

Cannulation intravenous cannulation involves putting a "tube" into a patient's vein so that infusions can be inserted directly into the patient's bloodstream.

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

Care Quality Commission the organisation that make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

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

CIP (Cost Improvement Programme) a Cost Improvement Programme (CIP) is the identification of schemes to increase efficiency/ or reduce expenditure. CIPs can include both recurrent (year on year) and non-recurrent (one-off) savings. A CIP is not simply a scheme that saves money. The most successful CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in a permanent cost savings, but also improve patient care, satisfaction and safety.

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

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

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

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

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

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

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

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

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

Emergency Department is a hospital department that assesses and treats people with serious and life-threatening injuries and those in need of emergency treatment. Also sometimes called A&E (Accident & Emergency).

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

Friends and Family Test (FFT) launched in April 2013, the FFT question asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

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.

Mortality means death rate. In the NHS it is used when referring to the expected death rate for conditions or procedures.

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

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

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

NHS Improvement support foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NHS Trust Development Authority (TDA) is the organisation that provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow. From 1 April 2016, the NHS Trust Development Authority will be part of NHS Improvement.

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.

QIPP (Quality Innovation Productivity and Prevention) In July 2010, the White Paper 'Equity and excellence: Liberating the NHS' set out the government's vision for the future of the NHS. The White Paper outlined the

government's commitment to ensuring that QIPP supports the NHS to make efficiency savings, which can be reinvested back into the service to continually improve quality of care.

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 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.

SHMI (Summary Hospital-level Mortality Indicator) The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

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

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

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

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

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

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

Please help us to improve the way we share information

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 2017**.

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	

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 2017/18 annual report is available? If so, please send us your email address

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Completed questionnaires can be sent to:

Communications Team, University Hospitals of Leicester NHS Trust, Medical Illustration, Level 2 Windsor Building, Leicester, LE1 5WW or communications@uhl-tr.nhs.uk

NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

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.

Design and Photography by UHL Medical Illustration 0116 258 5904