NHS
University Hospitals of Leicester
NHS Trust

Caring at its best

2017-18
Annual Report & Accounts

Our Values

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

Welcome from the Chairman and Chief Executive

Welcome from the Chairman and Chief Executive

We are delighted to present our Annual Report and Accounts for the University Hospitals of Leicester NHS Trust (Leicester's Hospitals) for 2017/18.

During the year (between November 2017 and January 2018), the Care Quality Commission (CQC) inspected five core services, across four locations, and carried out a 'well-led' inspection. They inspected urgent and emergency care at the Royal Infirmary, medical care at the Glenfield and Royal Infirmary, diagnostic imaging, maternity and outpatients at the Royal Infirmary and the General Hospital, and maternity services at all three sites, including St Mary's Birthing Centre.

We are really pleased to report that through our commitment to continuous improvement, we have improved in a number of key areas since our last ratings were published in January 2017. The report is available on our website. The CQC Inspectors have improved our ratings for the 'effectiveness' of services overall and for our maternity service, both of which are now rated as good (they were previously rated 'requires improvement'). We are also particularly pleased to see the very significant improvement in our urgent and emergency services ratings, despite continued pressure. In four of the five domains we have seen an improvement.

Overall, the Inspectors have rated our Trust as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. In addition, no elements of any of our services are now rated as inadequate.

The Inspectors observed good and outstanding practice and compassionate care being carried out by our staff, along with feedback from patients that staff treated them with kindness and provided emotional support to minimise their distress. They paid tribute to our maternity services, particularly our new dedicated Home Birth Team, prenatal and antenatal clinics, both locally and across borders, and the TED (Time, Escalation, Decision making) video created to improve outcomes for babies.

It is regrettable that following their inspection the CQC served us with a warning notice because the care we give diabetic patients in relation to the management of their insulin requires significant improvement. We recognise this shortfall and since the inspection, we have accelerated our programme of work to ensure immediate improvements and safety of our patients. Our actions focus on face to face education and training for our doctors and nurses, improved decision-making tools to aid prompt management and intervention, overseen by enhanced support from the diabetic specialist team. We are pleased to report that the early evidence supports these actions and have delivered improvements in knowledge and care of patients with diabetes.

Overall, we think that the CQC's assessment is accurate, balanced, and fair. In response, we have a robust action plan in place, which clearly maps out the improvements we need to make to our services.

Two very memorable moments in the year were the opening of our new £48m Emergency Floor at 4am on Wednesday 26 April 2017 and the subsequent visit of HRH The Princess Royal, in March 2018. What is clear from feedback is that the new department has not only improved the experience for patients, but also for the staff working in and with the department. Patient satisfaction has risen from around 85 per cent to 97 per cent, even during the peak period of winter pressures.

Regrettably, what our new department has not delivered is an overall improvement in our waiting time performance. This is due to a series of internal and external factors, but predominantly the flow of patients out of the department, through the rest of the hospitals, and into the community. We continue to work with partners in health and social care across Leicester, Leicestershire, and Rutland to tackle this on-going problem, which is sadly not unique to our area.

On completion of Phase 2 of the Emergency Floor in June 2018, we will see all of our assessment units relocate from their current locations across the Royal Infirmary, to right next door to the Emergency Department. Patients referred to these assessment units from the Emergency Department are assessed and diagnosed, and where necessary, immediate acute medical treatment is started. Patients either move to a main ward in our hospitals or are discharged home. Our assessment units include the Acute Frailty Unit and Emergency Frailty Unit, where older, frail patients will be treated in a purpose-built frailty friendly space, by geriatricians and members of the multi-disciplinary clinical team.

The new Department was opened in time for what feels like the most challenging winter in memory, which saw us – along with the rest of the NHS – struggle with operational pressures. In January, all NHS Trusts were instructed to cancel elective operations in a bid to free up capacity to treat the increased number of emergency patients needing care. This instruction was for the whole of January but in reality the situation lasted through February and March. Even more regrettable was the cancellation of some cancer surgery during that operationally challenging time. We do not take these decisions to cancel patients, particularly cancer patients, lightly. We know how distressing this is for everyone involved, but we cannot in good faith bring patients in for surgery if we do not have a bed somewhere to safely look after them following their surgery. In preparation for winter 2018/19 we are working on how we can increase capacity to reduce the chances of cancellations in the future.

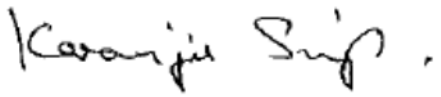
On 30 November, following almost 18 months of uncertainty, NHS England announced that they would continue to commission surgical services at our East Midlands Congenital Heart Centre, allowing us to continue to provide lifesaving surgery for children and adults in our region. The decision was a vote of confidence for our staff and service, and great news for our NHS partners across the East Midlands network. It has allowed the teams to focus on ways of working more effectively to enable more patients to be treated in our centre.

The service continues to see and treat more patients every year and works closely with all of our network hospitals, to ensure that they are able to offer East Midlands Congenital Heart Centre as an option to those patients who live closest to us and want to be cared for by us. We are pleased to report that we are on track to meet the surgical numbers required in the standards and are looking forward to implementing the exciting plans to co-locate the children's element of this service with other children's services at the Royal Infirmary by 2020.

Looking forward to 2018/19, we will continue to progress our plans (Delivering Caring at its Best) whilst we wait for news of national capital funding. These plans will see us relocate our intensive care service from the General, consolidating it on the Royal Infirmary and Glenfield hospital sites, which will trigger a number of moves for services reliant on intensive care. These plans are part of the wider system Sustainability and Transformation Plan or "Better Care Together" as we call it locally.

Finally, we could not end our introduction to this without giving our sincere thanks to the many people and organisations that support our work. To the hundreds of volunteers who give their time freely, every day, to help our patients and visitors; to the Patient Partners who act as critical friends to us and offer advice on our ideas; and to bodies such as Healthwatch, local Clinical Commissioning Groups, Local Authority partners, and GPs for their continued help and support.

Most of all, our unreserved thanks, on behalf of the whole Trust Board, must go to our staff. This past year has seen many challenges and pressures, but when we walk our wards, departments and corridors we are met with smiles and hear stories of people going above and beyond for our patients and their colleagues. We really appreciate you're their dedication to our organisation. We thank them for their on-going commitment to make things better, and we revere them for everything they do day in, day out to provide the best service they can.



Karamjit Singh CBE, Chairman

John Adler, Chief Executive

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.

Based in the heart of Leicester, we are one of the biggest and busiest NHS Trusts in the country, serving the one million residents of Leicester, Leicestershire and Rutland – and our specialist services serve another 2-3 million patients from areas across the rest of the country.

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.

We run three city hospitals, the Glenfield, General and Royal Infirmary, which is home to our Children's Hospital.

Having a role in the development of the next generation of clinical staff is important to us so we work closely with partners at the University of Leicester and De Montfort University to provide world-class teaching to nurture and develop future 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 across the globe 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 host an NIHR Biomedical Research Centre which supports key research into cardiovascular and respiratory disease, lifestyle and diabetes. We also host an NIHR Clinical Research Facility, which supports early phase clinical trials. Our Research Space has a new dedicated children's research facility catering for our youngest research participants. We are extremely proud that we have an Experimental Cancer Medicine Centre, and our HOPE facility is an instrumental factor in delivering clinical trials of new cancer treatments, generously supported by the locally-based charity Hope Against Cancer. We are helping to pave the way for a new era of personalised 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 be offered the latest medicines and treatments.

Our heart centre at the Glenfield hospital continues to lead the way in developing new and innovative research and techniques and has 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. Our vascular services are nationally renowned, with more patients surviving longer after following an aneurysm repair (to fix a life threatening bulge in a blood vessel).

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.

Our values and the NHS Constitution

We created our values with staff over five 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 (www.gov.uk/government/news/nhs-constitution-and-handbook-updated) 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.

There have since been a number of amendments and updates to the constitution. The latest version can be found on the gov.uk website.

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.

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The Accountability Report

Our Trust Board

Declaration of Interests

	Karamjit Singh CBE Trust Chairman	Family member is a Partner with Lakeside Practice, Corby.
	Vicky Bailey Non-Executive Director	Former Trustee and current Fellow of the Queens Nursing Institute
	Professor Philip Baker and Dean of the University of Leicester Medical School Non-Executive Director	Minority shareholder of Metabolomic Diagnostics – spinout company seeking to develop predictive tests for pregnancy complications Trustee of 'The Bridge' – a charity providing for the homeless in Leicester Dean of Medicine, Pro-Vice-Chancellor and Head of the College of Life Sciences, University of Leicester
	Dr Shirley Crawshaw (until 16.6.17) Non-Executive Director	None to declare
	Colonel (Ret'd) Ian Crowe Non-Executive Director	Member of the Royal British Legion Brother by award of the Order of St John (not active in the organisation) Member of the Royal Army Medical Corps Association
	Andrew Johnson Non-Executive Director	None to declare
	Richard Moore Non-Executive Director	Director, Peppercorn Services Offices Ltd. Director, EAI 555 Limited Director, Momentum 002 Limited. Director, Momentum Partners Chairman, 555 Fussball Projekt & SoccerWorld Deutschland GmbH. Corporate Director of Finance and Resources, Barnardo's
	Ballu Patel Non-Executive Director	Employment by RNIB
	Martin Traynor Non-Executive Director	None to declare

Our Trust Board

Declaration of Interests

John Adler

Chief Executive

None to declare

Eileen Doyle

Interim Chief Operating Officer

Managing Director of Dunain Health Management, a Limited Company currently in dormancy

Andrew Furlong

Medical Director

None to declare

Tim Lynch
(from 3.7.17 until 31.12.17)

Interim Chief Operating Officer

Director of Camlin Associates

Richard Mitchell
(until 2.7.17)

Chief Operating Officer

None to declare

Julie Smith

Chief Nurse

None to declare

Paul Traynor

Chief Financial Officer

Spouse is employed in a governance role by the LLR Alliance

Directors who provide advice to the Board

Louise Tibbert

Director of Workforce and OD

Member of the NHS Pension Board as an employer representative – 3-year appointment from 1.1.16

Stephen Ward

Director of Corporate and Legal Affairs

None to declare

Mark Wightman

Director of Strategy 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. Since September 2017 individual Non-Executive Directors have been identified as members of specific Board Committees (rather than attending them all), although papers of all those meetings are available to all Non-Executive Directors if they wish to see them. The Chairman and all Non-Executive Directors are members of our 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 (until September 2017 when it was replaced by the Quality and Outcomes Committee) Quality and Outcomes Committee (since September 2017)
Andrew Johnson	Charitable Funds Committee (until September 2017) People, Process and Performance Committee (from September 2017)
Richard Moore	Audit Committee
Ballu Patel	Charitable Funds Committee (since September 2017)
Martin Traynor, OBE	Integrated Finance, Performance and Investment Committee (until September 2017, when it was replaced by the Finance and Investment Committee) Finance and Investment Committee (from September 2017)

Remuneration Committee

Chair	Karamjit Singh, CBE
Members	Professor Philip Baker – Non-Executive Director Vicky Bailey – Non-Executive Director Col (Ret'd) Ian Crowe – Non-Executive Director Andrew Johnson – Non-Executive Director Richard Moore – Non-Executive Director Ballu Patel – Non-Executive Director Martin Traynor, OBE – Non-Executive Director

Audit Committee

Chair	Richard Moore
Members	Dr Shirley Crawshaw – Non-Executive Director Ian Crowe – Non-Executive Director Andrew Johnson – Non-Executive Director Ballu Patel – Non-Executive Director Martin Traynor – Non-Executive Director John Adler – Chief Executive Paul Traynor – Chief Financial Officer Stephen Ward – Director of Corporate and Legal Affairs (non-voting)

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 Wednesday 20 September 2017 at the Peepul Centre in Leicester, presenting our 2016/17 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

A nominated representative of Leicester, Leicestershire and Rutland Healthwatch attended and contributed to our public Trust Board meetings as a non-voting/co-opted member – Mr Evan Rees took over this role in May 2017. 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.

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 ('satisfactory') across all the 45 standards.

During the year we reported to the Information Commissioner's Office one serious untoward incident involving a lapse of data security. However, 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.

From April 2018, the new Data Security and Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit and, taking into account the advice of the Chief Information Officer, the Trust Board will self-assess our position against the defined security standards to assure itself that we are meeting our obligations on data protection and data security.

Anti-Fraud and Corruption Statement

The Bribery Act 2010 came into effect on 1 July 2011. Bribery is generally defined as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. The maximum penalty for bribery is 10 years imprisonment, with an unlimited fine.

In addition, the Act introduces a corporate offence of failing to prevent bribery by an organisation not having adequate preventative procedures in place. The organisation may avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The corporate offence is not a stand-alone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

As a result, we confirm that the University Hospitals of Leicester NHS Trust will commit sufficient time and resources to the development and embedding of an appropriate anti-bribery programme to include:

- A commitment to carry out business fairly, honestly and openly
- A commitment to zero tolerance towards bribery
- The consequences of breaching the policies for employees and managers
- The avoidance of doing business with others who do not commit to doing business without bribery as a 'best practice' objective
- The protection and procedures for confidential reporting of bribery (Whistleblowing)
- To support key individuals and departments involved in the development and implementation of the Trust's bribery prevention procedures

Going Concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Group and Trust's ability to continue as a going concern. In preparing the financial statements the Board of Directors has carefully considered the principle of 'going concern' against the requirements of IAS1.

The Directors concluded that although there are material uncertainties relating to the financial sustainability of the Group and Trust, they have made appropriate enquiries and still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. On this basis, the financial statements have been prepared on a going concern basis.

Corporate Governance Report

Directors Report

The Directors are aware of no relevant information of which the auditors are unaware. Each Director has taken all of the steps that they ought to have taken as a Director in order to make themselves 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, 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.

Annual Governance Statement 2017/18

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 our policies, aims and objectives. We recognise that our internal control environment can always be improved and strengthened, and this work will continue in 2018/19 as part of our commitment to continuous improvement.

In 2017/18 we identified a number of significant control issues which have impacted on our overall performance. This Statement gives an account of the remedial actions which have been, and are being, taken.

Scope of Responsibility

As the Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports adherence to our policies and the achievement of our aims and objectives, whilst safeguarding both 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 the 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 31st March 2018 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 thirteen members: a Chairman, seven Non-Executive Directors, and five Executive Directors.

During 2017/18 there have been a number of changes in the composition of the Board. Dr Shirley Crawshaw stood down as a Non-Executive Director in June 2017 and was succeeded by Vicky Bailey, who joined the Trust Board on 1st February 2018.

Richard Mitchell, Chief Operating Officer, left the Trust in June 2017 to become the Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust. Tim Lynch acted as Interim Chief Operating Officer between July and December 2017; Eileen Doyle has fulfilled the Interim Chief Operating Officer role between January and June 2018. Rebecca Brown will join the Trust as substantive Chief Operating Officer in June 2018.

Julie Smith, Chief Nurse, and Louise Tibbert, Director of Workforce and Organisational Development, left the Trust in April 2018. Carolyn Fox will take up the post of Chief Nurse in October 2018, while Hazel Wyton will join the Trust as Director of People and Organisational Development in August 2018.

During 2017/18, the post of Director of Strategy was abolished, and the responsibilities of the post were reallocated to the Director of Strategy and Communications (held by Mark Wightman) and Chief Financial Officer (held by Paul Traynor).

The Board continues to be supported in its work by the Director of Corporate and Legal Affairs, who has a standing invitation to attend all meetings, but not in a voting capacity.

In summary, although there has been some turnover in Director posts in 2017/18, the process of making substantive appointments to the Trust Board is now complete, creating a well-balanced Board to provide continuity of leadership going forward.

Performance Management Reporting Framework

I report 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 monthly at a joint meeting of the Board's People, Process and Performance Committee (PPPC) and Quality and Outcomes Committee (QOC). 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 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.

Our 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:

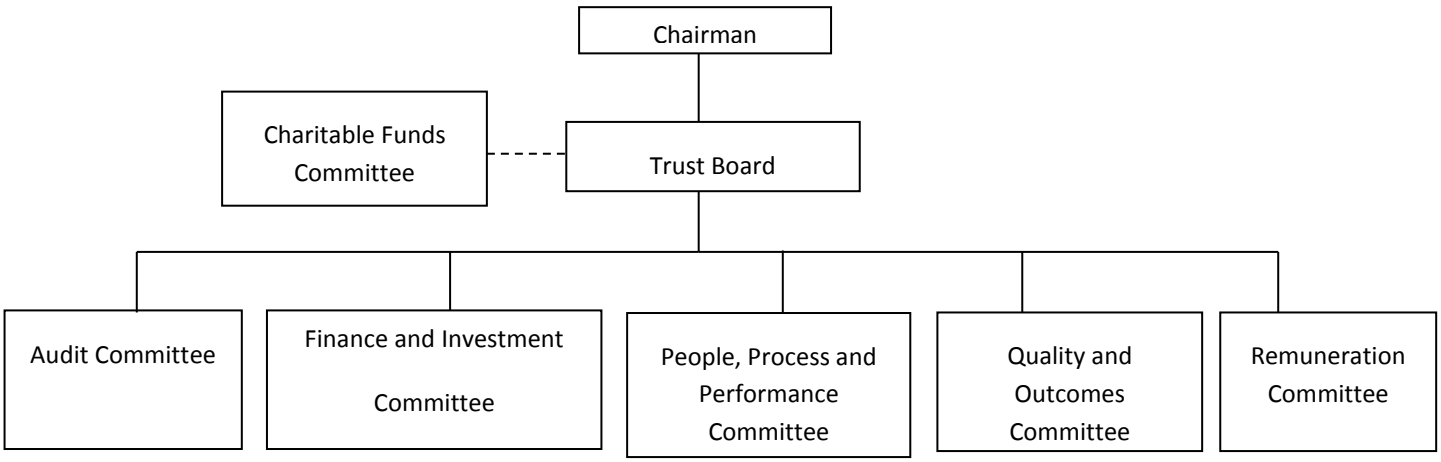
- staff and patient stories, which are presented in public at each Board meeting. These shine a light on staff experiences and individual experiences of patient care provided by our organisation, and act as a catalyst to our commitment to continuous improvement; and
- regular patient safety walkabouts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

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, patients, and public.

Committee Structure

We operate a committee structure to strengthen our focus on quality governance, finance, people, process and performance, and risk management. The Board agreed to revise the structure during 2017/18 to strengthen the focus on workforce issues and on organisational systems, processes and performance management. To this end, the People, Process and Performance Committee was established as a new standing Committee of the Board. The Committee meets monthly.

The committees carry out detailed work of assurance on behalf of the Trust Board. A diagram illustrating the Board committee structure is set out below:



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

The Audit Committee is established under powers delegated by the Trust Board, with approved terms of reference that are aligned with the NHS Audit Committee Handbook. The Committee has met on six occasions throughout the 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 Finance and Investment Committee meets monthly to oversee the effective management of our financial resources and financial performance across a range of measures. The Quality and Outcomes 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, highlighting material issues arising from the work of the committee to the Board.

Every meeting of the Trust Board and each Board committee meeting was quorate during 2017/18.

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 2017/18 is set out in appendix 1 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 body.

Board Effectiveness

On joining the Board, Non-Executive Directors participate in a full induction programme and given background information about the Trust and our activities.

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

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

During the year, the Trust Board participated in a formal Board effectiveness programme, facilitated by NHS Providers and sponsored by NHS Improvement. One of the outputs was to implement a programme of work to improve Board and Board committee reporting. This work has helped us to better:

- 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.

Part of the Board effectiveness programme involved a self-assessment by the Board against the NHS Improvement well-led framework.

The findings and resulting actions taken by the Board formed a backdrop to the Care Quality Commission's well-led inspection of the Trust between 10th and 12th January 2018. The Trust retained an overall rating of 'requires improvement', and was again rated 'requires improvement' in relation to the well-led domain. Actions to address the Commission's inspection findings have been agreed and implementation will be monitored by the Quality and Outcomes Committee on behalf of the Board.

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

Our Chairman set objectives for myself and for the Non-Executive Directors for the year. In turn, I set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the 2017/18 Annual Plan. Performance against objectives is reviewed formally on an annual basis by the Chairman and I, 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 and updated as required. These include standing orders, standing financial instructions, a scheme of delegation, and policies to counter fraud, bribery and corruption.

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).

NHS Trusts are subject to oversight by NHS Improvement which uses the Single Oversight Framework for the purpose. The Single Oversight Framework bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions and NHS Improvement has directed that NHS Trusts must self-certify compliance with licence conditions G6 and FT4, respectively.

The Trust Board undertakes a self-assessment of compliance against these conditions annually, having regard to guidance issued by NHS Improvement, and where necessary identifies actions to mitigate risks to compliance.

Following review, the Trust Board declared compliance with conditions G6 and FT4 for the 2017/18 financial year and confirmed that the Trust took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements arising under the NHS Acts and having regard to the NHS Constitution, noting the impact on waiting lists of the Trust's decision to temporarily suspend non-urgent elective procedures during Winter 2017, in line with NHS England guidance.

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

Information Governance

We recognise the importance of robust information governance. During 2017/18, the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian. The Chief Information Officer has assumed the role of Senior Information Risk Owner from May 2018.

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 ('satisfactory') across all of the 45 standards.

During the year we reported to the Information Commissioner's Office one serious untoward incident involving a lapse of data security. However, 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.

From April 2018, the new Data Security and Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit and, taking into account the advice of the Chief Information Officer, the Trust Board will self-assess our position against the defined security standards to assure itself that we are meeting our obligations on data protection and data security.

Review of economy, efficiency and effectiveness of the use of resources

The Trust's clinical and non-clinical activities are managed under a devolved management structure, governed by a scheme of delegation which is reviewed and updated, where required, on an annual basis.

For clinical activities, we have in place a clinical management structure to support the effective leadership of clinical services and ensure effective care. This management structure consists of 7 Clinical Management Groups (CMG), with each CMG having a leadership team that comprises a senior clinician, senior nurse and senior manager. This core team is supported by the human resources team and information and performance colleagues, with finance support provided through embedded heads of finance and an associated CMG-based finance team.

For non-clinical activities, we have in place a corporate directorate structure to support the organisation and to provide corporate services to the CMGs. This management structure consists of 10 corporate directorates with each directorate being led by a Director, with finance support provided through the corporate finance function.

We maintain a strong focus on performance management, with all CMGs and Directorates bearing responsibility for the delivery of financial and other performance targets. Performance is monitored through a system of performance agreements which are agreed and documented as part of the annual business planning cycle and reviewed through a series of regular performance meetings chaired by a Board-level Executive Director.

The Trust continues to adopt a project-based approach to savings delivery through an established cost improvement programme underpinned by project management office arrangements. Whilst we have enhanced our governance and oversight arrangements in respect of savings delivery during 2017/18, emerging cost pressures and operational challenges have resulted in a programme that has not been able entirely to deliver recurrent savings within the year. Non-recurrent benefits have closed this savings gap in-year, and we are aware that this position creates a further financial challenge heading into the next financial year.

The Finance and Investment Committee provides assurance to the Trust Board as to the achievement of the financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. This Committee interfaces with the other Trust Board Committees and Executive Board meetings, and also reviews the process of business planning, specific business case development, and capital programme management.

The Trust has developed an internal audit programme, based on key business governance themes with Internal Audit providers PWC, designed to enhance focus on business governance and to support improved compliance.

The Trust had a planned deficit in 2017/18 and breached the requirement under section 30 of the Local Audit and Accountability Act 2014 to achieve break-even taking one year against another over a three year rolling period. As such, the Trust's External Auditors have made a referral to the Secretary of State for Health. This referral has been made under Section 30 of the 2014 Act.

The Trust recognises that this position is set within the context of a wider sustainability gap across the local health economy. To address this challenge, work remains on-going through the Trust's longer term reconfiguration programme that is inherently linked to the Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership that includes the local health and social care partners.

The Risk and Control Framework

Capacity to handle risk

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.

The Medical Director is the lead Director for risk management at the Trust and is supported in this role by the Director of Safety and Risk and Risk and Assurance Manager, respectively. Staff are trained to manage risk in a way appropriate to their authority and duties via the risk management awareness training programme.

The review of risk registers is a standing item on the agenda of each monthly meeting held between the Executive Directors and individual Clinical Management Group senior management teams. Risks which threaten the achievement of the Trust's strategic objectives and which feature on the Board Assurance Framework are reviewed at each Executive Board meeting.

Good risk management encourages organisations to take well-managed risks that allow safe development, growth and change. However, it is impossible to eliminate all risks, and every organisation has to live with a degree of risk. Through its monthly review of the Board Assurance Framework, the Trust Board is able to decide the balance between the cost of mitigating risks, tolerating risks and accepting the risk which is not mitigated – in other words, to determine the Trust's risk appetite.

All key strategic risks are documented in our 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. 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. As Chief Executive, I highlight the key issues in a monthly

report to the public meeting of the Trust Board. A copy of the full Framework is also published monthly with the Board papers and scrutinised by the Board.

Our Annual Operational Plan 2018/19 responds to and addresses the strategic risks we face. The current Board Assurance Framework has been updated to reflect risks in the 2018/19 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, they 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.

Control measures are in place to ensure that our organisation complies with all of our obligations under equality, diversity and human rights legislation. Each of the Trust's policies is subject to an equality impact assessment and actions are taken as appropriate when an assessment identifies issues which warrant attention.

The Trust has an open and supportive reporting culture, and staff are actively encouraged to report not only actual incidents but also 'near misses'. Evidence of the Trust's good reporting culture is demonstrated by the fact that the Trust is placed in the top quartile for reporting incidents to the National Reporting Learning System (NRLS).

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure we comply with all employer obligations contained within the scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

We have carried out risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that we comply with our obligations under the Climate Change Act and the Adaptation Reporting requirements.

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.

On behalf of our Chief Nurse, the Director of Clinical Quality co-ordinates the preparation of our Annual Quality Account. This is reviewed in draft form by our Quality and Outcomes Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2017/18, the Quality and Outcomes Committee has noted and endorsed our internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – the Statement will be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 7th June 2018.

Our quality governance arrangements are set out in detail in our Governance Framework, the current version of which was approved by the Trust Board in October 2017. Our quality framework includes the following key components:

- an open and participative culture in which education, research and the sharing of good practice are valued and expected;
- a commitment to quality that is shared by staff and managers, and supported by clearly identified local resources, both human and financial;
- a tradition of active working with patients, users, carers and the public;
- an ethos of multi-disciplinary teams working at all levels in the organisation;
- regular Board level discussion of all major quality issues for the organisation and strong leadership from the top;
- good use of information to plan and to assess progress.

Data quality, including elective waiting time data

The following arrangements are in place to assure the quality and accuracy of data (including elective waiting time data):

- the Data Quality Forum meets regularly and oversees the process of assuring the quality of data reported to the Trust Board, and to external agencies to ensure by best endeavours that it is of suitably high quality, timely and accurate. This process uses a locally agreed data quality framework to provide scrutiny and challenge on the quality of data presented. Where such assessments identify shortfalls in data quality, the risks are identified together with recommendations for improvements to ensure that the quality is raised to the required standards;
- there are quarterly reports on the quality of commissioning data and clinical coding which are presented to the Executive Quality Board. These reviews of our position are compared to peer organisations within the NHS Data Quality Maturity Index (produced by NHS Digital) and include the benchmarking of coding completeness;
- an Information Quality Improvement Group establishes and agrees priorities for improving the quality of commissioning and administrative data. Activities include an audit of quality and a review of documentation and training guidance;
- a Corporate Data Quality meeting takes place each week, where inaccurate and incomplete data collections are challenged. The Data Quality Team act on a daily basis to maximise the coverage of NHS Number, accurate GP registration, and ensure singularity of patient records.

In 2017/18 we commissioned Internal Audit to carry out a review of the quality and accuracy of our data quality systems, which included an assessment of the four hour emergency care standard and three of the cancer waiting time standards. Four medium risk actions were identified, and these will be addressed during 2018/19 and implementation will be followed up by Internal Audit and reported to the Audit Committee.

Review of the Effectiveness of Risk Management and Internal Control

As Accountable Officer, I have the 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 our clinical leads who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft Quality Account 2017/18, along with other performance information made available to me.

During the year I have also been advised on systems of internal control by the Board, the Audit Committee, Finance and Investment Committee, People, Process and Performance Committee and Quality and Outcomes Committee. 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 2017/18, the Head of Internal Audit notes that Internal Audit have carried out twelve reviews during the year. Three of the individual assignment reports had an overall

classification of high risk relating to (a) the post project review – emergency floor phase 1; (b) General Data Protection Regulation review; and (c) Electronic Patient Record 'Plan B' review.

Post project review – emergency floor phase 1: This Internal Audit review examined our delivery of phase 1 of the new emergency floor and identified key issues relating to project governance and leadership; team working; change control; and handover of the new building. We have put in place a number of actions to address the findings of Internal Audit and to ensure that lessons learned are carried forward into phase 2 of the emergency floor scheme.

General Data Protection Regulation (GDPR) review*:* This Internal Audit review examined the approach taken to achieve compliance with the GDPR. Although some elements of good practice were noted, Internal Audit identified some significant gaps that needed to be addressed to enable us to be ready for the implementation of the Regulation in May 2018. A robust action plan to achieve compliance is in place, progress against which is monitored at each meeting of the Audit Committee (reporting to the Trust Board).

Electronic patient record 'Plan B' review*:* This Internal Audit review examined our plan (known as EPR 'Plan B') to become a paperless hospital at the point of care by 2020, in line with national requirements. The review identified areas for improvement around the EPR 'Plan B' programme set-up, and the existing IT infrastructure. We accepted the findings and have taken these into account in taking forward our EPR 'Plan B'.

None of the individual assignment reports had an overall classification of critical risk.

We have taken, and are taking action to address the findings of Internal Audit and the implementations of the actions in question will be reviewed by the Audit Committee during 2018/19.

The Head of Internal Audit is satisfied that sufficient internal audit work has been carried out in 2017/18 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 2017/18 is that governance, risk management, and control in relation to business critical areas are generally satisfactory. However, there are some areas of weakness 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 these findings and am committed to strengthening the internal control environment, as detailed in this Statement.

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

a. implementing our Quality Commitment;
b. managing effectively the levels of emergency and elective demand;
c. achieving and maintaining service levels that meet service requirements;
d. maximising our education and research potential;
e. working collaboratively with partners;
f. delivering a clinically sustainable configuration of services;
g. maximising our digital strategy;
h. engaging and empowering our staff effectively;
i. achieving efficiencies in support services;
j. implementing our commercial strategy; and
k. delivering our financial plans.

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

Annually, NHS Improvement issues guidance and model statements for NHS Trusts' Annual Governance Statements. While the guidance issued for 2017/18 differs from that issued in 2016/17, the content of the model statement is largely the same.

NHS Trusts are required to identify in their statements significant control issues and outline the action taken, or proposed, to deal with such issues.

The guidance issued by NHS Improvement offers examples of factors to consider when determining whether an internal control issue is significant, while not prescribing which issues should be considered to be significant.

I can confirm that, annually, we have regard to the guidance issued by NHS Improvement and I apply that guidance in arriving at a consistent view of what constitutes a significant control issue. I am advised in this task by the Audit Committee whom I consult in identifying the specific issues to be included in the Statement each year.

The following significant control issues have been identified in 2017/18:

Care Quality Commission (CQC) Inspection

In January 2018, the CQC published the findings of their inspection of our hospitals carried out between November 2017 and January 2018. The CQC rated the Trust overall as 'Requires Improvement'.

In December 2017, the CQC issued a Section 29A Warning Notice in relation to insulin safety. We were required to make significant improvements by 13th March 2018. Evidence illustrating the improvements made was submitted to the CQC in March 2018 and we expect the CQC to carry out a re-inspection within three months.

We are otherwise compliant with the registration requirements of the CQC.

Never Events

Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.

During 2017/18, we reported eight incidents which met the definition of a never event. These related to a misplaced nasogastric tube; retained foreign objects; wrong course of medication; wrong site surgery; and the unintentional connection of a patient requiring oxygen to an air flow meter.

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

A thorough root cause analysis of each incident was carried out to identify key actions to prevent recurrence and to share learning across the organisation. Implementation of these actions was tracked by the Quality and Outcomes Committee on behalf of the Trust Board.

Key Financial Duties

In respect of performance in 2017/18, against the key financial duties, we have:

a. not delivered the planned deficit of £26.7m; due to the impact of operational pressures experienced during Winter 2017/18, our actual deficit was £34.5m;
b. achieved the External Financing Limit (the limit placed on net borrowing) of £58.1m,
c. achieved the Capital Resource Limit (the limit placed on net capital expenditure) of £32.5m, with a permitted underspend of £0.2m.

The Trust's financial plan for 2017/18 forecasted the need for £116m of cash to continue to support revenue. This was reduced to £113.4m following receipt of £3.3m winter funding. At year end, the Trust had accessed £58.7m of 'Uncommitted Interim Revenue Support Facility'. Further cash support of £29.9m is projected as part of the 2018/19 financial plans and has been submitted to NHS Improvement as part of the annual planning process. The level of loans the Trust will hold is expected to rise to from £198.4m to £228.3m in 2018/19 representing over 23% of the Trust's projected turnover.

£34.1m of loans are due to mature over the next 12 months and although the mechanism for repaying these through the availability of renewed working capital or longer term loan facilities is yet to be defined, the Trust is planning that these facilities will be made available. The rate of interest of these new facilities is likely to be higher than the rates currently being paid.

The net increase in loans will be £29.9m.

The Trust's net assets have decreased from £230.7m (2016/17) to £215.3m (2017/18). This is a net impact of the increased cash borrowing, offset by the increase in asset valuations.

At its meeting in May 2017, the Audit Committee assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by consideration of a 2017/18 going concern statement, prepared by the Chief Financial Officer.

The Audit 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 2017/18, 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 2017/18 'going concern' position statement at its meeting in June 2017, on the recommendation of the Audit Committee.

Throughout the 2017/18 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, in 2017/18 we commissioned PricewaterhouseCoopers (PwC) to review our approach to cash management, cash forecasting, and the associated reporting of the cash position to the Finance and Investment Committee. We accepted PwC's final report and recommendations. Cash performance continues to be reviewed at each meeting of the Finance and Investment Committee and scrutinised further, on a periodic basis, by the Audit Committee.

The Board has agreed plans to deliver the agreed 2018/19 financial plan – a £29.9m deficit - which includes the delivery of a £51.0m Cost Improvement Programme. Acting on behalf of the Trust Board, the Finance and Investment Committee receives a report at each of its monthly meetings tracking performance against this Cost Improvement Programme.

Emergency Care

Unfortunately, we failed to meet the A&E 4-hour standard in 2017/18, achieving a performance of 77.6 per cent (79.6 per cent 2016/17) against a target of 95 per cent.

As a member of the Leicester, Leicestershire and Rutland A&E Delivery Board, we are fully committed to working with our partners across the health and social care sectors to improve emergency care performance in 2018/19. In particular, this will focus on reducing the substantial gap between current demand and capacity, which is the root cause of our on-going poor performance. It is anticipated that this will be achieved by reducing patient flows to us, dealing with (particularly frail) patients more effectively at the front door, expanding medical bed capacity, improving internal processes to reduce avoidable delays and expediting discharges (especially those requiring multi-agency input). Progress will continue to be the subject of monthly reporting to, and monitoring by, the People, Process and Performance Committee, acting on behalf of the Trust Board, as well as at the monthly meeting of the A&E Delivery Board.

Cancer waiting time standards

Our performance in 2017/18 against the cancer waiting time targets is set out below:

Performance Indicator	Target	2017/18
Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	93% or above	94.6%
Two week wait for Symptomatic Breast Patients (Cancer Not Initially Suspected)	93% or above	91.9%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96% or above	95.2%
31-Day Wait For Second Or Subsequent Treatment: Anti-Cancer Drug Treatments	98% or above	99.1%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94% or above	85.8%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94% or above	95.9%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85% or above	78.4%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90% or above	85.8%
Cancer waiting 104 days	0	18

We are fully committed to improving our performance in this area in 2018/19 and, specifically, to ensure that at least 85 per cent of cancer patients begin their first treatment within 62 days of an urgent GP referral. A comprehensive action plan is in place to achieve this objective, and performance will continue to be the subject of monthly reporting to the People, Process and Performance Committee, acting on behalf of the Trust Board.

Conclusion

My review confirms that we, the University Hospitals of Leicester NHS Trust, have a generally sound system of internal control that supports the achievement of our policies, aims and objectives. We recognise that the internal control environment can always be improved and strengthened, and this work will continue in 2018/19.

In 2017/18, we identified the following significant control issues which have impacted on our overall performance:

- the safe administration of insulin;
- the incidence of never events;
- non-delivery of the requirement to achieve financial break-even taking one year with another over a three year rolling period;
- non-delivery of the national A&E 4 hour standard; and
- non-delivery of a number of the national cancer waiting time standards.

In addition to the actions taken/to be taken to address the specific significant control issues identified above, further work will also be carried out in the coming year 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: 25/05/2018

Trust Board and Committee attendance 2017/18

Name	**Trust Board** maximum – 15	**Audit Committee** maximum – 6	**IFPIC** maximum – 5	**FIC** maximum - 7	**QAC** maximum – 5	**QOC** maximum - 7	**PPPC** maximum - 7	**Remuneration Committee** maximum – 8	**Charitable Funds Committee** maximum – 6
Karamjit Singh – Chairman	15/15	N/A	4/5	7/7	3/5	6/7	7/7	8/8	6/6
Vicky Bailey – Non-Executive Director **(1)**	4/4	N/A	N/A	N/A	N/A	1/2	2/2	1/2	N/A
Professor Philip Baker – Non-Executive Director	12/15	N/A	0/5	N/A	0/5	4/7	5/7	3/8	N/A
Dr Shirley Crawshaw – Non-Executive Director **(2)**	1/3	0/1	2/2	N/A	2/2	N/A	N/A	1/2	0/2
Ian Crowe – Non-Executive Director	13/15	5/6	5/5	N/A	4/5	7/7	6/7	6/8	3/6
Eileen Doyle – Interim Chief Operating Officer **(3)**	4/5	N/A	N/A	2/3	N/A	N/A	3/3	N/A	N/A
Andrew Johnson – Non-Executive Director	13/15	6/6	4/5	7/7	4/5	N/A	7/7	6/8	5/6
Tim Lynch – Interim Chief Operating Officer **(4)**	7/7	N/A	2/2	2/4	N/A	N/A	3/4	N/A	N/A
Richard Moore – Non-Executive Director	13/15	5/6	4/5	1/7	1/5	N/A	1/7	4/8	1/3
Ballu Patel – Non-Executive Director	15/15	3/3	5/5pension	N/A	5/5	7/7	7/7	8/8	6/6
Martin Traynor – Non-Executive Director	15/15	6/6	4/5	7/7	4/5	N/A	7/7	7/8	3/3
John Adler – Chief Executive	14/15	1/1	5/5	5/7	5/5	6/7	7/7	7/8	N/A
Mr Andrew Furlong – Medical Director	13/15	N/A	N/A	N/A	4/5	5/7	4/7	N/A	N/A

Name	**Trust Board** maximum – 15	**Audit Committee** maximum – 6	**IFPIC** maximum – 5	**FIC** maximum - 7	**QAC** maximum – 5	**QOC** maximum - 7	**PPPC** maximum - 7	**Remuneration Committee** maximum – 8	**Charitable Funds Committee** maximum – 6
Richard Mitchell – Chief Operating Officer **(5)**	2/3	N/A	2/3	N/A	N/A	N/A	N/A	N/A	N/A
Julie Smith – Chief Nurse	12/15	N/A	N/A	N/A	3/5	5/7	5/7	N/A	N/A
Louise Tibbert – Director of Workforce and OD (non-voting)	15/15	N/A	5/5	N/A	0/5	N/A	7/7	8/8	N/A
Paul Traynor – Chief Financial Officer	14/15	6/6	4/5	7/7	N/A	N/A	6/7	N/A	6/6
Stephen Ward – Director of Corporate and Legal Affairs (non-voting)	15/15	6/6	N/A	N/A	N/A	N/A	N/A	8/8	6/6
Mark Wightman – Director of Marketing and Communications (non-voting) **(6)**	14/15	N/A	N/A	5/6	N/A	N/A	N/A	N/A	4/6

Notes:-

(1) Non-Executive Director from 1 February 2018
(2) Non-Executive Director until 16 June 2017
(3) Interim Chief Operating Officer from 1 January 2018
(4) Interim Chief Operating Officer from 3 July 2017 – 31 December 2017
(5) Chief Operating Officer until 2 July 2017
(6) FIC attendee as of October 2017

Remuneration Report

Salary and Pension entitlements of senior managers – Salary 2017/18

	2017-18					
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						
EXECUTIVE DIRECTORS						
J Adler, Chief Executive	205-210	144*	0	0	12.5-15.0	230-235
R Mitchell, Chief Operating Officer (left 30th June)	35-40.	0	0	0	82.5-85.0	120-125
T Lynch, Interim Chief Operating Officer (from 3rd July 2017 left 31st Dec 2017)	100-105.	0	0	0	0	100-105
E Doyle, Interim Chief Operating Officer (from 29th Nov 2017)	45-50	0	0	0	20.0-22.5	65-70
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	32.5-35.0	215-220
NON EXECUTIVE DIRECTORS						
K Singh, Chairman	35-40.	0	0	0	0	35-40
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.
R Moore, Non-Executive Director	5-10.	0	0	0	0	5-10.
A Johnson, Non-Executive Director	5-10.	0	0	0	0	5-10.
Professor P Baker, Non-Executive Director	5-10.	0	0	0	0	5-10.
B Patel, Non-Executive Director	5-10.	0	0	0	0	5-10.
Dr S Crawshaw, Non-Executive Director (left 16th June)	0-5	0	0	0	0	0-5
V Bailey, Non- Executive Director (from 1st Feb)	0-5	0	0	0	0	0-5
SENIOR MANAGERS						
S Ward, Director of Corporate & Legal Affairs	105-110	0	0	0	5.0-7.5	115-120
M Wightman, Director of Marketing and Communications	125-130	0	0	0	17.5-20.0	145-150
L Tibbert, Director of Workforce and Organisational Development	110-115	0	0	0	0	110-115

* The taxable benefits relate to train, car parking, council tax and rental.

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. The Trust has determined that the senior managers shown in the above table are the regular attendees at the Trust Board meetings.There are no benefits in kind, performance related pay, nor severance payments (2016/17 - £nil) paid to any board member.

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						
EXECUTIVE DIRECTORS						
J Adler, Chief Executive	200-205	152	0	0	95.0-97.5	315-320
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						
K Singh, Chairman	40-45	0	0	0	0	40-45.
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	105-110	0	0	0	27.5-30.0	135-140

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 2018 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers Contribution to Stakeholder Pension £000
BOARD MEMBERS								
J Adler, Chief Executive	0.0-2.5	5.0-7.5	80.0-85.0	250.0-255.0	1,688	89	1,795	0
R Mitchell, Chief Operating Officer	0.0-2.5	0.0-2.5	30.0-35.0	65.0-70.0	286	16	354	0
E Doyle, Interim Chief Operating Officer ( )	0.0-2.5	0.0-2.5	5.0-10.0	10.0-15.0	109	3	122	0
A Furlong Medical Director	2.5-5.0	0.0-2.5	45.0-50.0	120.0-125.0	810	33	851	0
SENIOR MANAGERS								
S Ward, Director of Corporate & Legal Affairs	0.0-2.5	2.5-5.0	45.0-50.0	140.0-145.0	947	71	1,027	0
M Wightman, Director of Communications	0.0-2.5	0	30.0-35.0	75.0-80.0	475	47	526	0

J Smith, L Tibbert, T Lynch 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 and each case is considered on an individual basis. On an annual basis the remuneration committee decides on any pay uplift or pay award for VSM for the forthcoming year.

Exit Packages

2017-18

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
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	3	9,122	0	0	3	9,122	0	0
£50,001-£100,000	2	141,654	0	0	2	141,654	0	0
	5	150,776	0	0	5	150,776	0	0

2016-17

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
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	8,050	0	0	1	8,050	0	0
	1	8,050	0	0	1	8,050	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.

Staff Report

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

	2017/ 2018	2016/ 2017	2015/ 2016	2014/ 2015	2013/ 2014	2012/ 2013	2011/ 2012	2010/ 2011	2009/ 2010
Medical and Dental	1,709	1,753	1,680	1,645	1,570	1,551	1,496	1,477	1,496
Administration and Estates	3,976	3,806	2,500	2,383	2,095	2,066	2,417	2,534	2,624
Healthcare Assistants and other support staff	2,291	2,224	2,042	2,044	1,955	1,811	1,710	1,781	1,882
Registered Nursing and Midwifery	3,567	3,548	3,547	3,531	3,345	3,230	3,195	3,168	3,091
Scientific, Therapeutic and Technical	1,455	1,378	1,306	1,272	1,201	1,202	1,210	1,210	1,328
TOTAL	**12,709**	**12,709**	**11,075**	**10,874**	**10,167**	**9,860**	**10,029**	**10,171**	**10,421**

Staff group by composition				
	31st March 2018		31st March 2017	
Gender	**Heads**	**Wte**	**Heads**	**Wte**
Female	11,892	9,807	11,533	9,566
Male	3,537	3,191	3,450	3,143
Grand Total	15,429	12,998	14983	12709

Staff Costs

The table below shows an analysis of staff costs. Employee charges are included in the social security costs and pension contributions.

	Group			
			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	493,618	-	**493,618**	454,606
Social security costs	45,870	-	**45,870**	42,392
Apprenticeship levy	461	-	**461**	
Employer's contributions to NHS pensions	54,568	-	**54,568**	51,024
Pension cost - other	36	-	**36**	33
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	151	-	**151**	8
Temporary staff		21,076	**21,076**	30,053
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**594,704**	**21,076**	**615,780**	**578,116**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**594,704**	**21,076**	**615,780**	**578,116**
Of which				
Costs capitalised as part of assets	1,296	579	**1,875**	2,299

Reducing staff absence

Absence rates have continued to be proactively managed throughout 2017/18. These are reported retrospectively and an overall Trust sickness absence rate of 3.66 per cent was reported for February 2018 against a 3 per cent Trust target. The CQC Insight Report indicates that Trust sickness rates for all staff groups, with the exception of medical and dental, are better than the national average.

In September 2018, we committed to, and signed, the 'Time to Change' pledge which is a national initiative run by the charities Mind and Rethink Mental Illness. Its aim is to change how we think and act about mental health. Currently, approx. 20 per cent of sickness days lost are due to anxiety and depression.

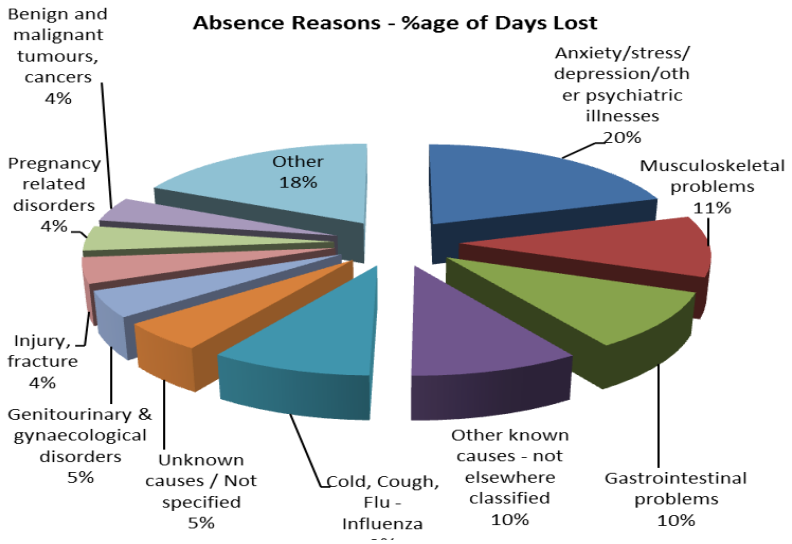
Our pledge is *'We pledge to create a culture where our staff feel they can openly discuss and manage their mental health and wellbeing. We will raise awareness of the importance of mental health and wellbeing at work, encourage staff to share their experience to break down stigma".* During October and November 2017 we recruited 39 Time to Change champions across all the three sites and with the champions have agreed a programme of work, including organising local Time to Talk events, sharing experiences/ case studies and promoting best practice.

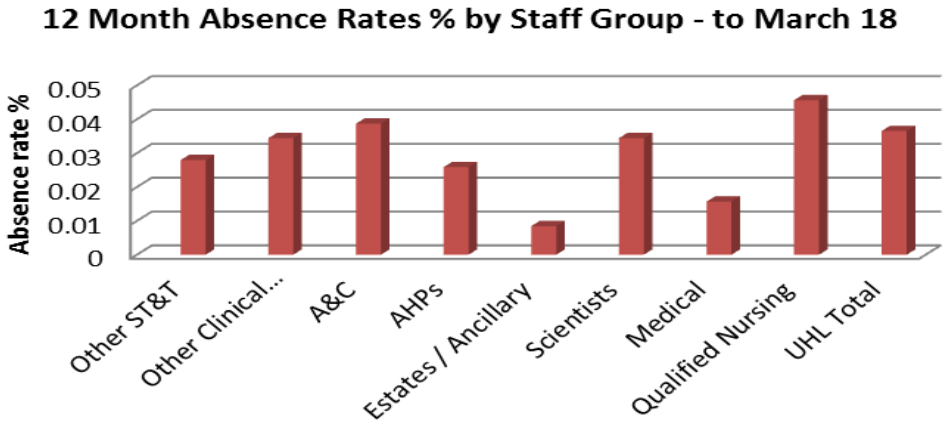
Our sickness absence target is 3 per cent, and our average sickness rate for the year was 3.68 per cent (4.08 per cent excluding Estates and Facilities (Estates and ancillary was under-reported until systems fully implemented post transfer).

The highest sickness rates are in 'Other clinical support and qualified nursing' staff groups. A&C are also above our target of 3 per cent.

Most sickness days lost are due to anxiety/ stress and depression (20 per cent).

The CQC's insight report indicates lower than comparative Trusts for back problems (0.16 per cent: 0.24 per cent) and stress (0.63 per cent: 0.78 per cent).





We have planned the following actions to reduce sickness absence:

- absences recorded using the in-house '***SMART Absence***' tool which facilitates reporting of absences and ensures structured Return to Work discussions are held, prompts Occupational Health referrals , Stress Risk Assessments and further support;
- we have signed the Time to Change pledge and have Time to Change champions in place and are sharing good practice and materials from Time to Change website. We also share stories;
- Health and well-being strategy being implemented with a focus on a different area each month.

Off payroll engagements

We have 51 relevant off-payroll engagements as of 31 March 2018, 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 2018, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	187
Of which, the number that have existed:	
for less than one year at the time of reporting	69
for between one and two years at the time of reporting	29
for between 2 and 3 years at the time of reporting	38
for between 3 and 4 years at the time of reporting	32
over 4 years at the time of reporting	19

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, 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 2017 and 31 March 2018; of which the number for whom:	80
assurance has been requested	80
assurance has been received	80

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

	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.	10

Policy in relation to disabled employees

It is our intention to value all staff, treating them fairly and equitably, providing real opportunities for people with a disability to join our organisation, be retained and to have equal access to training and development opportunities. It is also our intention to support employees with disabilities and to ensure their retention in work, thereby enabling us to retain their skills and experience.

We are committed to the 'Positive about Disabled People' initiative, this will include using the Disability 'two ticks' symbol on all job advertisements. We guarantee an interview to anyone declaring a disability providing that they satisfy the minimum essential criteria for the post.

All staff have responsibilities to undertake all mandatory training and comply with this policy by:

- Being aware of this policy and treating all individuals' that have a disability with respect.
- Attending training and awareness sessions offered and familiarising themselves with the contents of our Equality and Diversity web page.

Expenditure on consultancy

We incurred £0.8m on consultancy services.

Pay multiples

The banded remuneration of our highest paid director in the financial year 2017/18 was £205k-£210k (2016/17 £205k-£210k). This was 8.69 times (8.44 times in 2016/17) the median remuneration of the workforce, which was in the banding £20k-£25k (2016/17 £20k-£25k). The salary of the highest paid director has not changed and the median remuneration of the workforce has reduced by £1k.

In 2017/18, three employees received remuneration in excess of the highest-paid director (two employees in 2016/17). Remuneration across the Trust ranged from £7k-£244k (2016/17 £7k-£252k).

Signed: 

Chief Executive (on behalf of the Trust Board)

Date: 25/05/2018

The Performance Report

Overview

This section of the report provides an overview of our performance against key national standards, as well as our annual priorities and Quality Commitment for 2017/18.

We – along with the rest of the NHS – have had a very challenging winter labelled by many as the most difficult in NHS history. This means we have continued to struggle with operational pressures that have seen our hospitals in "escalation" for several months. In January all NHS Trusts were instructed to cancel elective operations in a bid to free up capacity to treat the increased number of emergency patients needing care. This instruction was for the whole of January but in reality lasted through February. Even more regrettable was the cancellation of some cancer surgery during that time. We do not take the decision of cancelling patients, particularly cancer patients, lightly. We know how distressing this is for everyone involved, but we cannot in good faith bring patients in for surgery if we do not have a bed somewhere to safely look after them following their surgery. We are working on increasing our intensive and high dependency care capacity to reduce the chances of cancellations in the future. Our work in 2018/19 will stand us in a stronger position for managing those challenges as we enter the coming winter.

Each year for the last few years we have created a set of annual priorities, which includes our Quality Commitment. This allows our organisation to focus on what is needed to delivering our ambition of Caring at its Best and to create services that are safe and high quality for our patients. In this section you will see how we have performed against those, as well as the national performance standards.

John Adler

Chief Executive

Performance Against National Standards

Performance Indicator	Target	2017/18	2016/17	2015/16
A&E - Total Time in A&E (4hr wait)	95%	77.6%	79.6%	86.9%
MRSA (All)	0	4	3	0
MRSA (Avoidable)	0	4	0	0
Clostridium Difficile	61	68	60	60
RTT - incomplete 92% in 18 weeks	92%	85.2%	91.8%	92.6%
Diagnostic Test Waiting Times	1.0%	1.9%	0.9%	1.1%
Cancer: 2 week wait from referral to date first seen - all cancers	93%	94.6%	93.2%	90.5%
Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	91.9%	93.9%	95.1%
All Cancers: 31-day wait from diagnosis to first treatment	96%	95.2%	93.9%	94.8%
All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.1%	99.7%	99.7%
All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	85.8%	86.4%	85.3%
All Cancers: 31-day wait for second or subsequent treatment - radiotherapy treatments	94%	95.9%	93.5%	94.9%
All Cancers: 62-day wait for first treatment from urgent GP referral	85%	78.4%	78.1%	77.5%
All Cancers: 62-day wait for first treatment from consultant screening service referral	90%	85.8%	88.6%	89.1%

Key Performance Measures

For the Trust Board to assure itself that key performance measures are being met they review monthly at Trust Board meetings a performance report and the Board Assurance Framework (BAF) – both are accessible on our website in our monthly Trust Board papers.

CQUINS, national performance standards, annual priorities incorporating our Quality Commitment are also key performance measures monitored by the Trust Board, and detail on achievements in year can be found throughout this report: national performance standards page 25; CQUINS page 26; annual priorities pages 30-71 and our Quality Commitment pages 33-40. The Annual Governance Statement on page 22 identifies risks and uncertainty and how these are mitigated.

Commissioning for Quality and Innovation payment framework (CQUINS)

A proportion of our income in 2017/18 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework (CQUINS).

The current CQUIN schemes will last for two years (2017-19), which will provide greater stability with the aim to improve quality of outcomes for patients.

There are six mandated national CQUINS which each have a minimum weighting of £1,153,949 and ten NHS England Specialised CQUINS with a total value of£ 5,315,312. This means that when we agreed contracts with commissioners and NHS England it was agreed that a percentage of the contract value would be received upon achieving certain quality indicators.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at: www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

We did not fully meet the targets set for two of the national CQUINS: Improving staff health & wellbeing and reducing the impact of serious infection. Similarly three of the NHS England Specialised CQUINS were only partially met; Hepatitis C Network, Enhanced Supportive Care and Hospital Medicines Optimisation.

As a consequence of the two year national planning guidance all but one of the national CQUINS are now within year two for 2018/19. NHS England has agreed a temporary relaxation of the 'Supporting Proactive and Safe Discharge' CQUIN on the basis that there are multiple initiatives supporting the discharge agenda. The CQUIN schemes have a total value of £12,004,826. The year-end forecast variance is £1,836,519.38.

Particular challenges where we were not successful included:

- Achieving a 5 per cent point improvement in the NHS annual staff survey in relating to the organisation taking a positive action on health, staff experiencing musculo-skeletal problems and staff feeling unwell as a result of work related stress;
- The overall usage of antibiotics has increased by 7 per cent. Increases are attributable to a change in case mix over winter when elective surgeries were cancelled; emergency admissions contribute significantly more to consumption of antibiotics than elective patients. In addition to this there were very high numbers of admissions of patients with severe respiratory tract infections in quarter 4; a typical pneumonia patient contributes a minimum of 10 DDDs per admission in comparison to 1 DDD contributed by an elective surgery patient. Additionally the overall usage of Meropenam (in the treatment of sepsis) is continuing to increase;
- Work relating to the Enhanced Supportive Care CQUIN started in 2016/17, however, in order to meet the 2017/18 scheme requirements there was a need to increase capacity within the Palliative Care team in order for them to provide services to patients earlier within the pathway. There has been insufficient resource to expand the service and therefore this CQUIN did not continue beyond Q2.

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 Estates and Facilities have successfully built/ refurbished and commissioned the following:

1. New Emergency Department Floor - (Royal Infirmary)
2. Refurbishment of Theatre Recovery with additional bed bays to enhance activity performance (Royal Infirmary) and (Glenfield Hospital)
3. New Hybrid Theatre (Glenfield Hospital) and general refurbishment/ upgrade to the Theatres (Royal Infirmary)
4. Remodel of Ward 23 to a new stage of the art Vascular Investigation and treatment Unit (Glenfield Hospital)
5. Remodel of an area to provide another state of the art Angiology Unit (Glenfield Hospital)
6. Various LED Lighting schemes (General Hospital)

All of the above have 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.

Heating and Power

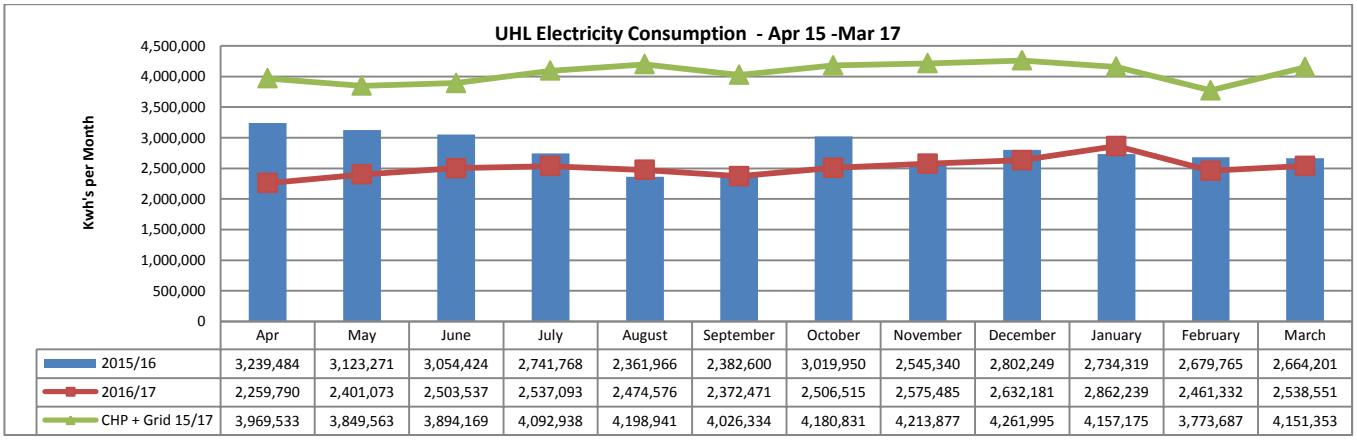
New CHP units have improved their availability as they have been fine tuned to the sites demand.

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**

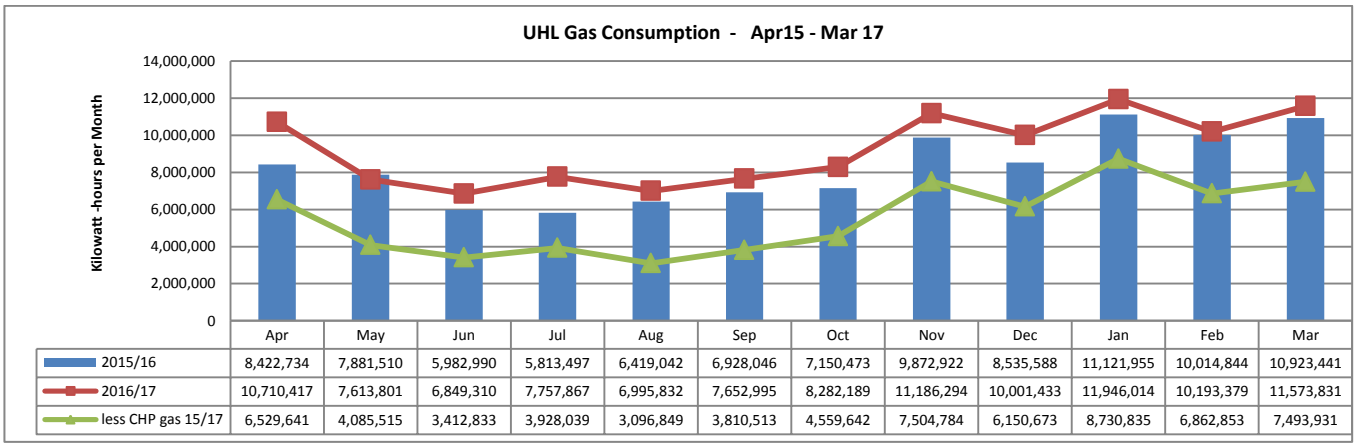
Description	Gas	Grid Electricity	Totals	Cost	CO2 Emissions	CO2 Emissions
Year	Usage (KWh)	Usage (KWh)	(KWh)	Costs (£)	(Tonnes)	(CRC Cost)
2006/07	116,873,611	29,357,222	146,230,833	£5,252,319	37,531	N/A
2007/08	99,831,667	30,681,111	130,512,778	£4,403,428	35,090	N/A
2008/09	109,781,944	33,822,222	143,604,167	£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

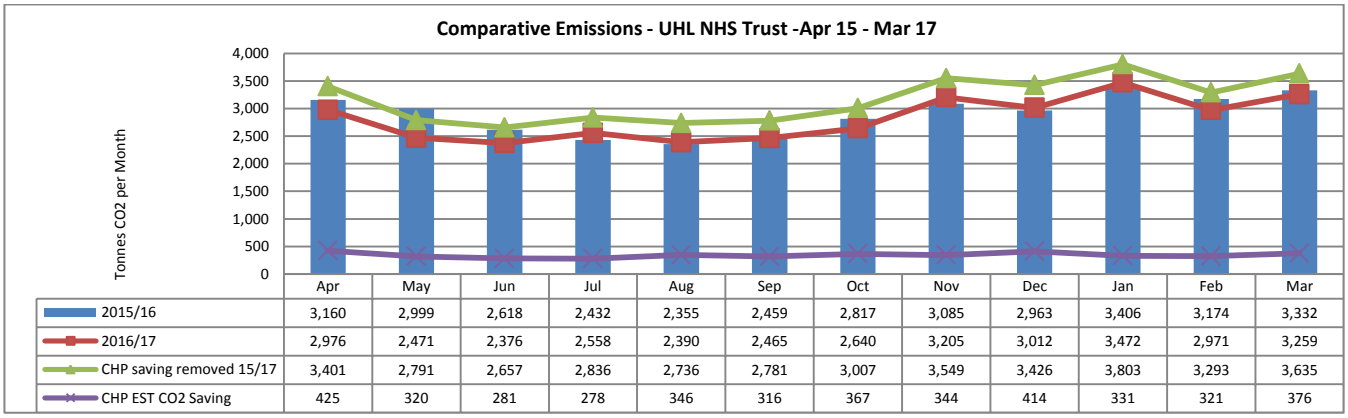
1. Consumption of power and or gas depend on activity, weather and the CHP units – just for volume
2. Cost of the utilities as commodity and non-commodity which is made up of several components plus the activity on the site and the CHP units availability.



	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 of our estates developments;
- We promote all alternative travel modes to staff, 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;
- The main surface level car park at the Royal Infirmary has a dedicated drop off and pick up area;
- We offer a variety of saver tickets for patients and prime carers;
- We are working with the police to promote security of cycles;
- We are working with the City Council and Sustrans to promote cycling across all three sites, this includes a partnership with local schools to decorate the bike shed at the Glenfield and cycle surgeries across all three sites;
- 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;
- Our Hospital Hopper service was re-launched in January 2017, and Centrebus have been awarded the contract for at least another three years.

Signed:

Chief Executive (on behalf of the Trust Board)

Date: 25/05/2018

Achievements against our Annual Priorities, including our Quality Commitment

Our priorities for 2017/18

For 2017/18 we reduced the number of things that we focused on to make it more manageable and achievable. This is what we were focusing on during 2017/18:

Safe, High Quality, Patient-Centred, Efficient Care

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

Organisation of care:

- align our bed capacity with expected demand(including by reducing delays through Red2Green, working more effectively to care for step down patients and increasing the medical bed base)
- Optimise processes in our new Emergency Department
- Work to separate emergency and elective work
- Transform the hospital pathway for frail complex patients
- Improve the efficiency of our operating theatres

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.

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Safe, High Quality, Patient-Centred, Efficient Care

Quality: our 2017/18 Quality Commitment

For 2017/18 we set the following three priorities as a part of our Quality Commitment and to deliver our annual priority Safe, High Quality, Patient-Centred, Efficient Care:

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

The following shows our achievements against each:

We said we would: Reduce avoidable deaths

In 2017/18 we:

- Rolled out the Medical Examiner Process across the Trust for the deaths of all patients aged 16 or above – the aim of the Medical Examiner process is to improve the quality of death certification and identify those patients that need a further review by the relevant clinical team or as part of the specialty mortality and morbidity review process
- Implemented a Structured Judgement Review (SJR) process – the aim of this process is to identify any problems in care that might have affected the patient's outcome or experience in order to ensure learning and actions are taken to improve the care of all patients

Further improvements we need to make are:

- To recruit additional Medical Examiners and Medical Examiner / Corporate mortality and morbidity administrative and analytical support

Results:

- 92 per cent of adult deaths since April 17 were screened through the Medical Examiner process
- 85 per cent of Quarter 1's adult deaths referred for a SJR were completed
- For the period October 2016 to September 2017, Leicester's Hospitals SHMI was 98. This is below the national average of 100

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

In 2017/18 we:

- Through NerveCentre (our clinical information system) we have:
  - Implemented Clinical Rules, alerts and assessments for sepsis
  - Implemented electronic observations across the Trust
  - Automated our Early Warning Score (EWS) and sepsis reporting
  - Made it easier for our clinical teams to identify patients with diabetes
- Moved anticoagulation services into the community under primary care with the anticoagulation nurses now taking on in-reach roles within Leicester's Hospitals to tackle difficult and complex cases on our wards
- Implemented an anticoagulation discharge summary
- Piloted IT solutions to support acting on results, targeting one of our busiest clinical areas, the Clinical Decisions Unit at Glenfield Hospital

Further improvements we need to make are:

- Increase the number of mobile devices available to clinical staff
- Further embed the use of Nervecentre for all medical handovers, ward rounds and board rounds
- Develop an e-learning tool for anticoagulation
- Embed processes in the emergency department to reduce the time to antidote administration in patient who present with anticoagulant related bleeding
- Focus on improving the skills and knowledge of our clinical staff in the recognition and management of hyperglycaemia
- Roll out acting on results IT solutions across the Trust

Results:

- An additional measure of harm was included in the incidents resulting in severe or moderate harm in 2017/18
- YTD (to January 2018) there have been 181 incidents resulting in severe or moderate harm against a YTD target of 110
- YTD, incidents resulting in severe or moderate harm have not reduced by the target 9 per cent - this is set against an overachievement of 41 per cent last year

Patient Safety Improvement Plan – 'Sign up to Safety' campaign

In September 2014 we signed up to the national 'Sign Up to Safety' campaign. The campaign aims to halve avoidable harm and save an additional 6,000 lives over three years.

As part of the 'Sign Up to Safety' campaign, we have pledged to:

- Put patient safety first
- Focus on continuous learning
- Be honest and transparent
- Collaborate with others to share learning and good practice
- Be supportive and help people understand why things go wrong

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 priorities are aimed at improving the recognition, escalation, response and effective on going management of the deteriorating patient.

In 2017/18, as the continuation of the 'Sign up to Safety' campaign we have:

- Recruited a dedicated Sepsis team with the Emergency Department, dedicated to the recognition and management of Sepsis;
- Created the "The Little Voice Inside" obstetric training package (TED) to share best practice and improve patient safety. This has been shared nationally;
- Continued to further develop the Patient Safety Portal functionality and user experience, through valuable feedback received from our stakeholders;
- Implemented the five e-learning modules hosted on HELM (our e-learning suite), which provide a more in-depth understanding of Human Factors and Ergonomics;
- Continued development and roll-out of electronic observations across all specialities within the Trust.

Going forward our Sign up to Safety patient safety improvement plan will be fully integrated into our dedicated Patient Safety improvement work within our Quality Commitment.

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

In 2017/18 we:

- Rolled out training and support in the use of individualised end of life care plans
- Held listening events and developed a future vision for our outpatient services
- Identified cross cutting themes for improving our outpatient services including: correspondence, the outpatient environmental, customer care, training, IT systems and hardware

Further improvements we need to make are:

- Continue to embed and audit the use of individualised end of life care plans
- Focus our efforts on making a demonstrable difference to outpatient service in Ear, Nose and Throat (ENT) and Cardiology as well as the cross cutting service improvements

Results:

- At the end of quarter three, 88 per cent of appropriate patients had an individualised end of life care plan
- Metrics for measuring improvements in our outpatient service have been scoped and take effect from April 2018

Improving the experience of our patients

We actively seek feedback from patients, family members and carers, both negative and positive. The vast majority of the feedback we receive is extremely positive, but to ensure that where we can make improvements based on feedback, services collect data from all of the sources and put displays - "You Said We Did" boards - in ward areas so that it is clear what actions have been taken in response to the feedback they have received.

Feedback is collected in numerous ways including:

- Patient experience feedback forms
- Family, carers and friends feedback forms
- Message to Matron
- NHS Choices/ Patient Opinion
- Patient stories
- Volunteer feedback
- Compliments and complaints provided to the Patient Information and Liaison Service (PILS)
- Our website
- Community conversations held by the Engagement Team.

The Friends and Family Test

The Friends and Family Test is a nationally set question asked by all NHS hospitals. It is offered to patients, carers and family when they are discharged and gathers feedback by asking the following question: *"How likely are you to recommend our ward to friends and family, if they needed similar care or treatment?"*

There are six options ranging from extremely likely to extremely unlikely, including 'do not know'. Following this question there is an opportunity for the respondent to comment on why they have given their answer. Responses of extremely likely and likely are recorded as recommended and extremely unlikely and unlikely responses are recorded as non-recommended. The charts below illustrate the response we have received over the last two years. As you can see there have been more months in the last year where the score has been above our target of 97 per cent people recommending care or treatment, with less than 1 per cent of

people saying they would not recommend care or treatment within our hospitals, which is an improving picture.

Friends and Family Test score - in-patient (incl. day cases) Trust level data												
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
% Recommend	**97.1**	**97.0**	**97.3**	**96.8**	**96.0**	**96.7**	**96.5**	**96.6**	**96.7**	**96.5**	**96.5**	**96.5**
% Non-recommend	0.8	0.8	0.8	0.9	1.5	1.2	0.9	1.0	1.0	1.0	0.8	1.0

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% Recommend	**97.3**	**97.2**	**97.2**	**96.8**	**97.0**	**97.3**	**96.7**	**96.9**	**97.2**	**97.2**	**97.4**	
% Non-recommend	0.5	0.7	0.8	0.8	0.8	0.7	0.9	1.0	0.7	0.8	0.7	

The Friends and Family Test feedback can be given via paper forms which are available in our ward areas, and there are also kiosks in the three hospital reception areas, as well as some electronic devices in several clinical areas and outpatients. Feedback can also be given by accessing our website. In some of our outpatient clinics we offer patients the opportunity to give feedback via text. The patient will receive a telephone text survey to encourage them to give their feedback in their own time.

To ensure that non-English speaking patients are given the opportunity to give their feedback, the Friends and Family Test question is available in the top three locally spoken languages in the area, which are Gujarati, Punjabi and Polish. We also make these translated surveys available in paper on the wards and in an electronic format in outpatients, some clinical areas and via the kiosks in the three hospital main entrances.

For patients who have learning disabilities, language or literacy issues, dementia or visual impairment there is an easy read version of the feedback form available, which uses pictures of faces, ranging from very happy to very sad, to ascertain their response to their experience of care. For the children we treat we offer them the option to use the rocket feedback, which shows pictures of faces and the paper version allows the child to draw a picture.

From April 2017 a new feedback form was launched. This form replaced the carers' survey that was carried out at various times throughout the year. It is recognised that many family members and friends have a caring responsibility in the community, but do not recognise themselves, or do not wish to be labelled as a carer.

Meaningful activity co-ordinators and dementia care

Improving care and experience for people living with dementia in Leicester's Hospitals is part of our Dementia Strategy. This year we have been working to support families, carers and people living with dementia through two new initiatives 'Stay With Me' and the Forget ME Not scheme.

'Stay With Me' is one of the key principles of John's Campaign, founded nationally in 2014 and supports families to remain with patients with a known diagnosis of dementia during their time in hospital. 'Stay with Me' builds on our Carers Charter which aims to create a 'welcoming environment' on all hospital wards, where there are no barriers for a family member who wishes to stay beyond visiting times for patients with dementia. Evidence suggests patients with dementia, who are often frail, vulnerable adults, have much more positive outcomes when they are with the people who are familiar.

The Forget ME Not scheme supports national recommendations for hospitals to have a system in place to support all staff to be able to recognise patients with dementia, ensuring the delivery of person centred care. Patients with a known diagnosis of dementia are placed on the scheme during their admission to hospital. A blue forget me not flower poster is placed in the bed space and a small forget me not flower sticker is attached to the patient's medical notes. Both identify the patient to all staff, supporting good communication, allowing more time for each interaction, encouraging additional drinks and snacks to be offered and reminds staff to find out about the patient by reading the Know Me Better Patient Summary.

We continue to increase the number of staff that are dementia champions and over 100 have volunteered to take on this role during the year.

The Meaningful Activity Service support patients with dementia on our older peoples wards at the Royal Infirmary and on some wards at the Glenfield Hospital. The Meaningful Activity Facilitators provide therapeutic activities to help patients with dementia in hospital. Examples of activities include arts and crafts, games, puzzles, reminiscence, and music and the team host special events on the wards to celebrate cultural and religious festivals. Families, friends and carers of patients are encouraged to be involved in all activities with their loved one.

The Meaningful Activity Service is supported by trained Forget Me Not Volunteers, who are passionate about dementia care. In 2017, events have been held inside and outside of our hospitals to promote dementia awareness Meaningful Activities, fundraising to support future activities.

Older people's feedback highlighted how important the small fundamental things are to improve their experience in hospital. Six of our wards have been working on 'Fixing the Fundamentals' to improve older people's experience of care in our hospitals. Patients were encouraged to sit out of bed and wear their own clothes; ward teams promoted and enhanced mealtimes to improve nutrition, making meal times a more sociable experience. Small freezers were introduced to provide ice cream, which was especially welcome on a hot day. Opus, a music therapy group, visited the wards each month to stimulate and entertain patients helping to make the day pass a little quicker. Improving personal care needs for patients included a visit from a barber and additional time set aside to assist patients with all aspects of personal care as this is fundamental to all our patients.

Specialist Palliative Care and Care at the End of Life

Palliative care is the holistic care provided to patients with an illness which cannot be cured. Palliative care is provided alongside other treatments and might be needed early on in a disease when patients may be receiving life prolonging treatment or towards the end of life and into bereavement. It involves managing physical symptoms such as pain, but also the psychological, spiritual and social needs of patients and families.

The Specialist Palliative Care Team provide direct support to our patients, both inpatients and outpatients, as well as providing education and support to staff, which is essential to those who will need to provide both palliative and end of life care.

Patients are described by the General Medical Council as approaching the end of life when they are likely to die within the next twelve months. This group therefore includes:

1. Patients who are imminently dying (in the next few days or hours);
2. Patients with advanced, progressive, incurable conditions (such as cancer which has spread to different organs in the body);
3. Patients with frailty and multiple illnesses which mean that they are expected to die within twelve months;
4. Patients with a condition which puts them at risk of a sudden acute crisis (e.g. a large inoperable abdominal aortic aneurysm); or
5. Life threatening acute conditions caused by a catastrophic event (e.g. an intracranial bleed in a patient who is not well enough for treatment or a patient with major trauma).

We play an important role in supporting and managing patients at the end of life because patients will often have repeated contact with hospital services in their final months of life and for many people (over two fifths) hospital may be where they die.

For some, this is not where they want to be looked after in their last days or hours, but for others this may be a place where they and their families can receive good care and where they can feel safe and looked after.

Whatever the situation, we need to make sure that the care provided is right for that person and as good as it can be as the experience of care makes such a big difference both to the dying and to the bereaved.

The End of Life and Palliative Care Committee has continued to drive forward improvements across the Trust in the last twelve months and work with our partner organisations to ensure that we move forward together with the interests of our local community at the core of what we do.

End of Life Care Hospital Improvement Programme

Over the past year we have been participating in an important programme of work called End of Life Care Hospital Improvement Programme. This is commissioned by Hospice UK and NHS Improvement and supports the work we are doing to improve the experience of care provided to patients who may be in the last few months of life.

Findings have demonstrated that there are significant opportunities to improve the overall experience of care for patients and families. These include:

- Improving the identification of patients who may be in the last months of life, having courageous conversations and involving them in planning their care;
- Improving the recognition of uncertain recovery at admission;
- Better planning for deterioration;
- Improved communication with patients to identify what is important to them;
- Earlier identification of dying patients and use of the Individualised Plan of Care to support their last days and hours.

The process involved a "Fresh Eyes Walkthrough" and feedback from the End of Life Care Hospital Improvement Programme team about the environment at the Royal Infirmary, including general areas, the Emergency Department, Bereavement Office and Mortuary. They had some very positive things to say, as well as some important observations about how we might make small improvements with big impacts for patients which we are currently reviewing.

We have started some quality improvement work alongside the Emergency Department, which has informed the plan of work for the End of Life and Palliative Care Committee for 2018 and beyond.

Care of the Dying Patient and their family

The End of Life Care facilitators (part of the Specialist Palliative Care Team) have continued to roll out education and provide support to colleagues across the organisation.

Although there is more staff still need to learn, there have been many examples of excellent care and our audit of the Five Priorities for Care of the dying person has shown continued improvement across the priorities.

We have signed up the National Audit for Care at the End of Life for 2018 which will allow us to benchmark our care against other trusts. Part of this audit will involve reviewing notes of patients who have died in our care to understand how the care has been provided and where we need to target further education and support.

In addition to this work, feedback from carers about the experience of care will help us to understand what actions we need to prioritise. We expect to have the results of this work in early 2019.

The Individualised Plan of Care for the Dying Patient has been reviewed in line with guidance recently issued by NICE and we have updated our patient information leaflets to ensure that families feel supported and know what to expect and how they might be involved in care if they wish.

Medications to manage symptoms in the last days of life

The Specialist Palliative Care Team have reviewed the guidelines for managing common symptoms in the last days of life and have worked hard with other team members to ensure that staff are trained in using McKinley T34 pumps across the organisation, significantly improving the numbers of staff trained and recorded as safe users.

Fifteen new pumps have been purchased and systems put in place which ensure that staff can access these pumps when they are needed, whether day and night. This is a really important piece of work which will ensure that patients have their symptoms controlled effectively.

Learning Disabilities

The Specialist Palliative Care Team has a core member in the Palliative Care with Learning Disabilities group which meets regularly to discuss how patients with a learning disability can be supported at end of life.

This work brings us together with teams in the community to ensure we all share knowledge and experience during peer support time. The group is currently working on advance care planning workshops that will allow any local people with a learning disability who are thought to be in the last year of life to access the hospice and through support develop a personalised care plan. This also enables their family and carers to see what support is available.

VALE

VALE is a project co- ordinated by members of the Specialist Palliative Care Team, which engages volunteers within the hospital to spend quality time with patients who are dying. They provide support to ward staff by assisting with meals, offering company to patients, and in some cases a hand massage.

They also offer a respite period for families who need some time to care for themselves, but would like to know their loved one is not alone. Use of this service is growing and feedback has been very positive.

Work across Leicester, Leicestershire and Rutland

We continue to engage with, and support, the work in the local Sustainability and Transformation Plan (STP) around end of life care.

Progress is being made and we look forward to being part of new ways of supporting patients and families in the future.

We are talking with local stakeholders about the possible introduction of a new document to record decisions about emergency treatment called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and exploring how this might support patients across the healthcare economy.

Ensuring that information can be accessed across organisational boundaries to improve the care of patients is important for many reasons, but particularly where patients are at the end of life. SystmOne provides clinicians and health professionals with a single shared Electronic Health Record available in real time at the point of care. There continue to be challenges, but we continue to work towards this goal.

Bereavement Support Service (for adults)

In December 2015 we launched a pilot Bereavement Support Service, available for all those affected by the death of a loved one aged 18 years or over who died in one of our hospitals.

The service is now an integral part of what we provide to support bereaved families and it links with our 'Learning from deaths' process.

It is recognised that family members, carers and others affected by bereavement may sometimes need further information, support or questions they would like to ask. Having the opportunity to have these questions answered can often help as they begin to come to terms with their loss. If required, the Bereavement Support Service can arrange for individuals or families to meet with a member of the medical or nursing team who cared for their loved one.

The service offers families the opportunity to talk through what matters to them regarding their bereavement. If we are unable to help, the Bereavement Support Nurse signposts people to someone who can, for example, although the service does not provide counselling, assistance can be offered with directing individuals to counselling or support organisations who can help.

Family members and carers may contact the service at any time and will be offered the opportunity to receive a 'follow up' contact from the Bereavement Support Nurse around six to eight weeks after their bereavement, either by means of a telephone call, letter or another method of their choice. Contact can be made in alternative languages or formats if required, e.g. for those with disabilities.

Providing spiritual and religious care

We offer 24/7 pastoral, spiritual and religious support to patients and families and our diverse team, including the NHS's first full non-religious team member, ensures that they have chaplains from a wide variety of faiths and outlooks to support them. We are on hand to support patients or families in urgent situations, especially around the time of death.

This year we have provided the chaplaincy service to Leicestershire Partnership NHS Trust, seeing patients and families across mental health units and community hospitals of Leicester, Leicestershire and Rutland.

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.

On each of our sites we provide multi-faith chapels and prayer facilities for patients, visitors and staff to use. These provide a place for prayer or quiet contemplation and are in constant use.

Over the year our chaplains and chaplaincy volunteers made about 13,000 visits to patients - an invaluable part of our commitment to delivering "Caring at its Best". We benefitted from about 3,500 hours donated to the Trust by volunteers.

The chaplaincy also organised the third "Celebrating Caring at its Best" event, held in May 2017 which focussed on celebrating positive patient experiences and the motivation of staff and volunteers.

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'

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

Our overall workforce plan has been focused on reducing gaps in demand and supply and in introducing new and innovative roles and working practices to attract the right people with the right skills into the organisation.

Reflecting the national picture of supply shortages, particularly for nursing staff, we still have challenges in meeting the gaps between demand and supply of nurses. To address some of these challenges we have pioneered the development of a Nursing Associate qualification which has been designed and implemented with our STP partners and to date there are 90 trainee Nursing Associates in place.

We have reviewed our Practice Placement Strategy to support two Higher Education Programmes at both De Montfort and the University of Leicester to enable a better supply of newly qualified nurses. The Practice Placement Strategy includes partners in the private, voluntary and care home sectors and is being led by us.

In addition we continue to have a joint approach to the development of Advanced Clinical Practitioners who are critical to the delivery of a more multidisciplinary approach to the delivery of tasks traditionally undertaken by medics and the emergent STP workforce plans.

We, with Leicestershire Partnership NHS Trust, have worked together on a newly qualified graduate rotation programme specialising in the frail and older person. This 27-month programme provided newly qualified nurses the opportunity to work in both organisations and also carry out insight visits to other areas of care, such as the voluntary sector, mental health, nursing homes, specialist care teams and LOROS to enhance and broaden their knowledge of caring for older people. The nurses were also supported with speciality study days and completed the in house post graduate accredited frail older people module.

Although we have been impacted by Brexit in terms of turnover and attraction to posts, we have continued to successfully recruit internationally for junior doctors and radiographers, and have developed a programme of overseas recruitment for nursing.

Our Pharmacy team have also had success in recruiting into roles at Band 4 and Band 7, which are traditional hotspots, through the introduction of apprenticeships and internal development schemes.

We have progressed a number of reconfiguration scheme workforce plans, which include a multidisciplinary frailty friendly workforce plan for Phase Two of the Emergency Floor, including the introduction of Meaningful Activity Coordinators and an increased presence of therapy staff, the development of a plan for East Midlands Congenital Heart Centre to meet activity requirements and plans for the interim move of Intensive Care Units.

We have developed a robust approach to improving our representation of BAME staff at the leadership level, including drawing candidates for our internal Graduate Training Scheme from the local community and setting trajectories at staff group level for improved representation.

We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget

The agency cap for 2017/18 was £20.6m and we achieved £20.39m through a robust approach to our management of agency expenditure including reducing rates and volumes.

We have achieved particular success in reducing medical agency spend from £10.1m to £8.85m, which overachieved our national target of a reduction of £718K. This has been achieved through a more robust approach to gap management and authorisation.

We will transform and deliver high quality and affordable HR, Occupational Health and Organisational Development services in order to make them 'Fit for the Future'

We are proud to have developed a new case management approach and electronic tracking system and have now appointed a dedicated Case Management Team in progressing this further during 2018/19. We are beginning to benefit from policy and practice improvements and focused mediation at early stages.

We continue to improve our recruitment services through stronger external collaboration with partners across Leicester, Leicestershire and Rutland and improved Clinical Management Group resourcing plans to strengthen workforce planning.

We have continued our organisational development up-skilling programme to increase organisational development capacity and capability across our service and work closely with system partners on building strong leadership and improvement skills across leaders and managers.

We will continue to work on transforming our services and are committed to providing 'fit for the future' services.

Our Nursing and Midwifery workforce

The national challenge of recruiting nurses is well documented. Through our dedicated nurse recruitment team, we continue to focus on attracting and retaining the best nurses to work in our hospitals.

Our Trust wide open days have been successful and we have been able to recruit nurses to all areas of our organisation, as well as giving us the opportunity to showcase the development opportunities and career pathways we can provide to nurses at all stages of their careers.

In 2017, we official opened of our Centre for Clinical Practice and Leicestershire School of Nursing Associates. The investment in new education and training facilities confirmed our commitment to the development of our clinical nurses and midwives.

We have continued to recruit nurses from the EU, India and the Philippines which have helped with our nursing vacancies. We know that our registered nurses from non-EU countries make a long term commitment to live and work in the UK, and so our recruitment strategy is an investment as it brings experienced and skilled nurses to support and enhance our nursing workforce in delivering care to all of our patients.

We continue to use the RCN (Royal College of Nursing) 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 is also very successful and we remain the main source of employment for De Montfort University (DMU) nursing and midwifery students, which is a testament of our commitment to support learners throughout their training so they can continue their career development as registrants with us.

The Nursing Associate was piloted as a new role by Health Education England in 2017. A Nursing Associate supports the registered nurse in ensuring patients and families receive high quality, compassionate care for adults and children in hospital or community environments, including mental health or learning disability. We are one of the pilot sites for the East Midlands Collaborative and we have developed our own programme for our Leicestershire trainees in partnership with De Montfort University. Our nurse educators now deliver the Nursing Associate Apprenticeship as a Foundation Degree in Science, which is a unique model and the only one of its kind in England. This programme is available to existing care assistants, or a similar caring role in any health or social care setting. Our first group of trainees are due to qualify from our Leicestershire School of Nursing Associates in January 2019 and our second cohort of 53 trainees started their apprenticeship programme in January 2018.

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

Through an integrated People Strategy we 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. Work has already started on this approach through such developments as Physician Associates, Nursing Associates and Advanced Clinical Practitioners.

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 role. In June 2016 we had four Physician Associates join us and are proactively promoting the role across both our organisation. In 2017/18, we employed seven Physician Associates. 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 Physician Associate postgraduate qualification delivered through De Montfort University started in September 2017 with a group of 12. Our US Physician Associates have proactively developed the programme and lectured on a number of modules.

In addition the Course Leader is jointly employed by us and De Montfort University. We are currently working with the University on the placement programme and have hosted six placements from the Worcester programme. Workforce plans have been developed in Clinical Management Groups which include Physician Associates as part of their workforce model.

On a Leicester, Leicestershire and Rutland wide basis, we continue to host 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 40 trainees on programme and eight due to complete this year. There are 36 fully competent Advanced Nurse Practitioners 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.

The Leicestershire Nursing Associate Programme delivered by us in collaboration with De Montfort University was validated in September 2017 and remains the only model of its kind in the UK.

A second Leicester, Leicestershire and Rutland wide cohort of 52 trainee Nursing Associates started in January 2018 and are now following an apprenticeship standard; 39 of this cohort are from our organisation with the remainder from Leicestershire Partnership NHS Trust.

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 is going through a period of expansion by recruiting trainee Coders. There is a national shortage of Clinical Coders but the Trust has two accredited Clinical Coding Trainers in post. They provide a structured and well-supported training programme which has enabled us to appoint 19 brand new trainee Coders since 2015. This is helping to resolve a long history of under-staffing and has removed the need for use of agency Coding staff to make the workload manageable.

We have an audit programme to review the quality of our Coding for approximately 200 cases per month. The Trust has two Accredited Coding Auditors in post to achieve this. Clinical Engagement is developing very well with Coding staff attending consultants meetings. In 2018 we held our first Clinical Coding conference in which four clinicians presented the intricacies of their specialist areas to the whole Coding Team.

A career framework for pharmacists has been introduced in order to support initiatives around retention. This outlines the scope for future pharmacists as independent prescribers, advanced practitioners and consultant pharmacists which support changing models of care across the Trust. In addition apprenticeship schemes for pharmacy technicians have been expanded to improve recruitment to Band 4 and Band 5 technician roles which have proved challenging in the past.

As well as hosting three National NHS Graduate trainees in 2017/18, we appointed a further six Graduate Management Trainees onto our own training scheme which we successfully piloted in 2015-2017. Eight of the original group of nine have secured their next appointment with us and one person is training as a Physician Associate. This year we have appointed a further six who are following an apprenticeship standard at level 7 as part of their education programme.

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

2017/18 has been a watershed year in respect of the equality and diversity agenda for us. A number of nationally driven standards, such as the Workforce Race Equality Standard, have informed our direction of travel and re-prioritisation of equality issues.

Other factors have also played their part in helping to re-evaluate the way in which we approach equality and diversity in terms of its employment and service delivery.

Workforce Equality

Our second year of WRES data saw a positive increase in the percentage of Black, Asian and Ethnic Minority leadership figures, which rose from 9 per cent in 2015/16 to 12 per cent in 2016/17 - a 3 per cent rise. Early signs demonstrate a further increase in 2017/18 to 13.6 per cent.

Although this is very positive, the overall BAME workforce is 30.96 per cent. Other WRES indicators show less favourable trends, such as the likelihood of BAME candidates being appointed to jobs from applying to the Trust than their White British counterparts.

We take equality and diversity extremely seriously and have taken the following actions:

- Continued Board Development on the race equality agenda via a dedicated 90 minute session on 10 January 2018 with the national WRES Team;
- Set race equality as one of its key priorities for delivery in 2017/18;
- Carrying out equality Learning Needs Assessments of all Executive Directors;
- Established our first BAME staff network (UHL Voice);
- Established an Equality and Diversity board chaired by the Chief Executive;
- Developed a refreshed strategic equality and diversity action plan which is outcome focused;
- Carried out in-depth analysis of rates of turn over to establish realistic race equality targets.

In addition we have:

- Carried out a gender pay gap analysis and set a target to reduce the gender pay gap from 29 per cent to 16 per cent over three years with an associated action plan;
- Working towards providing more support to staff who have been bullied or harassed through the Anti-Bullying and Harassment helpline and working Closely with the Freedom to Speak Up Guardian;
- Secured funds through the Better Care Together Programme to run a system wide Equality and Diversity Conference during May 2018.

Service delivery

We have achieved the following outcomes in respect of improving access for patients:

- Established a new provider of interpretation and translation services following the last provider's withdrawal of service during February 2016;
- Established positive relationships and new arrangements for providing local British Sign Language interpreting services;
- Carried out an audit of leaflets and their accessibility to patients;
- Provided leaflets in community languages and other formats on demand;
- Explored options for the introduction of a "dignity" gown to be trialled in radiography services following a request by one of our faith communities;
- Changed the FFT (Friends and Family Test) monitoring section to reflect comments received from the Transgender and non-binary community.

National NHS staff survey

The NHS Staff Survey was carried out in October and November 2017, 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.

This year we chose to carry out a full census survey – which means every member of staff (14,146) was eligible to take part and would have received a survey to complete. 4808 responses were returned, giving a response rate of 34 per cent. This was a decrease of 2.2 per cent from the previous year; the national average (median) for Acute Trusts stands at 45 per cent.

The results of the NHS Staff Survey showed improvements in some areas relating to patient concerns and feedback, however there was a decline in job satisfaction which mirrors the national picture.

		2014	2015	2016	2017	Position compared to 2016 result	Average (median) for acute trusts
Q21a	"Care of patients / service users is my organisation's top priority"	64%	72%	74%	74%		76%
Q21b	"My organisation acts on concerns raised by patients/service users"	67%	75%	74%	75%		73%
Q21c	"I would recommend my organisation as a place to work"	51%	60%	60%	57%		60%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	56%	64%	65%	65%		71%
Q22a	Patient/service user feedback collected within directorate/department	-	93%	85%	90%		89%

IR35

IR35 is tax legislation that is designed to combat tax avoidance by workers supplying their services to clients via an intermediary, such as a limited company, but who would be an employee if the intermediary was not used.

Number assessed as caught/ not caught by IR35	As at 31 March 2018 we had 187 off payroll arrangements : • 19 carrying out regular work • 14 ad-hoc workers • 153 are engaged through Locum Bookers or agencies • There are no off payroll engagements of Board members in 2017/18
Number engaged directly and are on the departmental payroll	From April 2017 the only way to pay workers is: • As employees of the Trust • UHL Bank • The Agency or Intermediary (who will be required to deduct tax and NIC before payment to the worker) • IR35 Payroll (processed through UHL payroll. We will deduct tax and NIC before payment to the worker. This does not provide any other employment rights to the worker) 14 workers are engaged through IR35 payroll

Number of engagements reassessed for consistency/ assurance purposes during the year.	Where workers or the agency/ intermediary believe the worker falls outside IR35, a HMRC on-line assessment must be completed and consistency checked by UHL. Between April 2017 and 31 March 2018, 43 HMRC on-line assessments have been considered, and 10 fell within IR35, 33 outside IR35.
Number of engagements that saw a change to IR35 status following the consistency review	14

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.

As we entered into 2017/18 we were delighted once again to hold the National Skills Academy Quality Mark for 'superior' delivery of education and training to the health sector. 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 an organisation we have also regained MATRIX Standard accreditation for our information, advice and guidance provision.

Since gaining main provider status with the Education & Skills Funding Agency we have developed three new lead governing roles during 2017/18 to record, develop and monitor our quality provision and deliver training to Education & Skills Funding Agency and Ofsted requirements. Our team of competent assessors and trainers facilitate and deliver skills, knowledge and behaviours required in new apprenticeship standards and associated qualifications, as well as support and prepare learners on their journey to the end point assessment which is carried out by external independent companies. This works supports us in developing the workforce we need to deliver our services to patients.

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

A new partnership working arrangement has been set up with Leicester College which further supports our workforce development both through apprenticeships and functional skills. Functional skills allow our staff to access maths and English education programmes from which their new skills impact not only their working lives but home lives and can impact on their families and local communities too.

Appropriate learning and development needs continue to be identified through the appraisal process within CMG's and enables 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.

During 2017/18, there were seven core business courses led through the team including appraisals and preparing for your retirement etc, which were attended by 954 members of staff. The IT Training Team within Learning and Development continue to deliver training in core clinical system functionality such as HISS and PatientCentre to our staff and staff in the Alliance. Other areas of the training portfolio include INsite (our intranet) and web training. The team continue to support current and future initiatives and projects across the organisation, e.g. Paperless Hospital 2020, replacement to the INsite application and roll-out of Windows 10 and lead on the organisation of the three cohorts of 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 have completed four

New Born Hearing Screening qualifications and have another ten on the screening programmes signed up for completion next year.

The department runs weekly corporate induction events across the year supporting circa 1500 new starters when they join our organisation. This is a good opportunity for new staff to meet the Chief Executive and allows us to set a standard at the start of their time with us around our values and behaviours and essential training such as fire safety, safeguarding and equality alongside receiving their new ID badge.

The Learning and Development Team are responsible for the delivery of Statutory and Mandatory Training. Staff compliance levels have ranged during the year and it is acknowledged that there have been difficulties with reporting and data trends for a significant period within 2017/18. The end of year compliance for staff completing their core mandatory training was 88 per cent against a target of 95 per cent. CMG's are encouraged to ensure that action plans are in place to sustain/ improve performance against all core programmes. Mandatory Training continues to be supported by the provision of e-learning programmes aligned to the national Core Skills Training Framework (Skills for Health) and ten of the eleven subjects within it are included in the above data. Work began to support Prevent training being rolled out by the subject matter expert and will continue to ensure this is included in reports.

During the year a number of eLearning programmes were written for us by the team and full reviews of Infection Prevention and Equality and Diversity Training also took place.

HELM saw the launch of new dashboard functionality and more than 700 managers have been provided with access to this. During 2017/18 we have also moved the reporting parameters from reporting CMG and Corporate data to reporting CMG and individual Directorate Data.

This year the team incorporated 1500 accounts to the learning management system for Estates staff and supported alternative ways of accessing and recording the material and completion of training.

Over 1800 learners attending the various training programmes outside of core mandatory training have been booked through HELM. It is acknowledged that the last 12 months have been very difficult for the functionality of the learning management system, however a number of positive elements have also come through such as the stability and accuracy of the system has improved greatly since launch yet there is more work in scope to do. User feedback suggests they find it very simple and easy to navigate and use. Managers and trainers are finding the Dashboard useful in chasing non-compliance and the CQC were happy with the training data they received from HELM.

Apprenticeships

We took up the mandate to adapt the offer of apprenticeships during 2017/18 to support the Public Duty of Care target (2.3 per cent of the workforce) and new Apprenticeship Levy Funding. We currently have 155 learners following apprenticeship education programmes, with 107 of these starting in 2017/18. We have delivered 54 per cent of our apprenticeships through our Apprenticeship centre and 13 learners on our internal centre programmes from other health and social care organisations. We anticipate the offer of Apprenticeships will continue to grow aligned to the emerging standards and workforce needs across the system.

Through the new Apprenticeship levy, which was introduced nationally in 2017/18, we have supported staff in accessing apprenticeship education programmes. To date we have spent £116,599.06 of the new Levy. It is important to note that the full cost of a programme is not paid 'up front' but paid over the term of the programme. Therefore the actual spend from the levy pot for the duration of the programmes will be significantly more than this. The Levy pot is funded from the government top slicing of our pay budget each month by 0.5 per cent. This money can be spent on solely on apprenticeship education programme costs and there are strict rules around it. At the end of March 2018 we will have access to a further levy pot of £2,255,137.00.

Through the launch of the new Apprenticeship Levy the employer is now more in control of the contracting for educational needs. A significant amount of procurement and contract work was done by the team in 2017/18 to secure training contracts with De Montfort University, University of the West of England in Bristol, City Wolverhampton College and Leicester College, often where no clear guidelines under the new funding rules existed. Discussions within the procurement process are in progress with seven new providers

as frameworks and new standards are developed. We have been successful in negotiating Levy saving from the Levy pot totalling £10,350 for programmes costs and £25,650 in End Point Assessment costs.

We have continued our relationship with South Leicester College, (Now North Warwickshire and South Leicester College) who have subcontracted the apprenticeship delivery for us for several years as well as the subcontracting for the delivery of functional skills for those learners who were recruited pre Levy.

Regent College have been a valued partner of ours for many years and deliver our Business Administration apprenticeship. During 2017/18 they continued to work with learners who started pre Levy until the end of their provision in March. The collaborative relationship will continue with the transition of their students who aspire to achieve careers in health with us.

In early 2018 we began to develop relationships with Regent College, Leicester College and South Leicester College to offer careers advice in apprenticeship opportunities to their health students.

It is acknowledged that 2017/18 was a very difficult first year for the new apprenticeship funding rules and readiness across the country of professions, workforces and training providers has taken a long time to start growing and becoming established. Many standards were not ready to use, variations in apprentice pay are unclear, procurement rules were hazy and workforce planning within divisions often lacked apprentice opportunities due to salary funding. Country wide 92 per cent of Levy funds have not been spent. We are not alone in these difficulties and have proactively developed our apprenticeship provision as a centre in spite of the moving landscape. Having more than six versions of the funding rules to date is increasing the clarity; however there is a long way to go. End Point Assessment conversations have started but the readiness of organisations to conduct this leaves employers and training providers with uncertainty.

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.

Celebrating achievements

Our annual training awards ceremony allows us to celebrate staff achievements in learning and development. At our annual event in June 2017, we presented 112 learners 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.

In November 2017, 82 people attended our 25 Year Service Recognition dinner, celebrating their long service with the NHS.

An annual Apprentice Graduation Ceremony took place in June 2017 organised and hosted by the Leicester Apprenticeship Hub. This event is eligible to all learners that have completed an apprenticeship in 2016/17. We had 27 learners in attendance celebrating the completion of their programmes.

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 following a judging panel made up of variety of key stakeholders 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.

Our 'Above and Beyond' informal recognition scheme, launched in November 2016, continues to go from strength to strength with 2522 nominations for staff who have been recognised by colleagues or peers as going 'above and beyond'. They receive a special thank you in the form of a pin badge and card.

Attracting and retaining staff – our benefits scheme

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 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. 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 enabling staff to view 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.*

Deliver the recommendations of "Freedom to Speak Up" review to promote an entirely open and honest culture

Our Freedom to Speak up Guardian, Jo Dawson, has been in post for over a year and, together with the Safety Team, is leading on some of our safety culture work.

During the year we have reviewed the resources available for staff to enable them to raise concerns. These include the 3636 staff concerns reporting line (online form and telephone number) and the junior doctors gripe tool, as well as open access to the Freedom to Speak up Guardian, the safety walkabout programme, and Director breakfast sessions. A dedicated Freedom to Speak up email has also been created for any member of staff to raise concerns.

In 2017/18 58 concerns were raised through the 3636 staff concerns reporting line, 77 direct to the Freedom to Speak Up Guardian and 111 through the Junior Doctor Gripes Tool.

Our Freedom to Speak up Guardian has attended a number of team meetings across our hospitals and offers team drop in sessions. We work closely with the National Guardian's Office and with local and regional colleagues to promote the national Freedom to Speak up agenda across our organisation.

Staff are both encouraged to raise safety issue, and are supported when they have done so. We seek feedback on their experience of raising concerns and provide quarterly reports to Executive and Board Committees on the relevant themes, services, issues and learning.

Number of 3636 Staff concerns received by financial quarter 2014/15 to 2017/18	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**
2017/18 Number of concerns received	13	23	8	14	**58**

Number of F2SU Staff concerns received by financial quarter 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2017/18 Number of concerns received	20	17	17	23	**77**

Number of Junior Doctor Gripes received by financial quarter 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2017/18 Number of Junior Doctor Gripes received	39	24	21	27	**111**

Modern Slavery Act

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 into force 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 suppliers comply with the MSA;
- Inclusion of MSA clause in our standard terms and conditions.

Equality and Human Rights

It is our aim to provide care and services that are appropriate and sensitive to all.

We always ensure that our services promote equality of opportunity, equality of access, and are non-discriminatory.

We are proud of our place in the local community and are keen to embrace the many cultures and traditions that make it so diverse.

The diversity of this community is reflected in the ethnic and cultural mix of our staff. By mirroring the diversity that surrounds us, our staff are better placed to understand and provide for the cultural and spiritual needs of patients.

Occupational Health Support

Our occupational health service continues to be an integral part of our organisation and works hard to provide high quality, independent and impartial health and work advice to workers and their managers, as well as strategic advice to the organisation.

The service was recently successful in achieving SEQOHS reaccreditation. SEQOHS stands for Safe, Effective, Quality Occupational Health Service and is a set of standards and a voluntary accreditation scheme for occupational health services in the UK. We received specific commendation for audit, governance, leadership and supporting development of occupational health staff.

The occupational health service responded to a challenging 2017/18 influenza season, giving a higher total number of influenza vaccines to staff than any previous year, covering over 71 per cent of frontline clinical staff.

In other good news, Dr Anne de Bono became President of the Faculty of Occupational Medicine in October 2017, and Dr Charles Goss succeeded her as Head of Service. Dr Harj Kaul remained National Training Programme Director, overseeing trainees in occupational medicine.

We continue to provide occupational health services across the local and regional healthcare community, including healthcare students at Leicester and De Montfort Universities, as well as other NHS and non-NHS organisations.

Health and Safety

The team continue to be involved in the planning and building of new/ relocated services across the Trust. The team were involved in ensuring that Phase 2 of the Emergency Floor is safe and meets the required standards and continue to be involved in the planning for the Intensive Care Unit extension at the Glenfield as well as the proposed modular ward builds, relocation of Medical Records and upgrading of Mansion House.

For the second year, 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

Like all hospitals across the country we have seen increased pressures, particularly across the winter. It is therefore not surprising to see an increase in reported incidents. This is also evidence of a positive reporting culture. This year we are reporting 56 RIDDOR reportable injuries/ incidents compared to 34 last year representing a 58 per cent increase. There are no particular themes or “hot-spots” but rather a general reflection on the unprecedented pressure we have been under.

As part of our work to reduce work staff injuries/ medical conditions, we have designed a bespoke office environment training and assessment room at the Bracken Centre – Glenfield. Here we can assess staff in a variety of settings with the use of the latest technology to aid comfort, promote safer working and reduce work related Musculo-Skeletal disorders.

We have not received any enforcement notices from the Health and Safety Executive this year.

Manual Handling

When the Care Quality Commission visited us earlier this year they were very positive about our safer handling practices, and made particular references to the availability of equipment, training and arrangements for bariatric patients. There were also positive references to the Bed and Equipment contract, with a particular mention by staff of the access of specialist patient surface equipment.

The rise in bariatric admissions has continued this year with more than 200 referrals being made to the team. This represents an increase of 33 per cent compared to last year and, by far the most that have been referred to us in one year. The manual handling advisors have been able to provide expert help, advice, support and equipment to meet the needs of these patients and the staff caring for them. In 2016 we forecast this rise in referrals and put measure in place to ensure we could meet that demand and still work efficiently.

Last year we reported that we had invested in specialist moving equipment for patients weighing more than 250Kgs which has helped us move two patients safely. We continue to forecast and anticipate the future needs of bariatric patients so that working with staff we can provide them with safe care.

Collaborative work with colleagues in Medical Physics we have identified and replaced, or installed new, patient hoists.

Security Management

Following the creation of a bespoke security management training facility we are now able to provide staff with a wide range of security related training on our own premises. We have also partnered with a private training company to widen the Conflict Management training course available and this has helped us maximise our opportunities to income generate.

As part of our commitment to provide a safe and secure working environment for our staff we continue to exercise powers of sanction against members of the public who behave in an aggressive or unacceptable manner. We continue to work in partnership with Leicestershire Police and has relationship has been enhanced with contacts for Leicester City Council. This collaborative approach to crime reduction has led to addressing criminal behaviour, preventing crime and an increase in prosecutions against perpetrators.

In 2017/18 we put in place a local security action management plan which has shown some steady improvements since last year.

Overall we have seen a slight decrease in reported physical and verbal assaults against staff compared to last year. Physical assaults have fallen by 5 per cent; despite an increase in our workforce.

The remit of the Security Management team has expanded since 2016, with the demand for expert security advice and support being sought by staff has increased as our reputation grows.

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. Our Patient Information and Liaison Service 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 or have a request for information.

The service is responsible for co-ordinating 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 2014 to March 2018

PILS Activity by Type & Financial year 2014/15 to 2017/18	14/15	15/16	16/17	17/18	Total
Formal complaints	2,110	1,558	1,445	1,865	**6,978**
Verbal complaints	974	1,449	1,152	840	**4,415**
Requests for Information	234	439	318	140	**1,131**
Concerns (excludes CCG & GP)	493	757	1,284	1,139	**3,673**
Totals:	**3,811**	**4,203**	**4,199**	**3,984**	**16,197**
Percentage change against previous year		**10% increase**	**0.1% decrease**	**5% decrease**	

Complaints

Complaints are a vital source of information from our patients, families and carers about the quality of our services, standards of our care and experiences of those who have used them. Our Patient Information and Liaison service administer all formal complaints and concerns, with concerns received by General Practitioner's (GP) managed by our GP Services team.

From 1st April 2017 to 31st March 2018 we received **1,865** formal complaints and **1,363** concerns.

The table overleaf shows the top five themes of formal complaints received by the Clinical Management Groups from 1st April 2017 to 31st March 2018;

Table showing top 5 subjects of formal complaints by Clinical Management Group for 2017/18

The top five subjects account for 1,382 (74 per cent) of the 1,865 formal complaints we received

Top 5 primary subjects of formal complaints by CMG	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	139	65	110	14	139	8	71	18	1	**565**
Waiting times	39	24	65	9	68	24	7	19	2	**257**
Appointments including delays and cancellations	38	17	29	12	73	7	12	24	8	**220**
Staff attitude	21	20	66	3	19	10	19	8	4	**170**
Communication	36	20	53	2	14	6	27	4	8	**170**
Totals:	**273**	**146**	**323**	**40**	**313**	**55**	**136**	**73**	**23**	**1,382**

10, 25 & 45 day formal complaints performance - April 2017 to March 2018

Throughout 2017/18 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 the Clinical Management Groups.

Actions for 2017/18 to further improve complaints engagement and learning were:

- To carry out a new complaints satisfaction survey using new approaches. We are currently working to identify the best route and format to capture feedback;
- To coach and further develop the skills of the PILS team to improve the quality of call handling and drafting of responses using plain English. The PILS team now all receive monthly one to one coaching sessions to include a review of a telephone call and draft letter;
- To develop further training for staff to enable them to manage and resolve concerns locally and earlier. Improved local management of complaints has been included in the Patient Safety training programme packages.

We continue to strive to improve our complaints process and handling of cases. Actions for 2018/19 are:

- To change current paper triage process to an electronic process;
- To review and improve the PILS patient information leaflet;
- To review and ensure consent within complaints process is in line with best practice and updated national guidance.

RE-OPENED COMPLAINTS

This year (2017/18) we have seen an average of 8.31 per cent of formal complaints reopened per quarter.

2017/18	Formal complaints received	Formal complaints reopened	% resolved at first response
Q1	381	45	**88%**
Q2	475	48	**90%**
Q3	487	29	**94%**
Q4	522	28	**95%**
Totals:	**1,865**	**150**	**92%**

PARLIAMENTARY HEALTH SERVICE OMBUDSMAN

This year we have again had less upheld cases by the Parliamentary Health Service Ombudsman, further details are provided below.

Parliamentary Health Service Ombudsman complaints - April 2014 to March 2018

PHSO Investigations	2014/15	2015/16	2016/17	2017/18	Total
Enquiry only - no investigation	2	2	4	1	**9**
Investigated - not upheld	5	8	12	3	**28**
Investigated - fully upheld	0	0	1	0	**1**
Investigated - partially upheld	7	2	3	0	**12**
Complaint withdrawn	0	0	1	0	**1**
No decision made yet	0	1	0	7	**8**
Total	**14**	**13**	**21**	**11**	**59**

There are no cases received in the current financial year that have been upheld or partially upheld

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 2017/18, we received 682 Freedom of Information requests and/or requests for environmental information, a slight reduction (1.9 per cent) compared to 695 in 2016/17. We responded to **95.3** per cent of these requests within the statutory 20 working-day deadline.

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 1093 instances where areas had to provide information (compared to 1036 instances on 2016/17).

The table below shows the number of times that different areas had to provide information during the year to respond to those 682 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 Freedom of Information section.

Freedom of Information/Environmental Information Regulation requests received between 1 April 2017 and 31 March 2018, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2017/18**	**Approx % of overall 2017/18 FOI activity (in terms of times needing to provide information)**
Finance and Procurement	157	14.4%

Freedom of Information/Environmental Information Regulation requests received between 1 April 2017 and 31 March 2018, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2017/18**	**Approx % of overall 2017/18 FOI activity (in terms of times needing to provide information)**
Operations	139	12.7%
Clinical Support and Imaging CMG	115	10.5%
Human Resources	108	9.9%
Corporate Nursing	78	7.1%
IM&T	73	6.7%
Women's and Children's CMG	58	5.3%
Musculoskeletal and Specialist surgery CMG	56	5.1%
Cancer, Haematology, Urology, Gastroenterology and General Surgery CMG	54	4.9%
Facilities & Estates	52	4.8%
Corporate Medical	52	4.8%
Emergency and Specialist Medicine CMG	48	4.4%
Renal, Respiratory and Cardiac CMG	31	2.8%
Corporate & Legal	31	2.8%
Critical Care, Theatres, Anaesthesia, Pain and Sleep CMG	22	2%
Marketing and Communications	9	0.8%
Strategy	5	0.5%
The Alliance	3	0.3%
Research and Innovation	2	0.2%
Total	1093	

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 1093 times that areas had to provide information) are higher than the total of 682 requests received.

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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.

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

Undergraduate Medical Education: This year has seen the implementation of the new undergraduate curriculum. The new curriculum incorporates a Foundation Assistantship during the final year, which provides the students with the opportunity to work closely with Foundation Doctors in preparation for their first post.

Our Education Fellow has used a technology based approach to seek 'real time' feedback from the medical students. The feedback identifies suggested improvements and changes and resulting actions are communicated directly back to the students.

Working with the University of Leicester, a number of our consultants have been awarded Honorary University titles in recognition of their work in education and training and a number of our Consultants were recognised at the recent University of Leicester Annual Medical School Day.

Physician Associate Students: 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 have appointed a Physician Associate Tutor to support students from De Montfort University and Worcester University, whilst they are on placement with us.

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

Postgraduate Medical Education

We continue to use an '**Education Quality Improvement Plan'** which informs Trust and Executive Boards on our performance.

Our bi-annual survey has a high response rate (>50 per cent) from junior doctors and the most recent survey revealed that 79.9 per cent of this staff group would recommend their current post to a colleague. The survey provides us with CMG and specialty level data which is used to identify good practice and drive forward improvement.

In September 2017, the Royal College of Physicians launched a Chief Registrar development programme to support aspiring clinical leaders. We appointed two Chief Registrar's, at the Royal Infirmary and Glenfield Hospitals, to participate in the programme. The Chief Registrars are leading a number of projects in both hospitals to improve the working lives of junior doctors.

One of these projects was to explore levels of morale at work for junior doctors and in October 2017, over 400 junior doctors responded to a local survey. Survey findings were presented to the Chief Executive and Medical Director and we are now using Listening into Action to improve junior doctor morale.

A new cross-specialty Grand Round Meeting for all medical staff will take place from 4th May 2018 on a monthly basis. This meeting is the result of a project between us and the University of Leicester to enhance collaboration between the two organisations.

Recognising the excellent standard of teaching within the Trust is to be celebrated in 2018 with the launch of 'Educator Awards'. The awards will be presented to senior and junior medical staff who teach both undergraduate and postgraduate medicine. There are also a number of awards to acknowledge the crucial role played by those who support the delivery of medical education. The award ceremony will be held in July.

We will develop a new 5 Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership.

Research and Innovation has developed a five year joint strategy with the University of Leicester that aims to use our existing work as a platform to drive a closer, more robust, integrated and sustainable strategic partnership between the two organisations by 2022. We are doing this because there is extensive evidence to support the observation that highly research active trusts deliver better outcomes for patients.

Research generated £18.7m for the Trust during this financial year, of which £2.6m was from commercial activity. We are proud to be rated as second in the country for clinical trials meeting the 70 day time and target benchmark (94.6 per cent of our research activity met this standard). 12,000 participants were enrolled into 1,025 active trials, 558 of which were interventional trials (assessing drugs or devices).

This year we officially opened our dedicated children's research facility in our Research Space and welcomed the first patients through its doors.

The National Centre for Adherence Testing (NCAT) based at the Royal Infirmary made national headlines with a urine test that confirms whether patients have been taking their blood pressure tablets and encourages them to comply with their prescription (Gupta and Patel).

A generous £5.15m donation was received from philanthropist George Davies for research into peripheral vascular disease, alongside a new Vascular Limb Salvage clinic at the Glenfield.

In December, we signed a Memorandum of Understanding with Nantong University Affiliated Hospitals to promote cooperation in medical research, training and education between the two institutions.

Towards the end of the year, our researchers (Bradding et al) announced that they had identified a way to distinguish between people with mild asthma and those with more severe forms of the disease, which could pave the way for tailored treatments.

NIHR Leicester Biomedical Research Centre and Clinical Research Facility

Both the NIHR Leicester Biomedical Research Centre and NIHR Leicester Clinical Research Facility (CRF) have successfully completed their first years' activities. Most notably the BRC has recruited over 7,500 research participants and has more than 150 studies open and actively recruiting. It has published in excess of 200 journal articles and secured more than £8m of additional external research funding from industry and charity collaborators.

The purpose of a Biomedical Research Centre is to take research findings and move them swiftly into clinical practice for the benefit of patients. The Arming Your Health study (Yates/Davies) showed the benefits of upper body exercise on improving the health of immobile diabetic patients and has implications for the management of the condition in diabetic foot clinics.

The Biomedical Research Centre, through Dr Adlam, is leading the way on developing a global clinical consensus on managing Spontaneous Coronary Artery Dissection, a type of heart attack found predominantly in women of child-bearing age who have no other clinical symptoms.

In the respiratory theme a pioneering urine test developed by UK company Mologic alerts people with Chronic Obstructive Pulmonary Disease that they are about to suffer a life-limiting attack has passed the first stage of development (Brightling et al). If fully implemented in the future, it could save the NHS £40m per year by preventing unnecessary hospital admissions and the over-prescribing of drugs to treat suspected attacks.

The Clinical Research Facility has successfully united several speciality clusters of clinical research activity around the trust into a new federal structure. During this inaugural year, 29 phase 1 and phase 2 studies have been supported, recruiting over 1,500 participants. The Clinical Research Facility has supported the delivery of ground-breaking clinical trials to patients in the Trust's acute units, particularly the EMBER study which looks into the use of novel breathomics (traces of chemicals and biological markers in the breath) in acutely unwell patients with the aim of using this information to swiftly diagnose and help doctors select the best treatment methods for a range of conditions in the future.

Integrating genomics into patient care

We have recruited over 900 patients with rare diseases and nearly 300 patients with cancer into the 100,000 Genomes project.

The project will end later in 2018 when genomic medicine will begin to become closely integrated into routine clinical care for many patients and the clinical genetics department is gearing up for these changes.

A group led by Professor Nigel Brunskill is designing and planning the necessary clinical service developments to support a new era of genomic medicine for us.

Leicester Precision Medicine Institute

The Leicester Precision Medicine Institute is a relatively new partnership (2016) with the University of Leicester led by Professor Martin Tobin. It brings together academia, the healthcare sector and industry to drive discovery and develop new medical interventions. It encompasses the Leicester Drug Discovery and Diagnostics (LD3) group, who translate the University's high quality biomedical research into medicines, therapies and diagnostic tests with 'real world' benefits for patients.

In 2017/18, the Leicester Precision Medicine Institute secured over £1m from the Medical Research Council for translational research and business engagement. Together with additional funding from the University, these awards support projects to develop novel therapeutics, diagnostics and medical devices that will positively impact patient outcomes.

This year, Leicester Precision Medicine Institute has funded nine joint PhD studentships with the Biomedical Research Centre and Cancer Research Centre to support priority research areas in cancer, cardiovascular, respiratory, and diabetes and lifestyle.

A Leicester Precision Medicine Institute Executive Committee has been formed, whose role it is to establish a roadmap to deliver priority precision medicine projects across the tripartite of the university, industry and us.

The Leicester Precision Medicine Institute 'brand' continues to grow and provides a competitive edge that has resulted in significant uplift of successfully funded precision medicine grant applications for both our staff and those at the university.

Looking forward to 2018/19, Research and Innovation will:

- Seek to retain funding from the National Institute for Health Research for our Clinical Research Facility for another three years;
- Strengthen our partnership with the University of Leicester and potentially develop new partnerships with other academic institutions and healthcare providers to support and grow integrated clinical research, education and training in Leicester, Leicestershire and Rutland of the highest standard;
- Look for opportunities to increase academic appointments for Allied Health Professionals, such as physiotherapists and midwives. In addition, we will create a post of Head Nurse for Research;
- Focus on creating a sharp, customer-focused service for research delivery that is responsive to the needs of internal researchers and industry collaborators;
- Develop more opportunities for public engagement with research through a newly-established Public Research Engagement Panel.

Underpinning this work will be a 'bench to ward' ethos with research activities become visible to all staff and patients. Clinical trial activity will increase and patients will have an expectation of enrolment into clinical trials wherever possible.

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.

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

There has been some good progress in introducing a focus on frailty into our Emergency Department; reaching out with a frailty focus to the rest of the organisation and wider healthcare community is now in the planning stage.

Delivery of this next stage will receive renewed focus though our 2018/19 priorities along with the introduction of new programme governance arrangements.

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 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 and responding to feedback regarding issues encountered. Our GP Services Team act as a conduit to facilitate dialogue and provide representation on interface matters. This workload now also includes the receipt and management of GP concerns and queries via an improved feedback system, together with leading on the identification of areas of improvement.

We produce a regular newsletter to update primary care on developments within our organisation; 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. We have focused on specific editions of the GP Newsletter which have proved popular; these have included editions on the new Emergency Department, Pathology and Blood Sciences and a planned E-Referral Service and Paper Switch-off.

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

Clinical conversations between GPs and consultants are still 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.

We will form new relationships with primary care in order to enhance our joint working and improve its sustainability

We have written and are working to a Primary Care Engagement and Education Strategy and we have set up a Primary Care Oversight Board, chaired by the Director of Strategy and Communication, to ensure that our integration and professional relationship with primary care is developed and we offer a high standard of provision and support for our referring primary care colleagues.

Patient and public involvement

This year we have successfully carried out three public 'Community Conversation' events across Leicester, Leicestershire and Rutland. The aim of these events is to enable members of the Trust Board to be more visible in local communities, to listen to a diverse range of public views on our services and promote and publicise the work we do. These well-attended events were held at Ulverscroft Manor, Healthwatch Rutland and at the Leicestershire Centre for Integrated Living. We are planning further 'Community Conversations' during 2018.

The Patient and Public Involvement team have also conducted a number of smaller scale community engagement events with a focus on developing relationships with local communities. Engagement activity has included visits to local groups for women, carers, people with autism and learning disabilities, cultural and faith groups. The Team have also increased engagement and networking opportunities with established local community organisations and health partners across Leicester, Leicestershire and Rutland.

In early 2018, we conducted a successful recruitment campaign to increase the number and diversity of Patient Partners who work with us across our organisation. 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. By June 2018, we will have 23 Patient Partners working with our teams to champion the patient voice.

We continue to run our monthly 'Leicester's Marvellous Medicine' health talks for member of the public. During 2017/18 these talks continued to be popular events and recent topics include: Sickle Cell Disease, MRI Scanning, The Myths of Arthritis and Bowel Cancer Screening.

Alliance

The Alliance is a collaboration of the main health organisations in Leicester, Leicestershire and Rutland and through a pillar contract they work with three of the partner organisations (us, Leicestershire Partnership NHS Trust and Leicester, Leicestershire and Rutland Provider Company Ltd), to deliver elective patient care.

Highlights for 2017/18:

- 92.2 per cent RTT (Referral to Treatment) in 18-weeks against a target of 92 per cent
- Cancelled operations 0.7 per cent with a target of 0.6 per cent
- DNA (did not attend) rate of 8 per cent against a target of 5 per cent
- Sickness absence rate 4.7 per cent against a target of 3 per cent
- Percentage of staff are in an annual appraisal 94.3 per cent

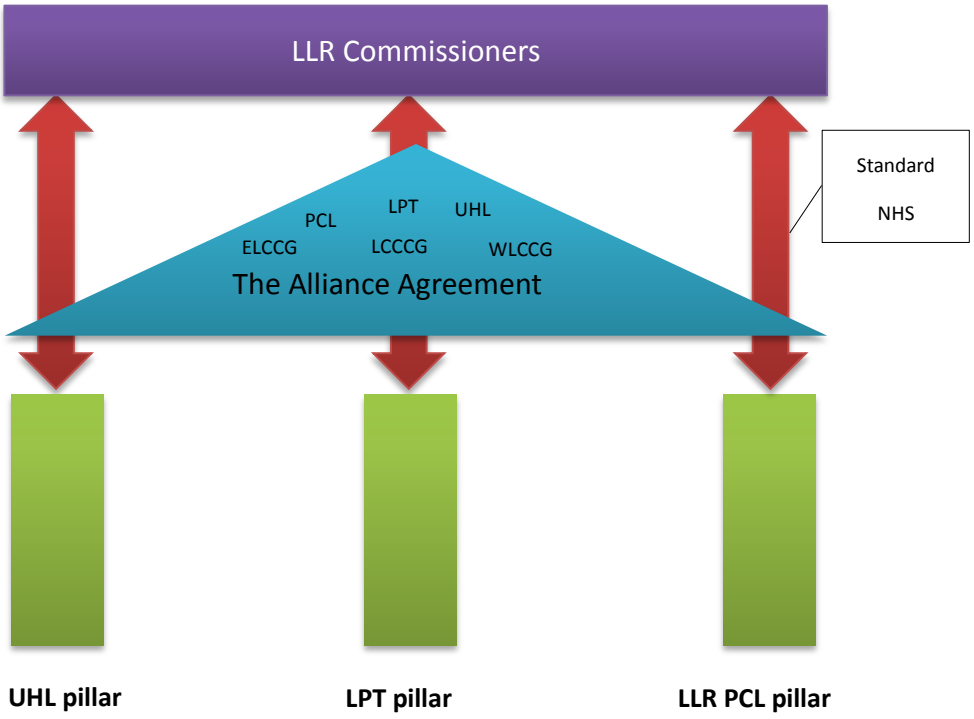
LLR alliance
Providing care around you together

The Alliance seven year contract is now in its fourth year, having started on 1st April 2014, with reviews taking place at years three and five.

Our Trust Board remains accountable for the services provided through the UHL pillar contract and this report serves to provide an overview of performance for the year 2017/18.

ACHIEVEMENTS

Outpatient Correspondence: The outpatient team have made excellent progress in resolving outpatient correspondence delays identified at the beginning of the year. At the year-end the Alliance has successfully achieved the target that no outpatient letters were waiting more than ten days, this is a significant reduction from just over 9,000 letters at the start of the year. The Alliance continues to work towards the reduced timeframe of seven days.



Activity Performance: The Alliance has increased the numbers of endoscopies in gastroenterology and urology and has moved 2,000 endoscopies from our organisation to the Alliance offering care closer to home. We have also increased the number of hernias and general surgery to community hospitals.

Workforce: The Alliance has trained a Nurse Endoscopist and currently has a second training through a Royal College accelerated training programme which will complete in July 2018. Workforce: From September 2017 the Alliance Glaucoma Nurse Specialist commenced clinic activity supporting the care of our Glaucoma Patients. We are expanding our nursing workforce with Trainee Assistant Practitioners and Nursing Apprentices. We are working with PCL to expand our pool of GPs with a special interest and have several new consultants from Leicester's Hospitals appointed (notably in Gastroenterology) who are providing outpatient and endoscopy services across Leicester, Leicestershire and Rutland.

Transformation and Change Activities: The Alliance has increased the focus and energy around the transformation agenda and has created a methodology for delivering change. By engaging staff and patients at the beginning of the process, has helped to improve communication and identify ideas for change that increase efficiency and productivity across services.

A review of admin and clerical processes has resulted in a consolidation of roles and centralising functions to create a more flexible and multi-skilled workforce.

Pathway redesign of Endoscopy services has resulted in a reduction in DNA rates and cancelled on the day procedures due to improved pre-assessment with the introduction of direct booking clinics and pre-assessment telephone and face to face appointments.

The Alliance continues to transform services and will be focusing on day case theatre utilisation and outpatient services to increase productivity and efficiency across all hospital sites.

FINANCIAL PERFORMANCE IN 2017/2018

The Alliance's financial plan 2017/18 is confirmed for both the UHL Pillar and PCL Pillar contracts. The financial plan is based on expected income from contracts and other activity, and planned expenditure to deliver those levels of service. The plan was set to achieve a breakeven position after delivery of a 3 per cent CIP (£730,000).

The Primary Care Pillar of the Alliance was made live in 2017 and has taken on a number of contracts and is delivering:

- Community non-obstetric ultrasound
- Echo
- Minor hand surgery
- Vasectomy
- Minor general surgery

This has meant that activity has been delivered in local community settings providing quality care and representing value for money.

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, once 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.

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

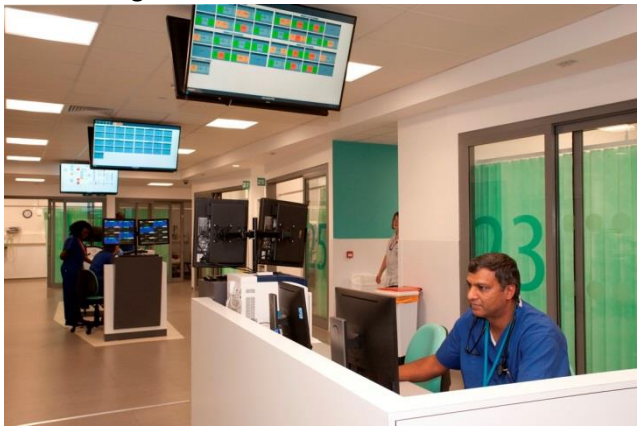
In 2017/18 we successfully delivered Phase 1 of our Reconfiguration Plan, which entailed:

- Opening the new Emergency Department (26th April). A key feature of the new department is the patient friendly signage used throughout. This signage was designed to reduce aggression in the emergency department by clearly explaining what happens at each stage of the patient journey;
- The successful move of vascular services from the Royal to the Glenfield site (5th May) and the opening of a new Angiography Suite;
- Opening of a new hybrid theatre (12th May) offering 'state-of-the-art' imaging equipment to allow a greater proportion of new and complex procedures not previously possible.

The Reconfiguration Plan Phase 2 funding (£30m) was announced by NHS England on 19th July and it will be used to fund the move of the Level 3 intensive care unit from the General Hospital.

The Emergency Floor is due for completion in June 2018, which will see the assessment units relocate to the space vacated in the Balmoral building by the old Emergency Department.

We continue to progress our plans to relocate the East Midlands Congenital Heart Centre from the Glenfield to the Royal Infirmary. Last year work we worked on completing the clinical models, operational policies and schedules of accommodation. Design work has started which will see the delivery of a full business case in autumn 2018; plans are in place to ensure the East Midlands Congenital Heart Centre service moves to the Royal Infirmary site to meet the co-location standard by March 2020.



Over the past year we continued to progress work on the detail of the overall Reconfiguration Programme. This has included further work on key models of care, for example, Women's, Out-patients and Theatres. This work has helped to inform the detail underpinning the STP and will be used to inform the Pre-Consultation Business Case, which is being developed during 2018/19.

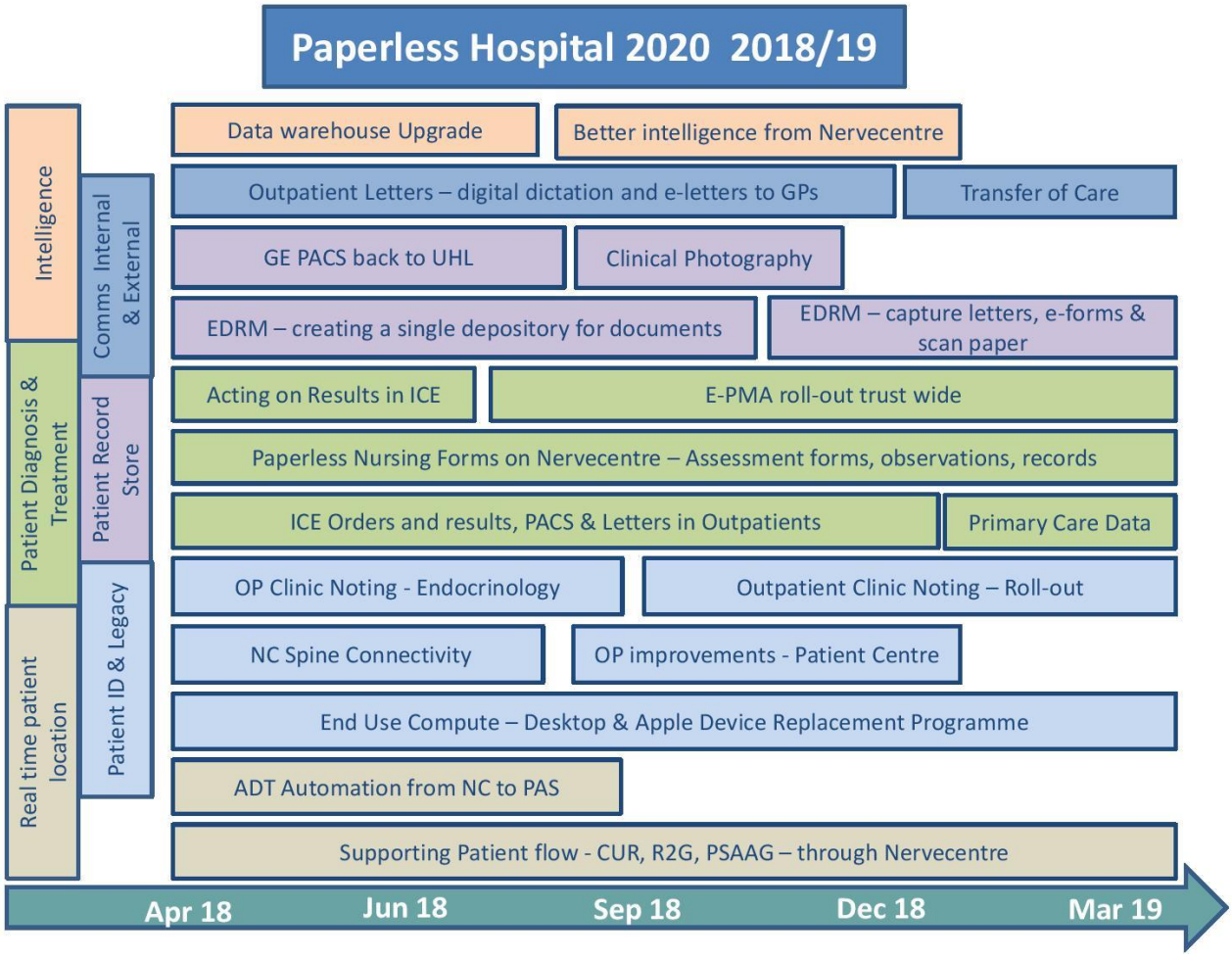
We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care

We have made significant progress with our EPR (electronic patient record) strategy and the implementation of its components. The largest part is centred on the use of Nervecentre, which we have made available to the entire organisation and we were successful in winning a major award for the Best Information/Administration system during 2017/18.

We have increased the amount of mobile devices available for staff and assisted the redesign of workflow to support the new approaches to our emergency floor. The first phase of our paperless hospital strategy was implemented in our new Emergency Department using Nervecentre as the core clinical application.

Thorough 2017/18 we focused on some of our core clinical systems, ensuring we bring them up to the latest versions. This meant some significant upgrades to ICE, ORMIS and Patient Centre; these with Nervecentre provide the heart of the electronic patient record moving forward. We continued to develop Nervecentre across our wards for e-obs and early warning scores, which support our quality commitment as well as creating an e-bed management system to support the allocation of beds and flow of the patient through the hospital.

We have approved the Paperless Hospital 2020 Strategy and the Governance Board to manage the delivery of the programme.



In 2018/19 we will be focussing on creating a new version of ICE (mobile ICE, acting on results, ICE in outpatients), a new version of Nervecentre which will give us better functionality, forms and reporting to support workflow and quality commitment, begin a replacement programme across the Trust of our computers to improve the product staff use; we will introduce electronic prescribing (EPMA) to the whole organisation to ensure we have a single, safe approach to prescribing; we will be bringing all PACS (picture archiving) systems back on site and under our own control and we will continue with our plans to make our

organisation paperless, removing paper through ICE/Nervecentre/new EDRM and through better integration with primary 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 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 our organisation 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 our UHL Academy.

Better Engagement/ Listening into Action – Classic LiA continues to support Pioneering Teams to make changes that benefit our patients and staff. Alongside this Thematic LiA Teams have seen some fantastic achievements including a new way of working in the East Midlands Congenital Heart Centre that increased theatre capacity from 5.6 surgical cases per week to 8.6 surgical cases per week using the same theatre space.

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.

Support has been given to a total of 24 teams during 2017/18.

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. The Toolkit is in use and work is continuing during 2018/19 to align change methodologies across the Leicester, Leicestershire and Rutland system. Supporting change in our organisation is the introduction of our LEAN Apprenticeship which will further embed efficiency and change methodologies throughout the organisation.

UHL Academy

Our UHL 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. Five cohorts completed the programme during 2017 and the programme is planned to continue throughout 2018/19. Further Academy offers have been developed and introduced and will continue to be available to all staff.

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.

Talent Management/Succession Planning

The Organisational Development Team will be taking a lead role in implementing our Talent Management Strategy. The strategy includes the development of an online talent portal which includes appraisal aligned to a People Capability Framework. During 2018/19 these systems and processes will be developed and all line managers developed to enable effective talent management and robust appraisals to take place.

We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities

All of our corporate services have been embracing opportunities to enhance productivity with a rigorous focus on improvement to core business operations.

The "Carter" target for "back office" cost to be no more than 7 per cent of Trust turnover by March 2018 has been achieved and work continues to identify long term sustainable efficiencies across all of our corporate services.

We will implement our Commercial Strategy, once agreed by the Board, in order to exploit commercial opportunities available to the Trust

The Trust Board approved the Commercial Strategy and the initiatives described for implementation within 2017/18 have been achieved. The core element of this programme related to the delivery of a new Partnership to deliver improved healthcare estates and facilities services.

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.

This year we delivered a deficit of £34.5m. This deficit was larger than the planned deficit due to the impact of winter operational pressures and the national directive to cancel elective activity throughout January 2018. With the exception of these winter operational pressures we would have delivered our planned financial deficit as part of our improvement trajectory as described within our 5-year financial strategy.

We continue to revise our 5-year financial strategy on a bi-annual basis integrating this within the wider health economy STP financial plan.

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 (http://www.leicestershospitals.nhs.uk/aboutus/departments-services/procurement-and-supplies/doing-business-with-us/).

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

Some particular highlights include:

- Enabling us to reduce its deficit through our work with both colleagues and suppliers. We have continued to enable £8m of cost improvement plan (CIP) savings during the financial year;
- Continuing to play a key role in the national NHS procurement agenda and in particular supporting delivery of the Lord Carter report;
- Successful delivery of the national Carter metrics;

- The team have achieved Level 2 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 one of 24 Trusts advising on their national procurement strategies;
- Supporting the delivery of our re-configuration programme.

Our plans for 2018/19 include…

- Continuing to improve the procurement and supplies processes in line with our three year Procurement Strategy;
- Refreshing our Procurement Transformation Plan;
- Delivering a further £8m or more of cash savings to the Trust (CIP);
- Continuing to lead and support delivery of the national procurement agenda (Future Operating Model) in the NHS;
- Transition to the Leicester, Leicestershire and Rutland Healthcare Facilities Management Services LLP model of working.

Emergency Planning

Emergency Preparedness, Resilience and Response

The patients and communities that we serve expect us to be there for them when they need it, irrespective of the circumstances we face. As such, we must do all that we can to ensure we are well prepared to respond to any disruptive challenges or emergencies that we might come to face, which could be anything from extreme weather events, outbreaks of infectious diseases, terrorist attacks or major transport accidents.

Over the past year, we have continued to make sure our services are resilient so that high quality patient care can continue uninterrupted, even during an emergency. The opening of our new emergency department at the Royal Infirmary has enabled us to redesign our decontamination procedures as part of the arrangements for responding to incidents involving substances which may be hazardous.

During the year we ran a major incident exercise - "Exercise Soteria" - to test our emergency arrangements for responding to a major incident. The exercise simulated how we would respond to the needs of a large number of casualties presenting to the Royal Infirmary following a hypothetical transport accident at one of the city's sports stadiums. The exercise involved 130+ people including our staff, and representatives from Leicestershire Police, the Army and other NHS providers.

We are required to assess our resilience on an annual basis against "NHS England's Core Standards for Emergency Preparedness, Resilience and Response", which are the minimum standards NHS organisations, like ours, must meet to comply with the requirements of the national framework, the NHS Contract and the Civil Contingencies Act.

The outcome of the self-assessment for 2017/18 showed that of the 90 applicable standards, we were:

- Fully compliant with 80 of the standards;
- Partially compliant with 10 of the standards;
- Non-compliant with 0 of the standards.

Where we were unable to provide full compliance against a given standard, we have begun to develop work plans to improve on these areas.

Emergency Preparedness, Resilience and Response - Looking ahead to 2018/19:

Our emergency planning team is currently carrying out a comprehensive review of our emergency preparedness, resilience and response arrangements, the outcome of which will inform a new programme of work for us to take forward in the coming 12 months.

Risk management

Effective risk management awareness and practice at all levels is an integral success factor for us. 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.

A risk management policy is in place to provide a framework for the management and reporting of all types of organisational risks. These risks are assessed and reported on our risk register, subsequently providing a dynamic risk profile to aid with decision-making. The policy includes accountability for managing risks and ensures a clear line of sight for reporting risks from 'ward to board'.

In response to feedback from external sources, including internal audit and CQC inspections, there has been increased emphasis to scrutinise risk treatment plans, by local management boards and at an executive level, to confirm actions are being managed within their specified time frames. Work plans to address the findings from these inspections will be developed and included in the programme of work for the next 12 months.

The Board Assurance Framework (BAF) has been closely monitored during the year by the executive team and at Trust Board, and includes a description about the principal risks which may have the potential to adversely affect the achievement of our strategic objectives and immediate priorities. The highest rated risks and areas of concern recorded on the BAF relate to workforce gaps, demand and capacity capability and management of finances.

Risk Management - Looking ahead to 2018/19:

- Work with CMG/ corporate leadership teams and the executive team to provide specialised support and guidance to help embed enterprise risk management, including acting on the findings from the recent CQC report;
- Focus on quality improvement by monitoring effectiveness of the risk control measures and treatment plans that are described in entries on the risk register;
- Review our training needs analysis and explore alternative methods to deliver our risk awareness training programme to different staff groups;
- Develop a risk assessment toolkit for our staff on our intranet, to describe the risk assessment process and provide advice about risk descriptions, control measures, and treatment plans;
- Explore the feasibility of using a web-based risk register tool to record and report risks.
- Link closely with strategy and quality departments to improve the functionality of the BAF and improve the management and reporting arrangements for the BAF and our objectives/ annual priorities.

Medical Device Incident Management

The Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England/ 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).

We continue to improve data quality in our work programmes in relation to medical device incident reports, subsequently enabling more effective data analysis to provide early indications of prevalent incident trends and opportunity to develop treatment plans to improve patient safety.

Medical Device Incident Management - Looking ahead to 2018/19:

- Strengthen medical equipment governance processes through regular liaison with medical device service providers to seek assurance that there are appropriate control arrangements are in place to mitigate risks to patient safety;
- Include a section on medical device incident reporting in the risk analysis papers to CMGs for review at their monthly board meetings to provide a focus any areas of concern and opportunities for improvement identified by the MDSOs.

Central Alerting System

National patient safety alerts, MHRA medical device alerts, important public health messages and other critical safety information and guidance are issued to NHS Trusts 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 April 2017 to 31st March 2018 we received a total of 109 national alerts, with no deadlines for compliance breached.

During 2016/17 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 alerts at management and operational level and a small number of recommendations, to strengthen the level of assurance, have been identified and will be applied during 2018/19.

Looking ahead to 2018/19:

- Work with CMGs to improve resilience and record keeping processes at all levels;
- Focus on quality improvement by monitoring effectiveness of the actions that we have signed off in the alert;
- Carry out a further review of CAS management at CMG level to monitor compliance with Trust policy and to review the progress of mitigations recommended in the previous internal reviews.

Signed:

Chief Executive (on behalf of the Trust Board)

Date: 25/05/2018

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Financial Statements and notes

The Financial Statements

Overview of 2017/18 Financial Position

We originally planned to deliver an income and expenditure deficit of £26.7m in 2017/18, which was predicated on the delivery of a Cost Improvement Programme (CIP) of £44.1m. This was predicated on the delivery of a planned CIP of £44.1m.

We achieved the revised deficit of £34.5m for the year, which was an increase over the original £26.7m due to the following:

- We received an additional £2.2m of winter pressures funding;
- The increased deficit to £34.5m to include the impact of £9.9m winter operational pressures:
- We achieved £39.3m CIP.

We spent £33.3m of capital against our initial planned capital programme of £54.4m, which matched the available funding and Capital Resource Limits. The capital spend was supported by internally generated funds of £25.6m and £7.7m capital loans from the Department of Health. The key elements of our capital programme were:

- Addressing backlog maintenance and investment within critical infrastructure;
- Phase 2 of our new Emergency Floor project;
- Redevelopments and investments to support the longer term estate reconfiguration plans and;
- Investment in IT and new equipment.

We delivered our other statutory duties.

The above means that we enter 2018/19 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 2018/19 which will mean that we are not eligible for STF funding for the year.

Financial Review for the Year Ended 31st March 2018

We did not meet all of our financial and performance duties for 2017/18:

Balancing the books	We delivered an income and expenditure deficit of £34.5m
Managing cash	We delivered both the External Financing Limit and Capital Resource Limits
Investment in buildings equipment and technology	We invested £33.3m in capital developments

Performance against our Financial Plan

We delivered a £34.5m deficit for the year against the original planned deficit of £26.7m. Our planned deficit changed in the year as a result of £2.2m income.

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

Total income	£963.5m actual; which was £22.4m above plan which includes £12.5m in relation to implementation of estates strategy together with deferred income release.
Total expenditure	£1000.1m actual; which was £32.3m over plan and includes overspends of £35.6m on pay and underspend of £3.3m on non-pay.
Impairment	£2.7m 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 £34.5m.
Capital expenditure	£33.3m against a revised capital resource limit of £53.8m.
Cash balance	£2.9m closing cash balance against a plan of £1.0m.
Cost Improvement Programme (CIP)	Delivered £39.3m against a £44.1m target.

Balance Sheet

Cash: We ended the year with a cash balance of £2.9m which included the Trust Med Pharmacy cash balance of £1.7m and secured external financing of £66.3m, which included:

- £26.7m to fund our deficit;
- £31.9m for working capital support: and
- £7.7m for capital financing in relation to our emergency floor project.

The total balance of our external financing at the year-end was £198.3m.

Non-current assets: The value of our non-current assets (including property, plant and equipment and intangible assets) increased by £29.4m mainly as a result of:

- £33.3m total net additions; less
- £18.5m upward revaluation; less
- £22.4m depreciation.

Working capital

Our receivables have increased by £15.6 driven by an increase in Non-NHS prepayments and accrued income.

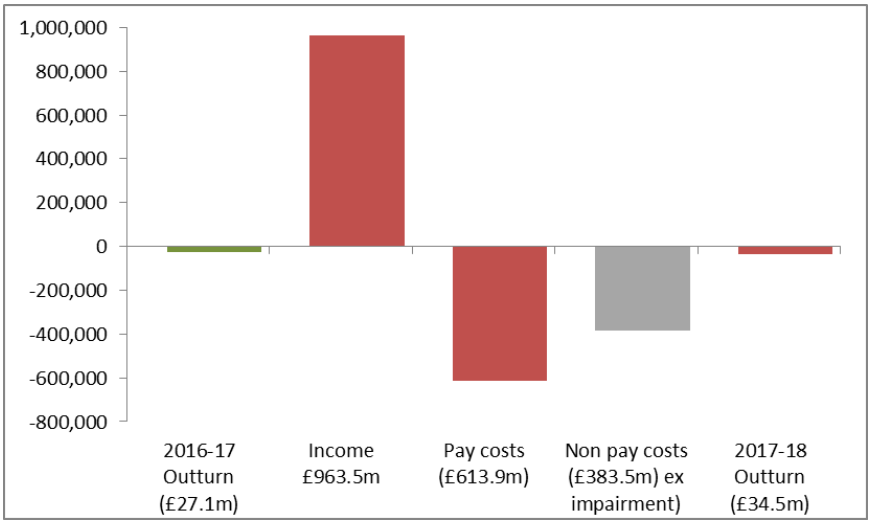
Our payables have increased by £10.5m due to receipt of working capital loans.

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 remained consistent from the prior year.

Our retained earnings reduced by £36.3m due to our financial deficit and impairment following an asset revaluation. Our revaluation reserve balance increased by £20.9m due to the asset revaluation.

Key Financial Indicators



Income: We received £963.5m of income which is a £39.2m (4.2 per cent) increase from the £924.3m we received in 2016/17.

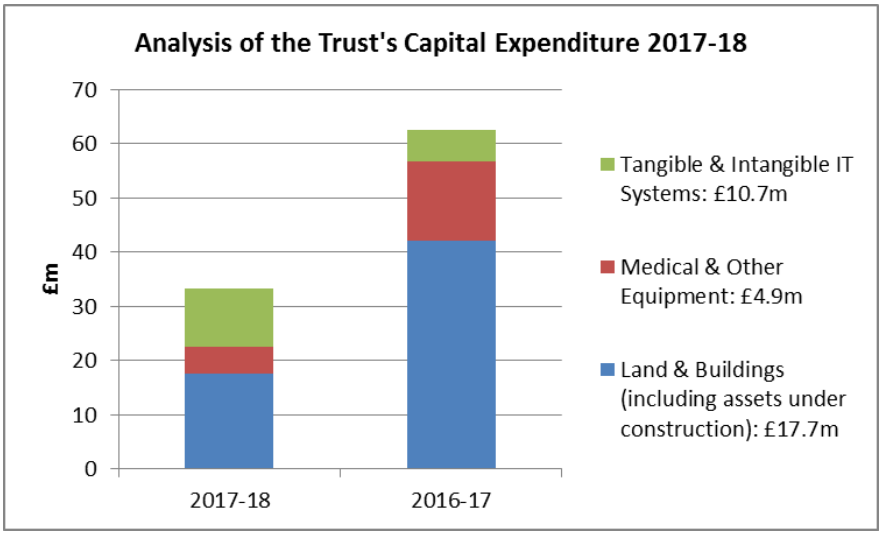
Pay expenditure by staff group: We spent £613.9m on staff costs, which is a £38.1m (6.6 per cent) increase over the 2016/17 total of £575.8m. £9.0m of this increase is due agency costs. £7.0m of this increase is due to increased social security and pension costs.

Non-pay expenditure: We incurred £386.2m of non-pay expenditure which was a £14.6m (3.6 per cent) decrease over the 2015/16 total of £400.7m.

We also had an impairment of our property, plant and equipment of £2.7m following a revaluation of its estate.

Capital expenditure

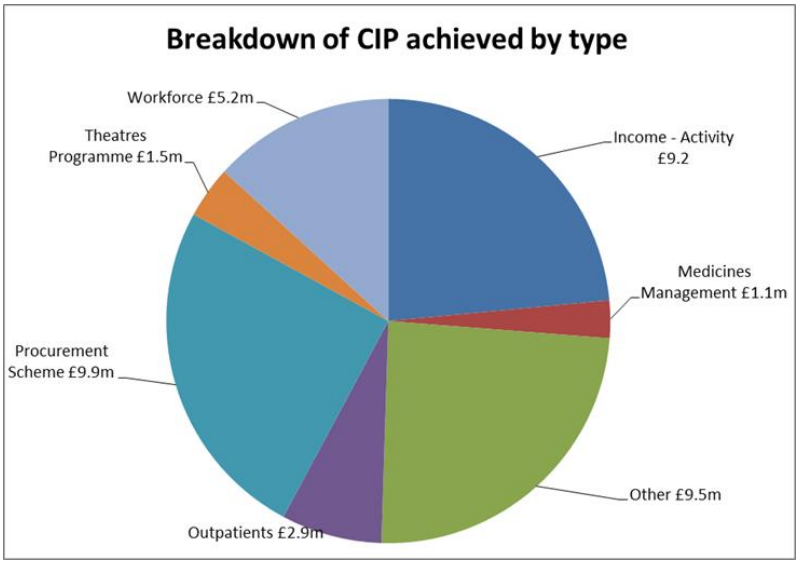
Our capital (excluding adjustments for donated assets) was £33.3m, a £29.3m reduction (47 per cent) on the 2016/17 total of £62.6m. A breakdown of the spend is shown in the graph below.



Capital expenditure for 2017/18 consisted of:

- £13.3m on reconfiguration schemes including £10.3m on the next phase of our new Emergency Floor;
- £5.6m on estates and facilities schemes;
- £3.2m on IM&T schemes;
- £6.5m on medical equipment, both purchased and leased;

Our efficiency programme: We delivered £39.3m against our £44.1m cost improvement programme in 2017/18. The programme focused on productivity whilst maintaining high quality patient services. £5.2m of improvements in the way workforce; £9.2m of savings came from income activity; and £9.9m 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 the Trust Board's assurance framework, which regularly reviews all key risks and action plans. These plans cover clinical as well as corporate and business risks.

As in 2017-18, 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 2018/19 plan to the NHS Improvement. The key details relating to the plan for 2018/19 are as follows:

- Planned I&E deficit of £29.9m;
- A major CIP plan of £51.5m;
- A capital expenditure plan of £50.4m, including the ICU projects;
- PDC funding of £27.4m to fund the capital programme;
- An external Financing Limit of £52.6m;
- A Financial Risk Rating of three (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 revenue financing in 2018/19 as follows:

- £29.9m to fund the 2017/18 deficit and
- £34.1m to repay the brought forward interim revenue support loan.

Net overdue payables brought forward totalled £16.4m (overdue receivables of £16.9m and overdue payables of £33.3m).

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 in 2018/19 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 2018/19: In 2018/19, we have set a challenging efficiency target of £51.5m. 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 2017/18 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 2018/19 involves up to £50.4m of investment. Major schemes include:

- £27.3m for the Interim ICU projects; and
- ff3.0m for the relocation of the East Midlands Congenital Heart Service

Signed:

Chief Executive (on behalf of the Trust Board)

Date: 25/05/2018

University Hospitals of Leicester NHS Trust
Annual accounts for the year ended 31 March 2018

Independent auditor's report to the Directors of University Hospitals of Leicester NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of University Hospitals of Leicester NHS Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2018 and of the group's expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the 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 Trust's Directors 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 Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust's financial performance in 2017/18 was a deficit of £34.455 million during the year ended 31 March 2018. This is made up of the financial performance deficit net of the CQUIN risk reserve of £2.309 million. The Trust also secured £66.360 million of external financing in 2017/18 in order to fund the deficit position, provide working capital support and for capital financing.

As stated in note 1.1.2, the Trust's financial plan for 2018/19 forecasts the delivery of a £29.900 million deficit, necessitating further revenue cash borrowing from the Department of Health and Social Care's Uncommitted Single Currency Interim Revenue Support Facility. In order for the Trust to access this facility, the Department of Health and Social Care must approve the Trust's daily cash flow forecast. These events or conditions, along with the other matters explained in note 1.1.2, indicate that a material uncertainty exists that may cast significant doubt about the group's and the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 1 to 91 and pages 147 to 155, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the group and Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 25 May 2018 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to University Hospitals of Leicester NHS Trust's ongoing breach of its break-even duty for the three year period ending 31 March 2018.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities set out on page 173, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the group or the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the group or the Trust.

The Board is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects, University Hospitals of Leicester NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust delivered a deficit of £34.455 million in 2017/18, made up of the adjusted financial performance deficit of £36.764 million less the CQUIN Risk Reserve of £2.309 million, against a budgeted deficit of £26.700 million.
- The Trust's cumulative financial deficit has increased from £136.353 million (2016/17) to £170.808 million (2017/18).
- The Trust has also set a deficit budget of £29.900 million for 2018/19 which is dependent on it achieving CIP savings of £51.500 million.

- As at the date of this report, the Trust has not agreed a control total for 2018/19, but has negotiated with local CCGs a contractual position to protect itself from fines and penalties.
- The Trust is seeking revenue support from the Department of Health and Social Care of £29.900 million in 2018/19.

These identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services.

These issues are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and 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 and to report where we have not been able to satisfy ourselves that it has done so. 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.

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 2017, as to whether in all significant respects, 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 2018, and to report by exception where we are not satisfied.

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 be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements 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.

Mark Stocks

Mark Stocks
Partner for and on behalf of Grant Thornton UK LLP

The Colmore Building
20 Colmore Circus
Birmingham B4 6AT
29 May 2018

Statement of Comprehensive Income

		Group	
		2017/18	2016/17
	Note	£000	£000
Operating income from patient care activities	3	820,331	780,582
Other operating income	4	140,459	143,687
Operating expenses	6, 8	(985,601)	(966,303)
Operating surplus/(deficit) from continuing operations		**(24,811)**	**(42,034)**
Finance income	11	74	54
Finance expenses	12	(5,410)	(2,718)
PDC dividends payable		(6,452)	(7,586)
Net finance costs		**(11,788)**	**(10,250)**
Other gains / (losses)	13	(16)	(7)
Surplus / (deficit) for the year from continuing operations		**(36,615)**	**(52,291)**
Surplus / (deficit) for the year		**(36,615)**	**(52,291)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,703)	(13,664)
Revaluations	15	22,920	10,299
Total comprehensive income / (expense) for the period		**(15,398)**	**(55,656)**
Surplus/ (deficit) for the period attributable to:			
University Hospitals of Leicester NHS Trust		(36,615)	(52,291)
TOTAL		**(36,615)**	**(52,291)**
Total comprehensive income/ (expense) for the period attributable to:			
University Hospitals of Leicester NHS Trust		(15,398)	(55,656)
TOTAL		**(15,398)**	**(55,656)**
Financial performance for the year			
Retained deficit for the year		(36,615)	(52,291)
Impairments (excluding IFRIC 12 impairments)		2,735	24,826
Adjustments in respect of donated and government granted asset reserve elimination		(575)	313
CQUIN Risk Reserve - 1617 CT non achievement adjustment		(2,309)	0
Adjusted retained deficit		**(36,764)**	**(27,152)**

We delivered a deficit of £36,764k excluding impairments of £2,735k.

Operating costs includes £2,735k (2016/17 - £24,826k) relating to the impairment of property, plant and equipment following a revaluation of the Trust's estate. This figure is removed from the Adjusted Retained Deficit figure in accordance with Department of Health and Social Care (DHSC) Accounting guidance.

Total Comprehensive Income for the year includes an amount of £575k relating to the receipt of donated assets net of donated asset depreciation (2016/17 - £313k). This figure is removed from the Adjusted Financial Performance figure in accordance with DHSC accounting guidance. This removes the effect on the Trust's financial performance of no longer having a donated asset or government granted asset reserve and ensures that performance can be measured consistently.

Within Total Comprehensive Income is an amount of (£1,703k) relating to a decrease in the value of the Trust's assets taken to the revaluation reserve. In 2016/17 the Trust had a decrease of (£13,664k) in its asset valuation that was taken to the revaluation reserve.

Other operating income includes £12,501k of VAT income which is due to the Trust under the Capital Goods Scheme. This relates to amounts that have become reclaimable from the HMRC due to the the establishment of our facilities management subsidiary in 2018/19.

PDC dividends payable are based on the average relevant net assets of the Trust. Dividend payments have decreased by £1,134k from 2016/17 due mainly to the impact of the deficit for the year, which decreased dividends by £603k and the increase in borrowings which decreased dividends by £502k.

Statement of Financial Position

	Note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	14	11,480	11,467	11,480	11,467
Property, plant and equipment	15	427,610	398,261	427,586	398,261
Investments in associates (and joint ventures)		-	-	4,000	-
Trade and other receivables	17	2,904	2,669	2,904	2,669
Total non-current assets		**441,994**	**412,397**	**445,970**	**412,397**
Current assets					
Inventories	16	23,829	19,975	22,356	19,975
Trade and other receivables	17	70,519	55,953	70,186	55,953
Cash and cash equivalents	18	8,919	1,238	7,259	1,238
Total current assets		**103,267**	**77,166**	**99,801**	**77,166**
Current liabilities					
Trade and other payables	19	(109,237)	(98,714)	(109,807)	(98,714)
Borrowings	21	(46,797)	(6,312)	(46,797)	(6,312)
Provisions	23	(448)	(475)	(448)	(475)
Other liabilities	20	(3,469)	(11,960)	(3,469)	(11,960)
Total current liabilities		**(159,951)**	**(117,461)**	**(160,521)**	**(117,461)**
Total assets less current liabilities		**385,310**	**372,102**	**385,250**	**372,102**
Non-current liabilities					
Borrowings	21	(168,469)	(139,766)	(168,469)	(139,766)
Provisions	23	(1,465)	(1,562)	(1,465)	(1,562)
Total non-current liabilities		**(169,934)**	**(141,328)**	**(169,934)**	**(141,328)**
Total assets employed		**215,376**	**230,774**	**215,316**	**230,774**
Financed by					
Public dividend capital		331,956	331,956	331,956	331,956
Revaluation reserve		98,349	77,428	98,349	77,428
Income and expenditure reserve		(214,929)	(178,610)	(214,989)	(178,610)
Total taxpayers' equity		**215,376**	**230,774**	**215,316**	**230,774**

The notes on pages 119 to 145 form part of these accounts.

Signed……

Name	John Adler
Position	Chief Executive
Date	**25 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**331,956**	**77,428**	**(178,610)**	**230,774**
Surplus/(deficit) for the year	-	-	(36,615)	**(36,615)**
Impairments	-	(1,703)	-	**(1,703)**
Revaluations	-	22,920	-	**22,920**
Other reserve movements	-	(296)	296	**-**
Taxpayers' and others' equity at 31 March 2018	**331,956**	**98,349**	**(214,929)**	**215,376**

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**329,856**	**81,133**	**(126,659)**	**284,330**
Taxpayers' and others' equity at 1 April 2016 - restated	**329,856**	**81,133**	**(126,659)**	**284,330**
Surplus/(deficit) for the year	-	-	(52,291)	**(52,291)**
Other transfers between reserves	-	(340)	340	**-**
Impairments	-	(13,664)	-	**(13,664)**
Revaluations	-	10,299	-	**10,299**
Public dividend capital received	2,100	-	-	**2,100**
Taxpayers' and others' equity at 31 March 2017	**331,956**	**77,428**	**(178,610)**	**230,774**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**331,956**	**77,428**	**-**	**(178,610)**	**230,774**
Surplus/(deficit) for the year	-	-	-	(36,675)	**(36,675)**
Impairments	-	(1,703)	-	-	**(1,703)**
Revaluations	-	22,920	-	-	**22,920**
Other reserve movements	-	(296)	(4,000)	296	**(4,000)**
Taxpayers' and others' equity at 31 March 2018	**331,956**	**98,349**	**(4,000)**	**(214,989)**	**211,316**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**329,856**	**81,133**	**-**	**(126,659)**	**284,330**
Taxpayers' and others' equity at 1 April 2016 - restated	**329,856**	**81,133**	**-**	**(126,659)**	**284,330**
Surplus/(deficit) for the year	-	-	-	(52,291)	**(52,291)**
Other transfers between reserves	-	(340)	-	340	**-**
Impairments	-	(13,664)	-	-	**(13,664)**
Revaluations	-	10,299	-	-	**10,299**
Public dividend capital received	2,100	-	-	-	**2,100**
Taxpayers' and others' equity at 31 March 2017	**331,956**	**77,428**	**-**	**(178,610)**	**230,774**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(24,811)	(42,034)	(24,884)	(42,034)
Non-cash income and expense:					
Depreciation and amortisation	6.1	22,400	26,487	22,397	26,487
Net impairments	7	2,735	24,826	2,735	24,826
Income recognised in respect of capital donations	4	(977)	(199)	(977)	(199)
(Increase)/decrease in receivables and other assets		(15,565)	(11,864)	(14,320)	(11,864)
(Increase)/decrease in inventories		(3,854)	(1,370)	(2,381)	(1,370)
Increase/(decrease) in payables and other liabilities		2,017	(1,049)	1,685	(1,049)
Increase/(decrease) in provisions		(125)	(278)	(125)	(278)
Net cash flows from / (used in) operating activities		**(18,180)**	**(5,481)**	**(15,870)**	**(5,481)**
Cash flows from investing activities					
Interest received		74	56	74	56
Purchase of intangible assets		(1,566)	(3,095)	(1,566)	(3,095)
Purchase of PPE and investment property		(27,932)	(60,165)	(27,905)	(60,165)
Receipt of cash donations to purchase assets		-	199	-	199
Cash for establishment of subsidiaries		-	-	(4,000)	-
Net cash flows from / (used in) investing activities		**(29,424)**	**(63,005)**	**(33,397)**	**(63,005)**
Cash flows from financing activities					
Public dividend capital received		-	2,100	-	2,100
Movement on loans from DHSC		64,262	78,517	64,262	78,517
Capital element of finance lease rental payments		(4,518)	(4,840)	(4,518)	(4,840)
Interest paid on finance lease liabilities		(1,025)	(626)	(1,025)	(626)
Other interest paid		(3,772)	(2,092)	(3,762)	(2,092)
PDC dividend (paid) / refunded		(5,681)	(6,513)	(5,681)	(6,513)
Net cash flows from / (used in) financing activities		**49,266**	**66,546**	**49,276**	**66,546**
Increase / (decrease) in cash and cash equivalents		**1,662**	**(1,940)**	**9**	**(1,940)**
Cash and cash equivalents at 1 April - b/f		**1,238**	**3,178**	**1,238**	**3,178**
Cash and cash equivalents at 1 April - restated		**1,238**	**3,178**	**1,238**	**3,178**
Cash and cash equivalents at 31 March	18	**2,900**	**1,238**	**1,247**	**1,238**

Closing cash shown on the above cashflow statement is £2,900k. This compares to the figure of £8,919k on the Statement Of Financial Position (SOFP). The difference of £6,019k is classified as an overdraft due to the timing of cash payments at the year end, and is included within borrowings on the SOFP and can be seen in note 21.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's and group's ability to continue as a going concern. Paragraphs 4.11 and 4.16 of the Department of Health and Social Care (DHSC) Group Accounting Manual identify that the continuation of the service is sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector. In preparing the financial statements the Board of Directors has considered the Trust's overall financial position against the requirements of IAS1.

The accounts have been prepared on a 'going concern' basis. The Trust reported a deficit of £27.152 million in 2016/17. The Trust's financial performance in 2017/18 was £34.455 million deficit which is the breakeven duty financial performance net of the £2.309 million CQUIN risk reserve in the Statement of Comprehensive Income. In 2017/18 the Trust secured external financing of £66.344 million. This included £26.764 million to fund our deficit position; £31.922 million for working capital support; and £7.658 million for capital financing in relation to our emergency floor project..

The Trust's financial plan for 2018/19 forecasts the delivery of a £29.900 million deficit, necessitating further revenue cash borrowing using the Department of Health and Social Care's Uncommitted Single Currency Interim Revenue Support Facility. The planned cash support in 2018/19 has been approved by the Trust Board as part of the overall financial plan for the year. In order for the Trust to access this facility, the Department of Health and Social Care must approve the Trust's daily cash flow forecast for 13 weeks from the date of each drawdown. The Trust has planned to receive £27.392 million PDC monies for capital support in relation to the ICU project.

The Trust is not currently seeking any additional cash support from NHS Improvement (NHSI) in 2018/19 over and above that required to fund its deficit. However, should cash be required for working capital support we will follow the NHSI process to apply for revenue support.

The Trust and group anticipates that it may take some time before it can achieve financial balance on a sustainable basis. The Board of Directors has carefully considered the principle of "going concern" and the Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust and group which may cast significant doubt about the ability of the Trust and group to continue as a going concern.

Nevertheless, the Directors have concluded that assessing the Trust and group as a going concern remains appropriate. The Trust has agreed contracts with local commissioners for 2018/19 and services are being commissioned in the same manner in the future as in prior years and there are no discontinued operations. Similarly no decision has been made to transfer services or significantly amend the structure of the organisation at this time. The Board of Directors also has a reasonable expectation that the Trust and group will have access to adequate resources in the form of support from the Department of Health and Social Care (NHS Act 2006 s42a) to continue to deliver the full range of mandatory services for the foreseeable future.

Although these factors represent a material uncertainty that may cast significant doubt about the Trust's and group's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust and group will have adequate resources to continue in operational existence for the foreseeable future. As directed by the DHSC Group Accounting Manual 2017-18 the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The Trust has a planned deficit and has breached the requirement under Section 30 of the Local Audit and Accountability Act 2014 to a break even taking one year against another over a three year rolling period. As such the Trust's external auditors have made a referral to the Secretary of State. Such a referral (25th May 2018) has been made under Section 30 of the Local Audit and Accountability Act of 2014. The External Auditor also needs to consider the Trust's status as a going concern. The expectation is that the Trust will return to break even position in 2023/24.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Control of a subsidiary
The Trust has control of a subsidiary, Trust Group Holdings. The financial statements are prepared at a group level and there are no significant restrictions on the Trust's ability to access or use assets or settle liabilities of the group. The Trust does not consider that there are any significant risks associated with interests in the subsidiary, or that there are any risks of a change of ownership or loss of control.

VAT income under Capital Goods Scheme
The Trust has included £12.5m within Operating Income which relates to VAT which has become reclaimable due to the establishment of a facilities management subsidiary. Whilst this subsidiary company has been established in March 2018 it is not currently trading and the Trust has not yet submitted a VAT claim to the HMRC. The critical judgements that the Trust has made in including this income are:

- the amount of VAT due to the Trust is accurate, based on the advice of external VAT experts;
- the VAT reclaim will be allowable under the provisions of the Capital Goods Scheme; and
- the VAT is claimable as at the 31st March due to the formation of the company.

Provision for doubtful debts
Under International Accounting Standard (IAS) 9.139, the Trust impairs financial assets and receivables on the 'incurred loss' model. The Trust does not calculate a general provision for doubtful debts. The Trust charges bad debts directly to the Statement of Comprehensive Income as soon as there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset (a 'loss event'); the loss event (or events) has an impact on the estimated future cash flows of the financial asset or group of financial assets; and this can be reliably estimated. The Trust does not recognise losses expected as a result of future events, no matter how likely.

MEA Valuation
The Trust engaged its valuers, Gerald Eve LLP, to revalue its estate as at the 31st March 2018. This revaluation appluied a Modern Equivalent Asset (MEA) valuation methodology, which took into account the Trust's long term reconfiguration strategy. The Trust provided the valuers with a report from external advisors to inform the MEA valuation. This report estimated that a site reduction of 18% could be achieved on the Trust's buildings and a potential reduction of 63 acres of land. The Trust's valuers have made the same 18% adjustment for land as for buildings, on the basis that, although the amount of land required to host the Trust's reconfigured MEA hospital could reduce by as much as 63 acres, the relative density of development that would be required on the remaining existing sites would increase, increasing the value. The 18% reduction in land area is therefore deemed to be a reasonable estimation by the valuers.

Note 1.2.1 Sources of estimation uncertainty

Recoverable VAT
The Trust has included £12.5m within Operating Income which relates to VAT which has become reclaimable due to the establishment of our facilities management subsidiary. Whilst this company has been established in 2017/18 it is not currently trading and the Trust has not yet submitted a VAT claim to the HMRC. The £12.5m is therefore an estimate at the 31st March based on the Trust's assessment and on information provided to it by external VAT expert advisors. Due to the lack of an actual submitted claim there is uncertainty in this estimate.

Valuation of assets
The value of our land and buildings is based on a Modern Equivalent Asset valuation which uses an estimate of the future likely configuration of our estate. This is assumed to be a smaller area than the Trust's current three sites. There is therefore some inherent uncertainty in this estimate.

Note 1.3 Consolidation

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiary for the year.

Where subsidiaries' accounting policies are not aligned with those of the Trust then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust currently consolidates one subsidiary - Trust Group Holdings.
The company is registered in the UK, company number 10388315, with a share capital comprising one share of £1 owned by the Trust. The company commenced trading on the 1 April 2017 as an Outpatient Dispensary services for UHL. The service is provided across the three UHL sites, operating in normal business hours. A significant proportion of the company's revenue is inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements.

The Trust does not consolidate the Leicester Hospitals Charity (LHC) as it is not material to the Trust as a whole. The Trust Board is the corporate Trustee to LHC and transactions between the Trust and LHC are described in note 28.

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's deficit for the period was £36.7 million (2016/17: £27.2 million). The Trust's total comprehensive expense for the period was £15.4 million (2016/17: £55.7 million).

The company 'Trust Group Holdings Limited' commenced trading on the 1 April 2017 and hence there are no transactions in the prior reporting year. Both sets of note are presented for consistency.

Note 1.4 Income

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. The Trust also receives income from private patients and overseas visitors in relation to patient care activities. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. At the year end, the Trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year-end, revenue relating to the partially complete spell is accrued and agreed with the commissioner.

The Trust receives patient care related income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Revenue from education, training and research is recognised in the period in which services are provided. The Trust also receives income for car parking and catering and this is recognised in the period in which services are provided. Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income from its subsidiary, Trust Group Holdings, in relation to the provision of administrative services provided by the Trust to the subsidiary. This income is adjusted out of the group position upon consolidation of the group accounts position.

The Trust has accounted for £12.5m of income Under the Capital Goods Scheme relating to VAT income which is due to the Trust. This relates to amounts that have become reclaimable from the HMRC due to the the establishment of our facilities management subsidiary in March 2018.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. We do not calculate an accrual for the

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction are valued at historic cost and are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Revaluations of property, plant and equipment

The Trust has revalued its assets with an effective date of revaluation of 31st March 2018.

The Trust's freehold and leasehold property values were updated by an external valuer, Gerald Eve LLP, a regulated firm of chartered surveyors. The valuation was prepared in accordance with the requirements of the RICS Professional Standards, the International Valuation Standards and IFRS.

The valuation has been prepared in accordance with the Government Financial Reporting Manual (FReM) to comply with IFRS, specifically with regard to IAS 16 'Property, Plant and Equipment' and IAS 40 'Investment Properties'.

The valuer's opinion of Fair Value was primarily derived using the Depreciated Replacement Cost approach to value the service potential, on a Modern Equivalent Asset (MEA) basis. The MEA valuation was based on the Trust's estates strategy, which outlines a five year major reconfiguration for the Trust's estate, and which effectively defines the Modern Equivalent Asset for the valuation.

The Trust's estates strategy is consistent with its clinical strategy and both strategies are intrinsically linked as we must reconfigure our estate in order to deliver our clinical strategy. We provided our estates strategy to our valuers, Gerald Eve LLP, to enable them to provide a more accurate MEA valuation based on our actual plans and future Trust configuration.

As a result of this valuation the Trust has incurred an impairment charge of £2,735k, which is included within Other Operating Costs in the SOCI. This figure is removed from the Adjusted Financial Performance figure in accordance with Department of Health (DH) Accounting guidance.

The Trust's revaluation reserve has also been reduced in value by £1,703k as a result of the revaluation. The revaluation reserve has also been increased by £22,624k as a result of an upwards revaluation.

Note 1.7.5 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at current value for existing use as they are held for service potential. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.6 Useful Economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	4	67
Dwellings	15	23
Plant & machinery	-	10
Transport equipment	-	8
Information technology	-	8
Furniture & fittings	-	8

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	-	8

Note 1.8.4 Donations of property, plant and equipment

The majority of donated assets have been purchased on behalf of the Trust by the Leicester Hospitals Charity.

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula.

Strategic goods held for use in national emergencies (stockpiled goods) are held as non-current assets within property, plant and equipment. These stocks are maintained at minimum capability levels by replenishment to offset write-offs and so are not depreciated, as agreed with HM Treasury. Stockpiled goods are held at current value in existing use.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Loans from the Department of Health and Social Care are disclosed at historic cost.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

• donated assets (including lottery funded assets)
• average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
• any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the Trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

Note 1.17 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Transfers of functions from other NHS bodies

As public sector bodies are deemed to operate under common control, business reconfigurations within the DH group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. This is not likely to have a material impact on the Trust's accounts.

- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. We are reviewing the requirements of this standard and will assess the impact on the Trust's 2018/19 accounts.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. This will have an impact on the disclosures that the Trust makes for operating leases and finance leases and will be reflected in the Trust's 2019/20 accounts.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. This is not likely to have a material impact on the Trust's accounts.

- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018. This is not likely to have a material impact on the Trust's accounts.

- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019. This is not likely to have a material impact on the Trust's accounts.

Note 2 Operating Segments

The Trust operates in one segment, which is the provision of healthcare.

Note 3 Operating income from patient care activities (Group)

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	131,477	129,299
Non elective income	229,179	199,177
First outpatient income	48,273	44,074
Follow up outpatient income	43,628	49,020
A & E income	29,718	26,663
High cost drugs income from commissioners (excluding pass-through costs)	84,231	82,045
Other NHS clinical income	246,388	243,154
All services		
Private patient income	2,872	2,872
Other clinical income	4,565	4,278
Total income from activities	**820,331**	**780,582**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	288,791	258,067
Clinical commissioning groups	522,902	513,658
Other NHS providers	739	865
NHS other	273	435
Local authorities	-	42
Non-NHS: private patients	2,872	2,864
Non-NHS: overseas patients (chargeable to patient)	2,655	1,318
NHS injury scheme	1,910	1,957
Non NHS: other	189	1,376
Total income from activities	**820,331**	**780,582**
Of which:		
Related to continuing operations	820,331	780,582

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	2,655	1,318
Cash payments received in-year	685	337
Amounts added to provision for impairment of receivables	-	432
Amounts written off in-year	1,131	-

Note 4 Other operating income (Group)

	2017/18	2016/17
	£000	£000
Research and development	34,439	28,791
Education and training	42,157	54,822
Receipt of capital grants and donations	977	199
Non-patient care services to other bodies	19,426	10,010
Sustainability and transformation fund income	-	11,408
Rental revenue from operating leases	449	1,314
Income in respect of staff costs where accounted on gross basis	13,282	9,268
Other income		
Car parking	4,420	3,659
Catering	2,989	2,431
Staff accommodation	1,334	1,574
Dispensing income	1,054	-
Income generation (see detail in note 5.1)	13,222	11,419
All other income	6,710	8,792
Total other operating income	**140,459**	**143,687**
Of which:		
Related to continuing operations	140,459	143,687

Note 5.1 Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - UHL Catering and Car Parking income	**2017/18**	2016-17
	£000s	£000s
Income	6,098	4,791

We provide retail catering services to patients and the public, and collect car parking income from our car parks. We started to collect this income from May 2016 and therefore the prior year comparatives represent 11 months of income. We do record the associated full costs of these activities as they are absorbed into the overheads of the Trust.

Summary Table - Estates and facilities services provided to Leicester Partnership Trust	**2017/18**	2016-17
	£000s	£000s
Income	10,189	8,505
Full cost	(10,189)	(8,108)
Surplus/(deficit)	**0**	397

Summary Table - Estates and facilities services provided to NHS property Services	**2017/18**	2016-17
	£000s	£000s
Income	3,033	2,914
Full cost	(3,033)	(2,507)
Surplus/(deficit)	**0**	407

We provide a range of estates and facilities services to Leicester Partnership Trust and NHS Property Services which we classify as income generation.

Note 5.2 Fees and Charges (Group)

	2017/18 £000	2016/17 £000
Income	13,222	11,419
Full cost	(13,222)	(10,615)
Surplus / (deficit)	**-**	**804**

Note 6.1 Operating expenses (Group)

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	1,128	3,216
Purchase of healthcare from non-NHS and non-DHSC bodies	4,560	5,313
Staff and executive directors costs	597,793	575,809
Remuneration of non-executive directors	83	86
Supplies and services - clinical (excluding drugs costs)	109,211	103,653
Supplies and services - general	13,585	14,368
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	105,789	102,168
Inventories written down	-	2
Consultancy costs	844	2,204
Establishment	6,426	6,533
Premises	33,753	33,308
Transport (including patient travel)	3,756	3,373
Depreciation on property, plant and equipment	20,207	24,314
Amortisation on intangible assets	2,193	2,173
Net impairments	2,735	24,826
Increase/(decrease) in provision for impairment of receivables	(802)	384
Increase/(decrease) in other provisions	(3)	110
Audit fees payable to the external auditor		
- audit services- statutory audit	99	147
- other auditor remuneration (external auditor only)	7	37
Internal audit costs	125	121
Clinical negligence	27,398	23,724
Legal fees	265	378
Insurance	135	85
Research and development	34,376	22,932
Education and training	945	1,292
Rentals under operating leases	6,426	6,426
Redundancy	151	8
Car parking & security	1,391	421
Hospitality	3	21
Losses, ex gratia & special payments	1,245	277
Other services, eg external payroll	2,978	2,941
Other		
Security	466	204
Interpreting	330	543
Hire of facilities	220	184
All other expenditure	7,783	4,722
Total	**985,601**	**966,303**
Of which:		
Related to continuing operations	985,601	966,303

Note 6.2 Other auditor remuneration (Group)

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	7	37
Total	**7**	**37**

Note 6.3 Limitation on auditor's liability (Group)

There is a £500k limitation on auditor's liability for external audit work carried out in 2017/18 (2016/17 £1,000k).

Note 7 Impairment of assets (Group)

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,735	24,826
Total net impairments charged to operating surplus / deficit	**2,735**	**24,826**
Impairments charged to the revaluation reserve	1,703	13,664
Total net impairments	**4,438**	**38,490**

Note 8 Employee benefits (Group)

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	492,251	454,606
Social security costs	45,870	42,392
Apprenticeship levy	461	-
Employer's contributions to NHS pensions	54,568	51,024
Pension cost - other	36	33
Termination benefits	151	8
Temporary staff (including agency)	21,076	30,053
Total gross staff costs	**614,413**	**578,116**
Total staff costs	**614,413**	**578,116**
Of which		
Costs capitalised as part of assets	1,875	2,299
Total employee benefits excl. capitalised costs	**612,538**	**575,817**

Note 8.1 Retirements due to ill-health (Group)

During 2017/18 there were 7 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £626k (£523k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

c) Other pension schemes

The Trust offers an additional defined contribution workplace pension scheme - the National Employment Savings Scheme (NEST). This is not material.

Note 10 Operating leases (Trust only)

Note 10.1 University Hospitals of Leicester NHS Trust as a lessor

This note discloses income generated in operating lease agreements where University Hospitals of Leicester NHS Trust is the lessor.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	449	1,314
Total	**449**	**1,314**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	80	302
- later than one year and not later than five years;	87	2
- later than five years.	70	-
Total	**237**	**304**

Note 10.2 University Hospitals of Leicester NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where University Hospitals of Leicester NHS Trust is the lessee.

Of the total minimum lease payments for 2017/18, £4,958k (2016/17 - £5,199k) relates to external contracts for the provision of haemodialysis services as defined under IAS 17 Leases. The Trust is provided with haemodialysis services from private sector suppliers from sites in Northamptonshire and Lincolnshire.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	6,426	6,426
Total	**6,426**	**6,426**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	2,955	4,420
- later than one year and not later than five years;	6,124	8,758
- later than five years.	-	18
Total	**9,079**	**13,196**

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	74	54
Total	**74**	**54**

Note 12.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	4,295	2,053
Finance leases	1,025	626
Interest on late payment of commercial debt	89	35
Total interest expense	**5,409**	**2,714**
Unwinding of discount on provisions	1	4
Total finance costs	**5,410**	**2,718**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	89	35

Note 13 Other gains / (losses) (Group)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	10
Losses on disposal of assets	(16)	(17)
Total gains / (losses) on disposal of assets	(16)	(7)
Total other gains / (losses)	**(16)**	**(7)**

Note 14 Intangible assets - 2017/18

	Group		Trust	
	Software licences £000	Total £000	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**27,368**	**27,368**	**27,368**	**27,368**
Additions	1,566	**1,566**	1,566	**1,566**
Reclassifications	640	**640**	640	**640**
Valuation / gross cost at 31 March 2018	**29,574**	**29,574**	**29,574**	**29,574**
Amortisation at 1 April 2017 - brought forward	**15,901**	**15,901**	**15,901**	**15,901**
Provided during the year	2,193	**2,193**	2,193	**2,193**
Amortisation at 31 March 2018	**18,094**	**18,094**	**18,094**	**18,094**
Net book value at 31 March 2018	**11,480**	**11,480**	**11,480**	**11,480**
Net book value at 1 April 2017	**11,467**	**11,467**	**11,467**	**11,467**

Note 14.1 Intangible assets - 2016/17

Group	Software licences £000	Total £000	Software licences £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**24,180**	**24,180**	**24,180**	**24,180**
Valuation / gross cost at 1 April 2016 - restated	**24,180**	**24,180**	**24,180**	**24,180**
Additions	3,095	**3,095**	3,095	**3,095**
Reclassifications	93	**93**	93	**93**
Valuation / gross cost at 31 March 2017	**27,368**	**27,368**	**27,368**	**27,368**
Amortisation at 1 April 2016 - as previously stated	**13,728**	**13,728**	**13,728**	**13,728**
Amortisation at 1 April 2016 - restated	**13,728**	**13,728**	**13,728**	**13,728**
Provided during the year	2,173	**2,173**	2,173	**2,173**
Amortisation at 31 March 2017	**15,901**	**15,901**	**15,901**	**15,901**
Net book value at 31 March 2017	**11,467**	**11,467**	**11,467**	**11,467**
Net book value at 1 April 2016	**10,452**	**10,452**	**10,452**	**10,452**

Note 15 Property, plant and equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**46,478**	**273,626**	**7,978**	**11,592**	**159,428**	**199**	**57,886**	**2,268**	**559,455**
Additions	-	15,657	50	2,651	9,958	13	3,186	215	**31,730**
Impairments	(1,800)	(2,629)	(9)	-	-	-	-	-	**(4,438)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	4,200	8,623	364	-	-	-	-	-	**13,187**
Reclassifications	-	967	-	(2,436)	291	-	490	-	**(688)**
Disposals / derecognition	-	-	-	-	(3,039)	-	(17)	(23)	**(3,079)**
Valuation/gross cost at 31 March 2018	**48,878**	**296,244**	**8,383**	**11,807**	**166,638**	**212**	**61,545**	**2,460**	**596,167**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**16**	**-**	**-**	**111,750**	**109**	**47,658**	**1,661**	**161,194**
Provided during the year	-	9,363	370	-	8,418	14	1,952	90	**20,207**
Revaluations	-	(9,363)	(370)	-	-	-	-	-	**(9,733)**
Reclassifications	-	(16)	-	-	(32)	-	-	-	**(48)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(3,023)	-	(17)	(23)	**(3,063)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**117,113**	**123**	**49,593**	**1,728**	**168,557**
Net book value at 31 March 2018	**48,878**	**296,244**	**8,383**	**11,807**	**49,525**	**89**	**11,952**	**732**	**427,610**
Net book value at 1 April 2017	**46,478**	**273,610**	**7,978**	**11,592**	**47,678**	**90**	**10,228**	**607**	**398,261**

Note 15.1 Property, plant and equipment - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**47,690**	**256,743**	**8,645**	**31,231**	**152,118**	**156**	**62,096**	**2,160**	**560,839**
Valuation / gross cost at 1 April 2016 - restated	**47,690**	**256,743**	**8,645**	**31,231**	**152,118**	**156**	**62,096**	**2,160**	**560,839**
Additions	-	14,648	10	27,460	14,391	47	2,776	189	**59,521**
Impairments	-	(38,468)	(22)	-	-	-	-	-	**(38,490)**
Revaluations	4,400	(6,297)	(193)	-	-	-	-	-	**(2,090)**
Reclassifications	-	47,006	-	(47,099)	-	-	-	-	**(93)**
Disposals / derecognition	(5,612)	(6)	(462)	-	(7,081)	(4)	(6,986)	(81)	**(20,232)**
Valuation/gross cost at 31 March 2017	**46,478**	**273,626**	**7,978**	**11,592**	**159,428**	**199**	**57,886**	**2,268**	**559,455**
Accumulated depreciation at 1 April 2016 - as previously stated	**5,612**	**22**	**462**	**-**	**109,189**	**102**	**52,424**	**1,670**	**169,481**
Accumulated depreciation at 1 April 2016 - restated	**5,612**	**22**	**462**	**-**	**109,189**	**102**	**52,424**	**1,670**	**169,481**
Provided during the year	-	11,996	393	-	9,622	11	2,220	72	**24,314**
Revaluations	-	(11,996)	(393)	-	-	-	-	-	**(12,389)**
Disposals/ derecognition	(5,612)	(6)	(462)	-	(7,061)	(4)	(6,986)	(81)	**(20,212)**
Accumulated depreciation at 31 March 2017	**-**	**16**	**-**	**-**	**111,750**	**109**	**47,658**	**1,661**	**161,194**
Net book value at 31 March 2017	**46,478**	**273,610**	**7,978**	**11,592**	**47,678**	**90**	**10,228**	**607**	**398,261**
Net book value at 1 April 2016	**42,078**	**256,721**	**8,183**	**31,231**	**42,929**	**54**	**9,672**	**490**	**391,358**

Note 15.2 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	48,878	289,269	8,383	11,807	28,154	74	11,914	645	**399,124**
Finance leased	-	-	-	-	20,073	-	-	-	**20,073**
Owned - government granted	-	689	-	-	-	-	-	-	**689**
Owned - donated	-	6,286	-	-	1,298	15	38	87	**7,724**
NBV total at 31 March 2018	**48,878**	**296,244**	**8,383**	**11,807**	**49,525**	**89**	**11,952**	**732**	**427,610**

Note 15.3 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	46,478	267,385	7,978	11,592	22,934	71	10,187	520	**367,145**
Finance leased	-	-	-	-	23,720	-	-	-	**23,720**
Owned - government granted	-	662	-	-	-	-	-	-	**662**
Owned - donated	-	5,563	-	-	1,024	19	41	87	**6,734**
NBV total at 31 March 2017	**46,478**	**273,610**	**7,978**	**11,592**	**47,678**	**90**	**10,228**	**607**	**398,261**

Note 16 Inventories

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Drugs	6,090	4,159	4,617	4,159
Consumables	17,657	15,634	17,657	15,634
Energy	82	182	82	182
Total inventories	**23,829**	**19,975**	**22,356**	**19,975**

Inventories recognised in expenses for the year were £147,075k (2016/17: £137,002k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £2k).

Note 17.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Trade receivables	26,421	18,872	26,407	18,872
Accrued income	33,291	30,316	33,429	30,316
Provision for impaired receivables	-	(1,024)	-	(1,024)
Prepayments (non-PFI)	7,271	4,797	7,246	4,797
PDC dividend receivable	-	764	-	764
VAT receivable	2,011	1,605	1,579	1,605
Other receivables	1,525	623	1,525	623
Total current trade and other receivables	**70,519**	**55,953**	**70,186**	**55,953**
Non-current				
Trade receivables	3,460	3,217	3,460	3,217
Provision for impaired receivables	(928)	(920)	(928)	(920)
Prepayments (non-PFI)	372	372	372	372
Total non-current trade and other receivables	**2,904**	**2,669**	**2,904**	**2,669**
Of which receivables from NHS and DHSC group bodies:				
Current	38,168	31,859	38,168	31,859

Note 17.2 Provision for impairment of receivables

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April as previously stated	**1,944**	**1,651**	**1,944**	**1,651**
At 1 April - restated	**1,944**	**1,651**	**1,944**	**1,651**
Transfers by absorption	-	-		
Increase in provision	8	105	8	105
Amounts utilised	(214)	(91)	(214)	(91)
Unused amounts reversed	(810)	279	(810)	279
At 31 March	**928**	**1,944**	**928**	**1,944**

Note 17.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
Group	**Trade and other receivables**	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	2	-	-	-
30-60 Days	45	-	4	-
60-90 days	55	-	2	-
90- 180 days	332	-	59	-
Over 180 days	4,074	-	1,879	-
Total	**4,508**	**-**	**1,944**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	2,906	-	-	-
30-60 Days	1,457	-	-	-
60-90 days	1,004	-	1,496	-
90- 180 days	722	-	500	-
Over 180 days	3,739	-	2,434	-
Total	**9,828**	**-**	**4,430**	**-**

	31 March 2018		31 March 2017	
Trust	**Trade and other receivables**	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	2	-	-	-
30-60 Days	45	-	4	-
60-90 days	55	-	2	-
90- 180 days	332	-	59	-
Over 180 days	4,074	-	1,879	-
Total	**4,508**	**-**	**1,944**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	2,906	-	-	-
30-60 Days	1,457	-	-	-
60-90 days	1,004	-	1,496	-
90- 180 days	722	-	500	-
Over 180 days	3,739	-	2,434	-
Total	**9,828**	**-**	**4,430**	**-**

Note 18 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April	**1,238**	**3,178**	**1,238**	**3,178**
Net change in year	7,681	(1,940)	6,021	(1,940)
At 31 March	**8,919**	**1,238**	**7,259**	**1,238**
Broken down into:				
Cash at commercial banks and in hand	-	89	1,146	89
Cash with the Government Banking Service	8,919	1,149	-	1,149
Total cash and cash equivalents as in SoFP	**8,919**	**1,238**	**1,146**	**1,238**
Bank overdrafts (GBS and commercial banks)	(6,019)	-		
Total cash and cash equivalents as in SoCF	**2,900**	**1,238**	**1,146**	**1,238**

Note 18.1 Third party assets held by the Trust

University Hospitals of Leicester NHS Trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	-	-
Monies on deposit	1	3
Total third party assets	**1**	**3**

Note 19.1 Trade and other payables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade payables	55,863	58,807	59,311	58,807
Capital payables	4,307	4,808	4,307	4,808
Accruals	23,558	15,073	23,563	15,073
Social security costs	6,969	6,439	6,957	6,439
Other taxes payable	5,892	5,584	5,882	5,584
PDC dividend payable	7	-	7	-
Accrued interest on loans	587	123	587	123
Other payables	12,054	7,880	9,194	7,880
Total current trade and other payables	**109,237**	**98,714**	**109,808**	**98,714**
			-	
Of which payables from NHS and DHSC group bodies:				
Current	18,188	10,063	18,188	10,063

Note 19.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	211		212	
- number of cases involved		66		50
- outstanding pension contributions	7,495		6,941	

Note 20 Other liabilities

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Deferred income	3,469	11,960	3,469	11,960
Total other current liabilities	**3,469**	**11,960**	**3,469**	**11,960**

Note 21 Borrowings

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Bank overdrafts	6,019	-	6,019	-
Loans from DHSC	36,260	1,838	36,260	1,838
Obligations under finance leases	4,518	4,474	4,518	4,474
Total current borrowings	**46,797**	**6,312**	**46,797**	**6,312**
Non-current				
Loans from DHSC	162,075	132,235	162,075	132,235
Obligations under finance leases	6,394	7,531	6,394	7,531
Total non-current borrowings	**168,469**	**139,766**	**168,469**	**139,766**

Our opening financing consisted of a £134,073k of loans and we finished the year with £198,335k of capital and revenue loans, including £66m of Interim Revolving Working Capital Facility (IRWC) that we have been permitted to carry forward to 2018/19 when it will need to be repaid.

During 2017/18 sucessfully applied for additional loans to support our revenue position of £19,129k and working capital support of £31,986k. We also received £7,658k of capital loans to fund our emergency floor project. A loan of £34,100k is repayable in February 2019 and we will secure a new loan to enable this repayment to be made.

Loans are usually repayable in full, three years after we receive them. There are two capital loans which repay in instalments, with a total of £2,160k being repayble annually over 25 years. We fund these repayments through our internal financing.

Note 22 Finance leases

Managed Equipment Service (MES) finance lease

The Trust has a finance lease in relation to its managed equipment service as defined by IAS 17 *Leases.*

Commencement date: 2007-2008
End date: 2025-2026

Payment for the fair value of the services received

The annual unitary payment is applied to meet the annual finance cost and to repay the lease liability over the contract term.

Interest costs charged to revenue

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

Property plant and equipment assets recognised on the balance sheet

The finance lease assets are recognised as property, plant and equipment. The asset values, life and depreciation for the MES scheme are provided to the Trust by the Lessor.

Depreciation on the property, plant and equipment is charged to revenue.

Liability

A liability is recognised at the same time as the assets are recognised. It is measured initially at the same amount as the fair value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17 *Leases.*

Asset replacement

Any assets, or asset components replaced by the operator during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

Assets contributed by the Trust to the operator for use in the scheme (MES only).

Assets contributed for use in the scheme are recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Note 22.2 University Hospitals of Leicester NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Gross lease liabilities	**12,142**	**13,618**	**12,142**	**13,618**
of which liabilities are due:				
- not later than one year;	4,518	4,474	4,518	4,474
- later than one year and not later than five years;	3,099	3,285	3,099	3,285
- later than five years.	4,525	5,859	4,525	5,859
Finance charges allocated to future periods	(1,230)	(1,613)	(1,230)	(1,613)
Net lease liabilities	**10,912**	**12,005**	**10,912**	**12,005**
of which payable:				
- not later than one year;	4,518	4,474	4,518	4,474
- later than one year and not later than five years;	2,842	3,012	2,842	3,012
- later than five years.	3,552	4,519	3,552	4,519

Note 23.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions - early departure costs	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,172**	**13**	**852**	**2,037**
Arising during the year	26	77	159	**262**
Utilised during the year	(218)	(13)	(153)	**(384)**
Reversed unused	-	-	(3)	**(3)**
Unwinding of discount	1	-	-	**1**
At 31 March 2018	**981**	**77**	**855**	**1,913**
Expected timing of cash flows:				
- not later than one year;	218	77	153	**448**
- later than one year and not later than five years;	763	-	702	**1,465**
Total	**981**	**77**	**855**	**1,913**

Other provisions includes £199k for employer and public liability cases as notified to us by the NHS Litigation Authority; £510k permanent injury benefits and £147k for potential litigation or employment tribunals.

Note 23.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions - early departure costs	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,172**	**13**	**852**	**2,037**
Arising during the year	26	77	159	**262**
Utilised during the year	(218)	(13)	(153)	**(384)**
Reversed unused	-	-	(3)	**(3)**
Unwinding of discount	1	-	-	**1**
At 31 March 2018	**981**	**77**	**855**	**1,913**
Expected timing of cash flows:				
- not later than one year;	218	77	153	**448**
- later than one year and not later than five years;	763	-	702	**1,465**
Total	**981**	**77**	**855**	**1,913**

Note 23.3 Clinical negligence liabilities

At 31 March 2018, £334,763k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals of Leicester NHS Trust (31 March 2017: £282,547k).

Note 24 Contingent assets and liabilities

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities				
Other	(144)	(122)	(144)	(122)
Gross value of contingent liabilities	**(144)**	**(122)**	**(144)**	**(122)**
Net value of contingent liabilities	**(144)**	**(122)**	**(144)**	**(122)**

The Trust's contingent liabilities relate to property, employer and public liability cases. All of these are administered by the NHS Litigation Authority and are expected to be resolved.

Note 25 Contractual capital commitments

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	4,002	6,895	4,002	6,895
Intangible assets	-	156	-	156
Total	**4,002**	**7,051**	**4,002**	**7,051**

Note 26 Financial instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at the 31st March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 26.2 Carrying values of financial assets	Group		Trust	
	Loans and receivables	Total book value	Loans and receivables	Total book value
	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018				
Trade and other receivables excluding non financial assets	61,848	**61,848**	61,991	**61,991**
Other investments / financial assets	-	**-**	4,000	**4,000**
Cash and cash equivalents	8,919	**8,919**	7,215	**7,215**
Total at 31 March 2018	**70,767**	**70,767**	**73,206**	**73,206**

	Loans and receivables	Total book value	Loans and receivables	Total book value
	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017				
Trade and other receivables excluding non financial assets	49,188	**49,188**	49,188	**49,188**
Cash and cash equivalents	1,238	**1,238**	1,238	**1,238**
Total at 31 March 2017	**50,426**	**50,426**	**50,426**	**50,426**

Note 26.3 Carrying values of financial liabilities	Group		Trust	
	Other financial liabilities	Total book value	Other financial liabilities	Total book value
	£000	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018				
Borrowings excluding finance lease and PFI liabilities	204,354	**204,354**	204,354	**204,354**
Obligations under finance leases	10,912	**10,912**	10,912	**10,912**
Trade and other payables excluding non financial liabilities	73,029	**73,029**	73,172	**73,172**
Total at 31 March 2018	**288,295**	**288,295**	**288,438**	**288,438**

	Other financial liabilities	Total book value	Other financial liabilities	Total book value
	£000	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017				
Borrowings excluding finance lease and PFI liabilities	134,073	**134,073**	134,073	**134,073**
Obligations under finance leases	12,005	**12,005**	12,005	**12,005**
Trade and other payables excluding non financial liabilities	63,616	**63,616**	63,616	**63,616**
Total at 31 March 2017	**209,694**	**209,694**	**209,694**	**209,694**

Note 26.5 Maturity of financial liabilities	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
In one year or less	119,749	70,290	119,892	70,290
In more than one year but not more than two years	2,792	36,923	2,792	36,923
In more than two years but not more than five years	125,051	66,457	125,051	66,457
In more than five years	40,703	36,023	40,703	36,023
Total	**288,295**	**209,694**	**288,438**	**209,694**

Note 27 Losses and special payments

Group and trust	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Cash losses	3	5	1	0
Bad debts and claims abandoned	485	1,131	156	91
Stores losses and damage to property	-	-	1	2
Total losses	**488**	**1,136**	**158**	**93**
Special payments				
Compensation under court order or legally binding arbitration award	1	3	-	-
Ex-gratia payments	130	106	120	184
Total special payments	**131**	**109**	**120**	**184**
Total losses and special payments	**619**	**1,245**	**278**	**277**

Note 28.1 Related parties (Group)

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the University Hospitals of Leicester NHS Trust.

Mr K Singh, Trust Chairman, has a family member who is a Partner with Lakeside Healthcare. During the reporting year, the Trust made payments to Lakeside Healthcare amounting to £2,740k.

Professor Philip Baker, Non Executive Director, is the Dean of Medicine, Pro-Vice-Chancellor and Head of the College of Life Sciences, University of Leicester. Transactions with the University of Leicester are shown below.

Mr Ballu Patel, Non-Executive Director, is Chair of Leicester Hospitals Charity. Transactions with the Leicester Hospitals Charity are shown below.

Mr J Adler, Chief Executive, is an unpaid Trustee of NHS Providers. During the reporting year, the Trust made payments amounting to £9k to NHS Providers.

The spouse of Mr P Traynor, Chief Financial Officer, is currently an Interim Business Development Manager at LLR Alliance. During the reporting year, the Trust made payments amounting to £154k to LLR Alliance.

Louise Tibbert, Director of Workforce and OD, Member of the NHS Pension Board as an employer representative.

The Trust has outstanding loans totalling £198,335k at the 31 March 2018, issued by the Department of Health.

MATERIAL DEPARTMENT OF HEALTH AND SOCIAL CARE ENTITIES

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year the University Hospitals of Leicester NHS Trust has had a significant number of material transactions with the DHSC and with other entities for which the DHSC is regarded as the parent Department. These entities are listed below:

CLINICAL COMMISSIONING GROUPS

NHS Cambridgeshire And Peterborough CCG
NHS Corby CCG
NHS Coventry And Rugby CCG
NHS Leicester City CCG
NHS Lincolnshire East CCG
NHS Lincolnshire West CCG
NHS Nene CCG
NHS Rushcliffe CCG
NHS South Lincolnshire CCG
NHS South West Lincolnshire CCG
NHS Southern Derbyshire CCG
NHS West Leicestershire CCG

NHS TRUSTS

Leicestershire Partnership NHS Trust
Northampton General Hospital NHS Trust
Nottingham University Hospitals NHS Trust
Staffordshire and Stoke on Trent Partnership NHS Trust

NHS FOUNDATION TRUSTS

Derby Teaching Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
North West Anglia NHS Foundation Trust
George Eliot Hospital NHS Trust

OTHER

Health Education England
National Health Service Pension Scheme
NHS Blood and Transplant
NHS England
NHS Litigation Authority
NHS Property Services
Public Health England

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the following organisations:

HM Revenue and Customs - VAT
HM Revenue and Customs - Other Taxes and Duties
Leicester City Council
Leicestershire County Council

University of Leicester:

During the reporting year, the Trust made payments to the University of Leicester amounting to £8,737k (2016/17 - £13,833k). The majority of these payments relate to the provision of services to the Trust by medical staff employed by the University of Leicester, and research payments. As at 31st March 2018 a sum of £2,643k (2016/17 - £343k) is included in payables in respect of the University of Leicester. The University paid us £4,847k (2016/17 - £4,782k) in the year, relating primarily to research work, and £1,622k (2016/17 - £1,771k) was included within receivables at 31st March 2018.

Leicester Hospitals Charity

The Trust is the Corporate Trustee for Leicester Hospitals Charity which is an independent charity registered with the Charity Commission. In 2017/18 the Trust received total asset donations of £900k (£199k in 2016/17). Full details will be included in the Charity's accounts as submitted to the Charity Commission.

Note 28.2 Related parties (Trust)

Trust Group Holdings

The financial statements of the parent (Trust) are presented together with the consolidated financial statements. Any transactions or balances between the group entities have been eliminated on consolidation. Trust Group Holdings does not have any transactions with the NHS or other Government entities except those with the parent Trust and HMRC (payroll and social security taxes). The Trust's receivables includes £4.1m owed by the subsidiary and the Trust's payables include £4.4 owed to the subsidiary.

Note 29 Events after the reporting date

There are no events after the reporting date to be reported.

Note 30 Better Payment Practice Code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	166,500	566,455	159,196	636,385
Total non-NHS trade invoices paid within target	48,025	356,760	30,207	396,325
Percentage of non-NHS trade invoices paid within target	28.84%	62.98%	18.97%	62.28%
NHS Payables				
Total NHS trade invoices paid in the year	5,213	124,245	4,979	116,179
Total NHS trade invoices paid within target	807	65,156	498	80,292
Percentage of NHS trade invoices paid within target	15.48%	52.44%	10.00%	69.11%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 32.1 External financing

The Trust is given an external financing limit against which it is permitted to underspend.

	2017/18 £000	2016/17 £000
Cash flow financing	58,082	82,374
External financing requirement	58,082	82,374
External financing limit (EFL)	58,082	87,578
Under / (over) spend against EFL	-	5,204

Note 32.2 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	33,296	62,617
Less: Disposals	(16)	(20)
Less: Donated and granted capital additions	(977)	(199)
Charge against Capital Resource Limit	**32,303**	**62,398**
Capital Resource Limit	32,514	62,419
Under / (over) spend against CRL	**211**	**21**

Note 32.3 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(36,764)
CQUIN Risk Reserve - 1617 CT non achievement adjustment	2,309
Breakeven duty financial performance surplus / (deficit)	**(34,455)**

Note 33 Breakeven Duty Rolling Assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		51	1,013	88	91	(39,655)	(40,648)	(34,051)	(27,152)	(34,455)
Breakeven duty cumulative position	3,910	3,961	4,974	5,062	5,153	(34,502)	(75,150)	(109,201)	(136,353)	(170,808)
Operating income		697,692	696,257	719,154	758,665	770,393	834,376	866,036	924,269	960,790
Cumulative breakeven position as a percentage of operating income		0.6%	0.7%	0.7%	0.7%	-4.5%	-9.0%	-12.6%	-14.8%	-17.8%

The breakeven duty in-year financial performance is not disclosed on the same basis as the figures reported in the SOCI for Retained Deficit (£36,615k) or the Adjusted Retained Deficit (£36,764k). In accordance with DHSC guidance we have disclosed the above financial performance (excluding the CQUIN Risk Reserve - 1617 CT non achievement adjustment) as:

	2016/17	2017/18
Financial performance for the year	**£000**	**£000**
Retained deficit for the year	(36,615)	(52,291)
Impairments (excluding IFRIC 12 impairments)	2,735	24,826
Adjustments in respect of donated and government granted asset reserve elimination	(575)	313
Adjusted retained deficit	**(34,455)**	**(27,152)**

The Trust has a comprehensive medium term reconfiguration plan anticipated to achieve a breakeven position in 2023/24.

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the University Hospitals of Leicester NHS Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

25th May 2018.....Date.....  .....Chief Executive

25th May 2018.....Date.....  .....Chief Financial Officer

Looking forward to 2018/19

Our priorities for 2018/19

Safe, High Quality, Patient-Centred, Efficient Care

- To improve clinical effectiveness
- To improve patient safety
- To improve patient experience

Improve Emergency Care and Cancer Performance:

- We will eliminate all but clinical 4-hour breaches for non-admitted patients in ED
- We will resolve the problem of evening and overnight deterioration in ED performance
- We will ensure timely 7 days a week availability of medical beds for emergency admissions
- We will deliver the 62-day standard for cancer during 2018/19.

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 2018/19…

- We will develop a sustainable 5-year workforce plan by the end of Q1 2018/19, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire
- We will launch our People Strategy in Q1 2018/19 to attract, recruit and retain a workforce that reflects our local communities across all levels of the Trust, with a specific focus on meeting the Workforce Race Equality Standards

Education & Research

To deliver high quality, relevant education and research in 2018/19…

- We will improve the experience of our medical students and address specialty-specific shortcomings in postgraduate medical education, improving our local retention rate and our medical student satisfaction score
- We will explore the model for an Academic Health Sciences Partnership as part of our 5-year Research Strategy and align priorities with our local universities

Partnerships & Integration

To develop more integrated care in partnership with others in 2018/19…

- We will integrate the new model of care for frail people with partners in other parts of health and social care in order to deliver an end to end pathway by the end of 2018/19
- We will increase the support, education and specialist advice we offer to our patients and our partners to help them receive/deliver care in the community in order to reduce demand on our hospitals
- We will lead the development of a 5 year regional Specialist Services Strategy which will place us at the heart of a regional network and supporting local District General Hospital services

Key Strategic Enablers

To progress our key strategic enablers in 2018/19…

- We will progress our hospital reconfiguration plans by developing our plans for PACH and the maternity hospital and finalising plans to relocate Level 3 ICU and dependant services at the Royal and Glenfield
- We will make progress towards a paperless hospital with user-friendly systems by replacing all computers over 5 years old, computerising services to outpatient clinics, using technology to support Quality Commitment objectives and implementing an in-house digital imaging solution in 2018/19
- We will deliver the Year 3 implementation plan for the 'UHL Way' to support and develop staff, (medical and non-medical) and offer tailored education programmes focussing on key areas
- We will implement Year 2 of our Commercial Strategy in order to exploit commercial opportunities available to the Trust
- We will improve the efficiency and effectiveness of our key services and our operating theatres and implement our Carter-based LLR corporate consolidation programme
- We will continue on our journey towards financial stability as a consequence of the priorities described here, aiming to deliver our financial target in 2018/19.

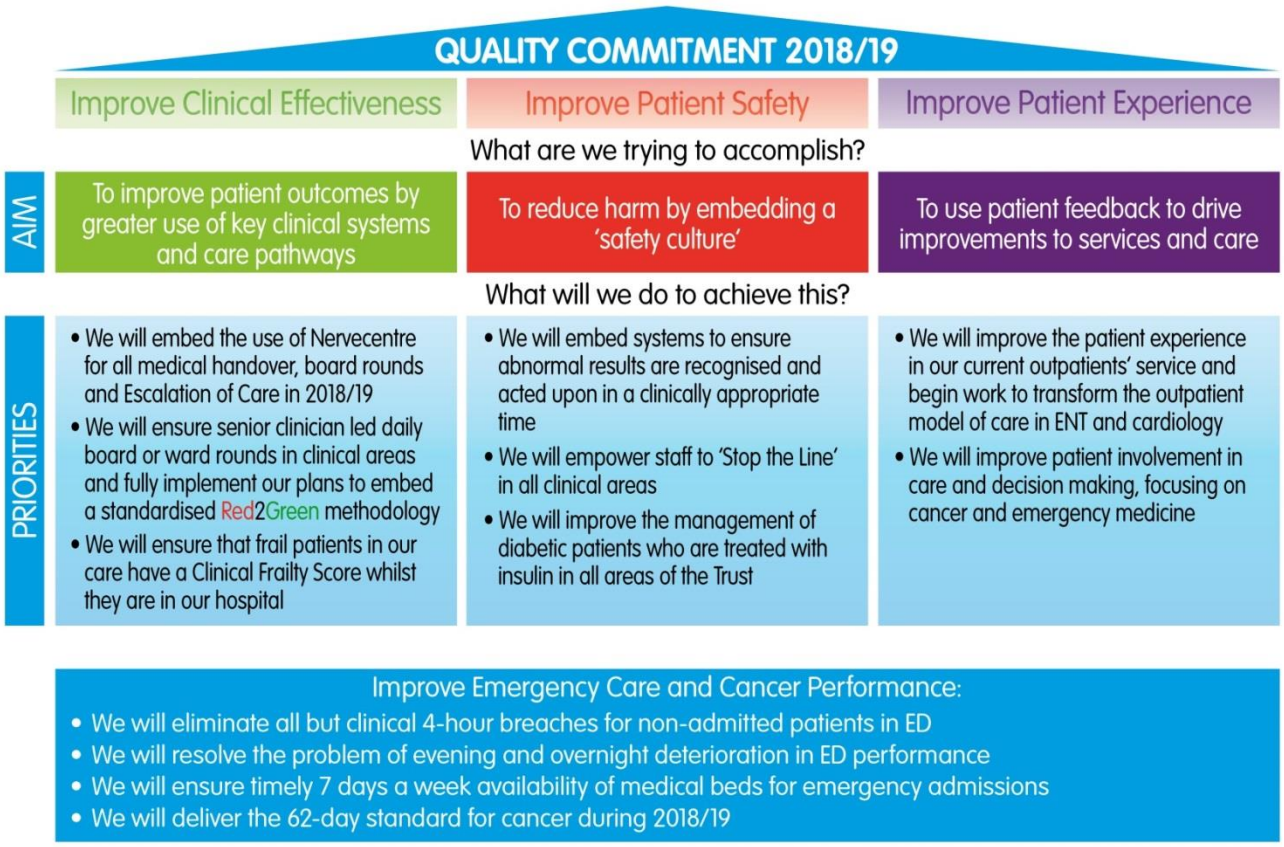
Quality Commitment for 2018/19

Our **Quality Commitment** has proven very successful so will remain, updated for 2018/19.

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".

Last year we added a new element to the Quality Commitment, **'Organisation of Care',** bringing together several aspects of operational improvement including maximising the potential of our new Emergency Department and balancing demand and capacity. For 2018/19 this has been renamed Improve Emergency Care and Cancer Performance.



Glossary of terms

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.

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

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.

A&E (Accident & Emergency) see Emergency Department.

Board Assurance Framework (BAF) is a key mechanism which Trust Boards should be using to reinforce strategic focus and better management of risk.

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.)

Commissioner is responsible for getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, 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.

CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. This means that a proportion of our income depends on achieving quality improvement and innovation goals, agreed between the Trust and its commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital.

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).

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 England leads the NHS in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

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.

Urgent Care Centre is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centres primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit. Urgent care centres are distinguished from similar ambulatory healthcare centres such as emergency departments and walk in centres by their scope of conditions treated and available facilities on-site.

Walk-in-Centre (WiC) is a medical centre offering free and fast access to health-care advice and treatment. Centres provide advice and treatment for minor injuries and illnesses and guidance on how to use NHS services.

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 2018**.

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 2018/19 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 ટેઇપ 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.

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