

# Integrated Quality and Performance Report

# Integrated Quality and Performance Report

<b>Presented for:</b>	<b>Governance</b>
<b>Presented by:</b>	<b>Executive Leads</b>
<b>Author:</b>	<b>Information Department</b>

<b>Trust Goals</b>	
The best for patient safety, quality and experience	✓
The best place to work	✓
A centre for excellence for research, education and innovation	✓
Seamless integrated care across organisational boundaries	✓
Financial sustainability	✓
<b>Key points</b>	
This report is in full the Integrated Quality and Performance Report for May 2023 Trust Board.	

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# Interpreting the Dashboard

Reporting Period: March/April 2023

Target/Trajectory		
<b>Y</b>	<b>NA</b>	<b>N</b>
Where the Contractual or Constitutional Target/Trajectory has been achieved in the reporting period	A Target or Trajectory is not in place for the metric	Where the Contractual or Constitutional Target/Trajectory has not been achieved in the reporting period
Assurance		
Target Consistently Hit	Target Hit & Missed at Random	Target Consistently Failed
<b>P</b>	<b>R</b>	<b>F</b>
Where the lower process limit is above the target (for greater than targets)	Where the target is between the upper and lower control limits	Where the upper process limit is below the target (for greater than targets)
Where the upper process limit is below the target (for less than targets)		When the lower process limit is above the target (for less than targets)
Variation		
Special Cause/Investigate	Common Cause	Special Cause Concern
<b>SC</b>	<b>CC</b>	<b>SC</b>
Special cause variation <b>A rule has been triggered indicating a positive special cause</b>	Common cause variation	Special cause variation <b>A rule has been triggered indicating a negative special cause</b>

# Dashboard

CQC Domain	Metric	Target	Trajectory	Assurance	Variation	CQC Domain	Metric	Target	Trajectory	Assurance	Variation	CQC Domain	Metric	Target	Trajectory	Assurance	Variation				
Responsive	CancelledOps	N	NA	F	CC	Safe	PSIRP	NA	NA	NA	CC	Caring	People-FFT Response Rate – A&E	N	NA	R	CC				
	Cancer 2ww	N	NA	F	CC		CDI	NA	NA	R	CC		People-FFT Experience Rate – A&E	Y	NA	R	CC				
	Cancer 31 Days	N	NA	R	CC		MRSA	Y	NA	R	CC		People-FFT Response Rate – Inpatient/Day Case	Y	NA	R	CC				
	Cancer 62 Days	N	NA	F	CC		E.Coli	Y	Y	R	CC		People-FFT Experience Rate – Inpatient-Day Case	Y	NA	P	CC				
	Ambulance Handover SJUH	N	NA	F	CC		Pseudomonas	Y	Y	R	CC		People-FFT Experience Rate – Outpatient	Y	NA	P	CC				
	Ambulance Handover LGI	N	NA	F	SC		MSSA	NA	NA	R	CC		People-FFT Experience Rate – Maternity	Y	NA	P	CC				
	Diagnostic Waits	N	NA	F	SC		Klebsiela	Y	Y	R	CC		People-FFT Response Rate – Maternity	Y	NA	R	CC				
		NA	NA	NA	NA		VTE	Y	NA	P	CC		Use of Resources	No Reason to Reside					NA	NA	NA
	ECS	Y	NA	P	CC		Harm Free Care- Perfect Ward	Y	NA	P	CC										
	Outpatient Measures	NA	NA	NA	SC		Harm Free Care- Falls	Y	Y	R	CC										
	RTT	N	NA	F	CC		Harm Free Care- Pressure Ulcers	Y	Y	R	CC										
	Complaints	NA	NA	NA	NA		Responding to Risk – 2222 Calls	NA	NA	NA	CC										
	PALS	NA	NA	R	CC																
Effective	Readmissions – Elective/Non Elective	NA	NA	NA	CC	Well-Led	Service Delivery	NA	NA	R	CC										
	Mortality	N	NA	R	CC		Medical Records	NA	NA	NA	CC										

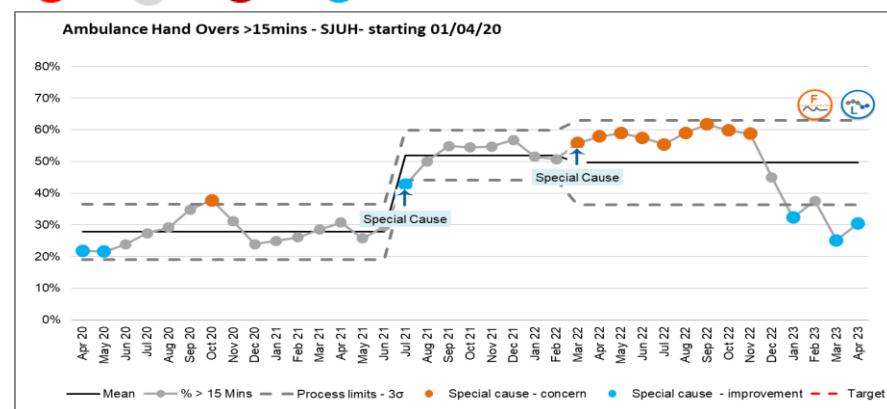
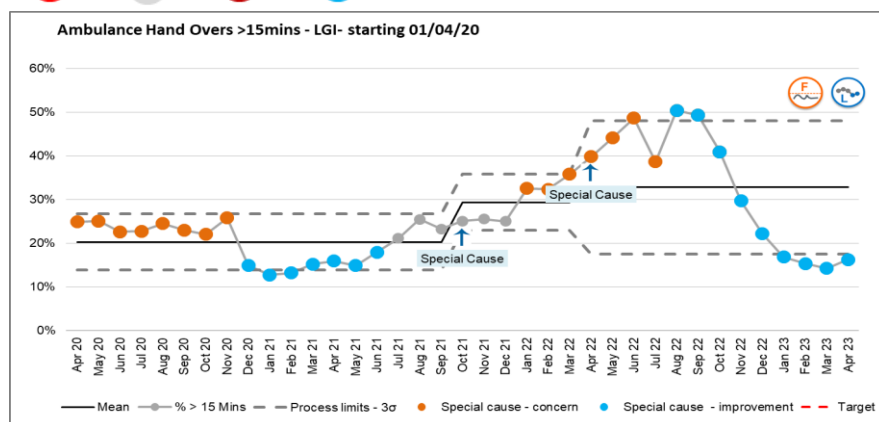
# Ambulance Handover

Reporting Month: April 2023

Executive Owner: Clare Smith (Chief Operating Officer)

Management/Clinical Owner: Jo Wood (ADOP)

Sub Groups: None



## Background / target description:

- 100% of all handovers should take place within 15 minutes
- Handover data is recorded by the both the handover nurse and YAS staff on software managed by YAS and the data is submitted to NHSI/E directly. There is no mechanism for validation by LTHT of this data or the correction of errors

## What does the chart show:

- The SPC charts show ambulance handovers that have taken more than 15 minutes, split by the LGI site and by the SJUH site
- LGI – In April 2023 there were 347 handovers over 15 minutes (16.2%). The average handover time at LGI was 09:21 minutes
- SJUH – In April 2023 there were 750 handovers greater than 15 minutes (30.4%). The average handover time at SJUH was 12:04 minutes
- For March 2023 (latest data available) LGI placed 1st and SJUH placed 3rd nationally out of 183 hospitals.

## Context:

- Performance improved following use of the Leeds Improvement Methodology work between LTHT and YAS
- Improved handover recording delivered 90% of conveyances at LGI recorded as handover completed in April 2023. SJUH had 89% of conveyances recorded as handover completed
- The April validated position resulted in 0 breaches over 1 hour for both sites. The LGI validated position has had 0 breaches over 1 hour for 4 consecutive months and 2 consecutive months for SJUH

## Actions:

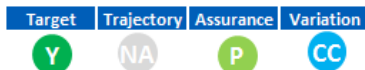
- YAS CPD event supported by LTHT in May 2023 to encourage the use of PCAL to reduce the volume of ambulance conveyances to A&E
- Weekly collaboration meetings continue with YAS to sustain continual improvement and collaboration on the handover processes
- PCAL promotional videos has been shared with YAS to support crew knowledge around the PCAL service to improve PCAL use for YAS patients. This has resulted an increase to 341 YAS calls to PCAL in April 2023 compared to 283 in March
- NHSE have been asked to support discussions regarding validation of data as this will affect all providers and better help describe the true opportunity for improvement
- A city-wide programme called PCAL plus has commenced a rolling programme of tests of change. This is aimed at better connecting YAS to primary and community services to route patients to services that will offer an improved experience and provide right care first time

# Emergency Care Standard

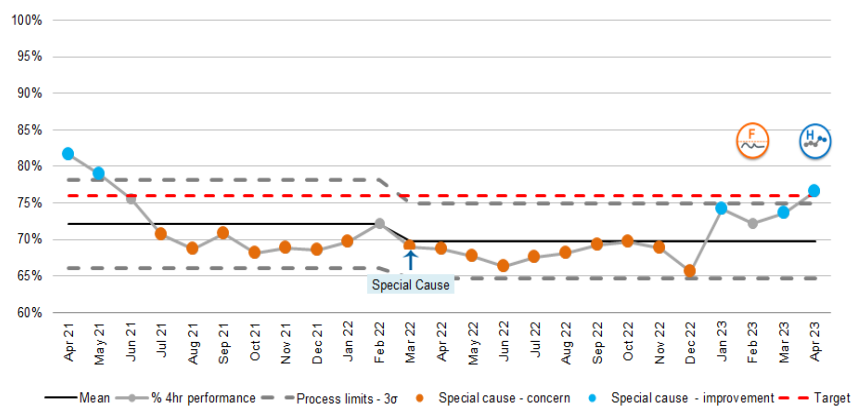
## Reporting Month: April 2023

Executive Owner: Clare Smith (Chief Operating Officer)

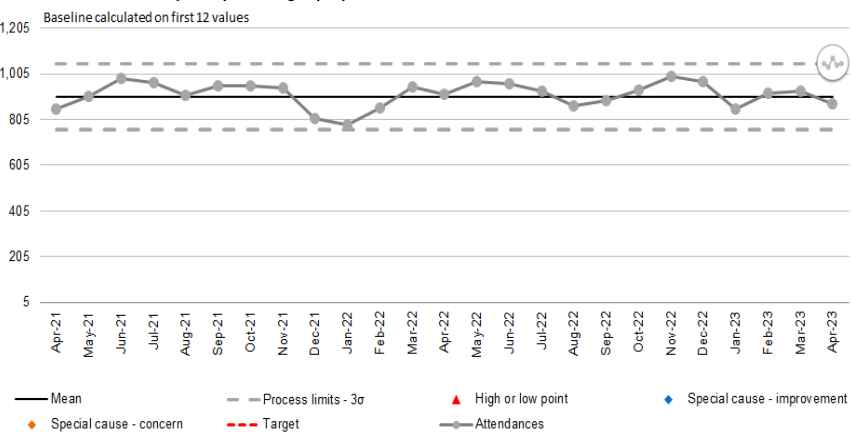
Management/Clinical Owner: Jo Wood (ADOP)



Emergency Care Standard- starting 01/04/21



A&E Attendances per day- starting 01/04/21



### Background / target description:

- The constitutional standard is 95% of attendees to A&E are admitted, transferred or discharged in 4 hours
- 2023/24 national planning priority is to deliver 76% by March 2024

### What does the chart show/context:

- ECS delivery (including walk-in and Urgent Treatment Centres) for April 2023 was 76.5% against a trajectory of 70%
- LTHT ranked 26th out of 109 Trusts for ECS performance in April 2023
- Attendances across all sites in April 2023 decreased by 3.6% compared to April 2022
- Across peers, LTHT ranks 2nd for attendances and 2nd for ECS performance in April 2023

### Underlying issues:

- On average 34 patients per day waited over 12 hours in the A&E departments. This is an improved position when compared with April 2022 (61 patients per day)
- On average 2 patients per day waited over 24 hours the A&E department in April 2023. Again, this is an improved position compared to April 22 (6 per day)
- In April 2023, the average occupancy for adult beds at midnight was 98.9%, for paediatric beds this was 89.0% and for the Trust overall 98.1%. Average adult occupancy was at 100.5% when patients awaiting bed in A&E without a bed outcome are included
- LTHT ranked 10<sup>th</sup> out of 10 peer organisations and 120<sup>th</sup> of 124 Trusts for bed occupancy
- Across both sites for April 2023 the average time in A&E for admitted patients was 422 minutes. This is an improvement, as between June 2022 and December 2022, the average time in department was 614 minutes

### Actions:

- Launch of "Think LEOU" in May 2023 at the LGI to promote the use of Extended Observation Unit (LEOU) and avoid patients breaching the 4-hour standard
- Completed the trial for Radiographer Led Discharge Pathway in Paediatric ED, to be implemented by July. This will support delivery of the Paeds ED trajectory for improvement
- Development of Primary Care Access Line has involved a city medical team reviewing where ambulance conveyances to A&E could have been avoided if primary care offers had been utilised. Next steps are to review of criteria and a PDSA cycle to understand size of opportunity
- Additional Paediatric consultant is recruited to support the service following the sustained increase in demand from 2022/23
- Community Ambulatory Paediatric service (CAPs) tested as an on-day response to reduce A&E attendances is showing 95% utilisation of over 200 on day appointments per week. Full review has led to a further year's funding for this service Monday to Friday
- Working with city partners to deliver a plan to reduce no reason to reside numbers and subsequently reduce bed occupancy
- CSUs developing A3 plans for the annual commitment including to reduce LOS by 0.5 days
- St James's emergency front door and SDEC redesign is on schedule for November 2023

# Cancelled Ops

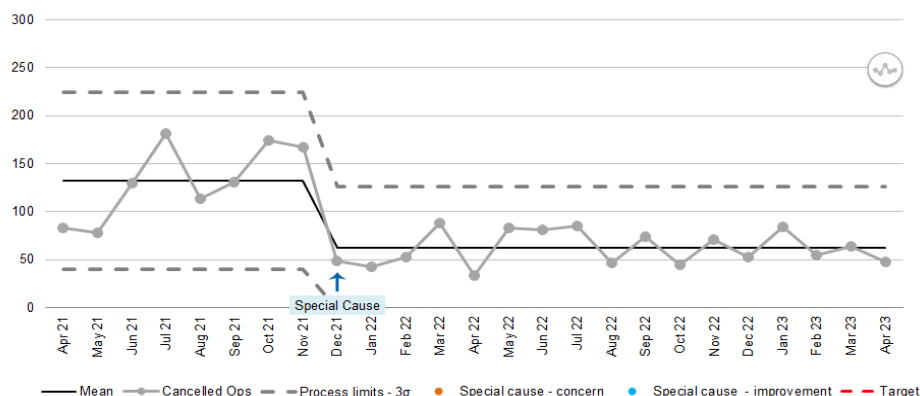
Reporting Month: April 2023

Executive Owner: Clare Smith (Chief Operating Officer)

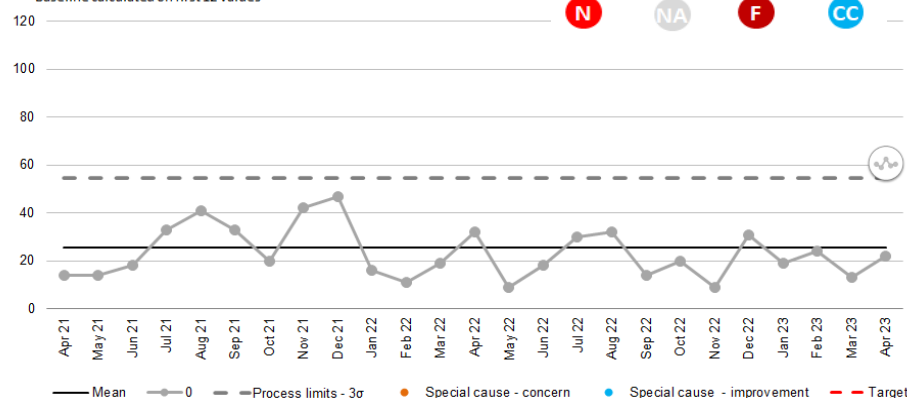
Management/Clinical Owner: Rob Armstrong (ADOP)

Sub Groups: F&P Committee

Last Minute Cancelled Ops- starting 01/04/21



Cancelled Ops 28days-Cancelled Ops 28days starting 01/04/21  
Baseline calculated on first 12 values



## Background / target description:

Ensure all patients who have operations cancelled on the day of surgery, for non-clinical reasons are offered another binding date to be treated within a maximum of 28 days (zero tolerance standard)

## What does the chart show/context:

### Cancelled Operations

- There were 48 LMCO in April 2023, which is a reduction of 25% compared to 64 in March 2023. It is a reduction of 42% when compared to the 88 in March 2022.
- LMCO numbers are below the mean and within the process control limits

### 28 Day Breaches

- There were 22 breaches of the 28 day standard in April 2023, this was an increase of 69% when compared to 13 breaches in March 2023. This is 13 more breaches than the 9 breaches in April 2022.
- The 28 day standard is below the mean and remains within normal process control limits

### Quarter 4

- In Quarter 4 LTHT had 203 LMCO and 56 breaches of the 28 day standard. LTHT ranked 8<sup>th</sup> out of our 10 peers.

### Underlying issues:

- Non-elective pressures continue to impact the elective bed base resulting in on day cancellations due to capacity
- Industrial action led to cancellations of routine electives and reduced elective capacity
- Challenges remain with critical care, ward and HOBs bed availability due to inability to regularly step patients out of ACC resulting in cancellation of electives
- High G&A bed occupancy, in April, average bed occupancy was 98.1%.
- Surgical prioritisation supports the most clinically urgent patients being listed first

### Actions:

- 2 additional theatres and a ward approved at CAH, works to complete by March 2025
- 2 additional theatres planned for WDH, works to complete by April 2024
- Continue to review BADs procedures to reduce the pressure on elective beds
- Continue to improve theatre utilisation and increase cases/session.
- Work with the Independent Sector partners & Commissioners to transfer suitable patients to the Independent Sector
- Ad hoc meetings when required, with ADOPs, theatres and CSUs to try and prevent patient cancellations due to site pressures and staff sickness

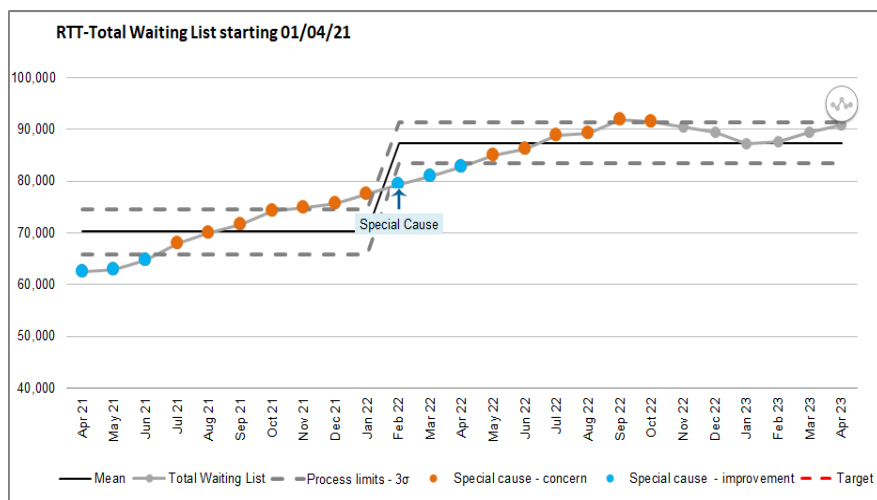
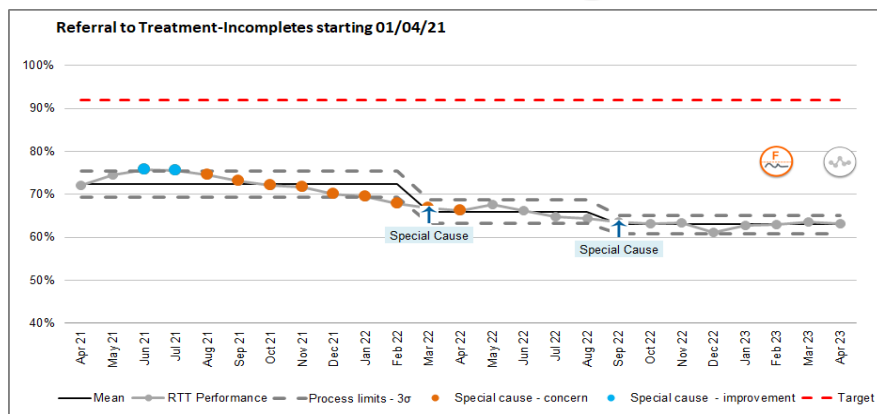


## Reporting Month: April 2023

**Executive Owner:** Clare Smith (Chief Operating Officer)

**Management/Clinical Owner:** Tim Hiles (Director of Operations)

**Sub Groups:** F&P Committee



### Background / target description:

- Ensure 92% of patients are treated within 18 weeks of referral
- Reduce maximum waiting times to below 65 weeks by April 2024

### What does the chart show/context:

- RTT delivery was at 63.2% for April 2023, a decrease of 0.4% on last month
- The number of patients waiting over 18 weeks was 33,441 for April 2023, in comparison to 32,542 for March 2023, which is an increase of 899 patients
- The total waiting list was 90,867 for April 2023, which is an increase of 1,390 patients from March 2023
- 2 patients had waited over 104 weeks at the end of April 2023
- There were 122 patients who had waited over 78 weeks at the end of April 2023
- LTHT ranked at 66 of 147 Trusts for RTT delivery in March 2023 (latest available data)

### Underlying issues:

- Continued industrial action, restricting routine elective and outpatient activity
- Increase in staff annual leave and patient unavailability due to school Easter holidays
- Reduction in activity due to two bank holidays
- High G&A bed occupancy, in April 2023, average bed occupancy was 98.1%
- 2 x 104week waiters are due to patient choice

### Actions:

- Successful implementation of Robotic Processing to support with the validation of patient waiting lists; reassuring patients that they are still on the waiting list and identifying any patients who no longer require an appointment
- In-depth manual validation of RTT pathways for our long waiting patients by the Corporate Performance Team, ensuring RTT clock stops are actioned and RTT waits are accurate
- Focused administrative support programme to be undertaken with CSUs to look at where improvements are to be made, with the development and implementation of daily management processes. This will improve RTT pathway recording, capture more clock stops and reduce duplicate RTT clocks
- LTHT adding patients to DMAS (Digital Mutual Aid System) seeking national support for specialties at risk of failing to deliver the 78week target
- Weekly meetings with CSUs to monitor and discuss their 78-week position with ambition to clear all 78 week waiters by the end June 2023, with the exception of Spines
- Additional meetings with COO to consider additional support requirements for more rapid improvement on 78-week delivery

# RTT – 104 Weeks / 78 weeks / 65 Weeks

Reporting Month: April 2023

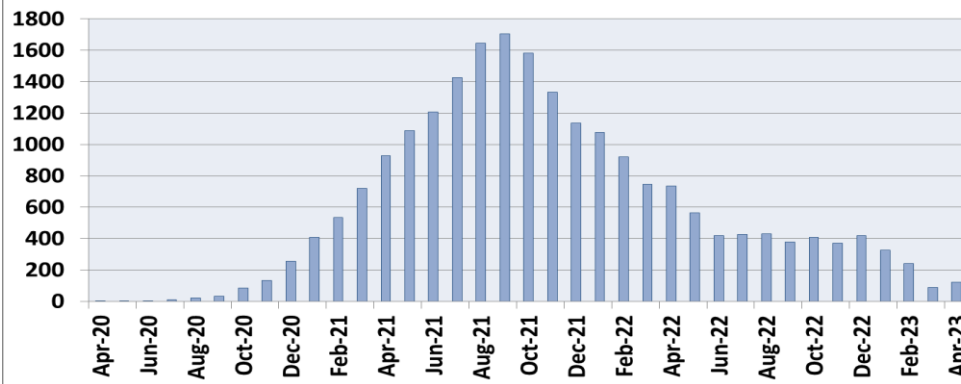
Executive Owner: Clare Smith (Chief Operating Officer)

Management/Clinical Owner: Tim Hiles (DoP)

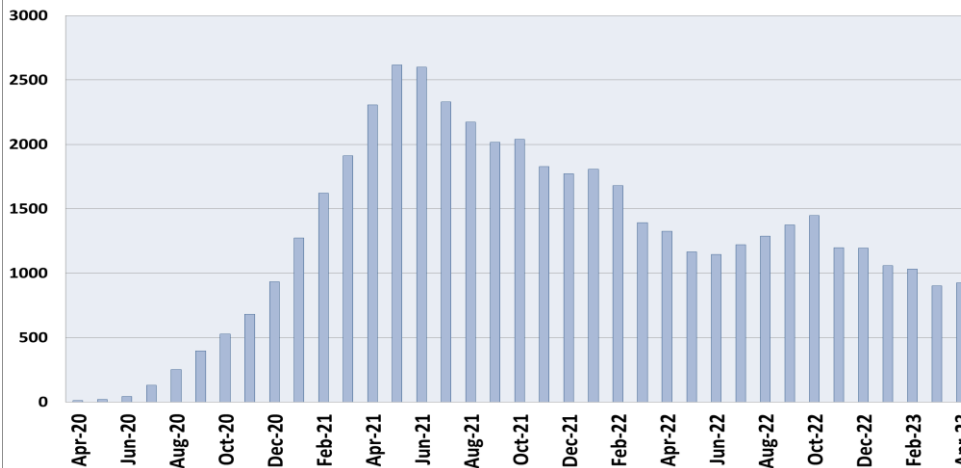
Sub Groups: F&P Committee



78 Week Backlog Remaining



65 Week Backlog Remaining



## Background / target description:

- 104 week target was to have no 104 breaches by July 2022
- 78 week target was to have no 78 week breaches by 31 March 2023
- 65 weeks target is to have no 65 week breaches by 31 March 2024

## What does the chart show/context:

- At the end of April 2023 there were 2 patients over 104 weeks for treatment
- At the end of April 2023 there were 122 patients who had waited over 78 weeks for treatment
- At the end of April 2023 there were 926 patients who had waited over 65 weeks for treatment.

## Underlying issues:

- 104 week breaches in April were both because patient's chose to delay treatment until after breach date
- Further strike action in April 2023, again restricted elective and outpatient activity
- Surgical prioritisation in some specialties such as Colorectal, Neurosurgery, Adult Spines, Paediatric Spines and Congenital Cardiac impacts on long waiting patients
- There is no other Trust able to support long waiting Neurosciences or Colorectal surgical patients either due to complexity of the patients, or local waiting list positions

## Actions:

- Weekly meetings with CSUs to report on 78 week position and actions being taken to reduce numbers
- Standard work and production boards used to support Corporate and CSU teams to manage delivery against 78 week and 65 week trajectories
- Use of insourcing teams in endoscopy
- Use of subcontract arrangements to support treatment of long waiting patients in the Independent Sector
- In-depth manual validation of RTT pathways for our long waiting patients by the Corporate Performance Team, ensuring RTT clock stops are actioned and RTT waits are accurate.
- Enhanced Care Beds opened at CHOC to increase case complexity for Orthopaedics and Adult Spines
- NHSE Tier 2 for elective recovery with weekly update meetings

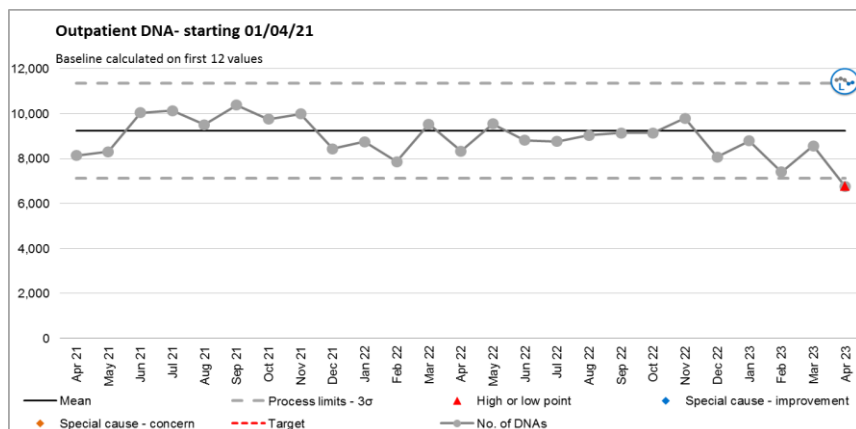
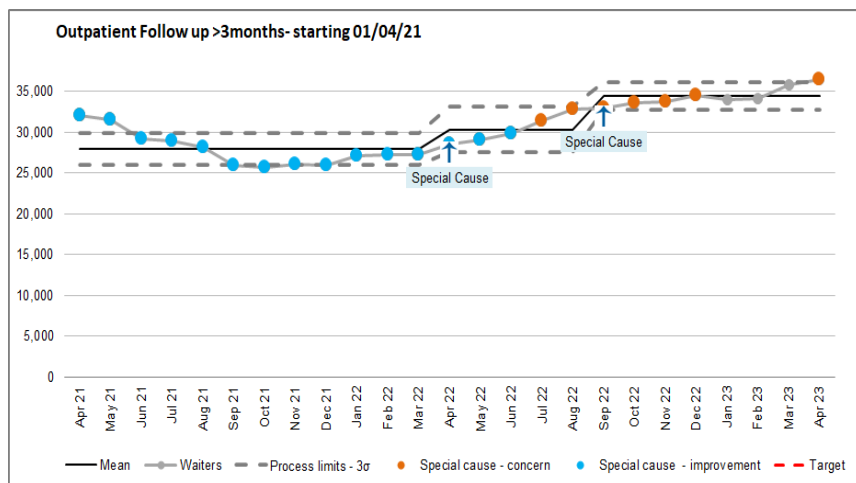
## Reporting Month: April 2023

**Executive Owner:** Clare Smith (Chief Operating Officer)

**Management/Clinical Owner:** Ruby Ali (ADOP)

**Sub Groups:** None

Target	Trajectory	Assurance	Variation
NA	NA	NA	SC



### Background / target description:

- Reduce the number of patients waiting for follow-up appointments beyond 18 weeks of intended appointment date
- Ensure Did Not Attend (DNA) / Was Not Brought (WNB) rate is below peer average

### What does the chart show/context:

- April 2023 has seen an increase of 562 in the number of patients overdue their follow up appointment, compared with March 2023
- The chart (bottom) shows the outpatient DNA number for LTHT. There were 1,818 fewer DNAs in April 2023 compared to March 2023 and the April 2023 DNA rate of 7.6%, is a reduction of 0.3% from March 2023

### Underlying issues:

- Strike action has reduced outpatient activity and efficiency
- Increase in staff annual leave and patient unavailability due to Easter school holidays
- Reduced activity due to two bank holidays

### Actions:

- Validation of all non-admitted patients at risk of waiting 26 weeks at year end, with implementation of Robotic Process Automation (RPA)
- Increase use of Patient Initiated Follow-Up (PIFU) pathways to reduce follow-up backlog as well as increasing capacity for alternate activity
- Patient Hub: Gives patients more control of appointments and reduces mislaid or lost letters. >90% Business units using Patient Hub with most seeing reductions in the DNA/WNB by 1%+.
- Bookwise (digital clinic room booking tool) – phase 1 of organisational scale up (Bexley Wing) was delivered February 2023 with implementation in the wider organisation planned by Spring 2023. This will deliver additional physical capacity to house increased activity and generate efficiencies
- Task & Finish Group (clinically supported) established to review the DNA/WNB and cancellation rates, to support targeted and collective actions in Q4 2022/23 to deliver outpatients attendance optimisation
- E-Outcome Form Project in development to ensure timely capture of disposal outcomes of OPAs and improve accuracy of the data to ensure progression of patients' pathways - with implementation of RPA to deliver. Proof of concept to be tested in April 2023
- Weekly huddles (clinically supported) to review plans for reducing follow up activity and the implementation of CSU trajectories. The weekly huddle will run throughout 2023/24

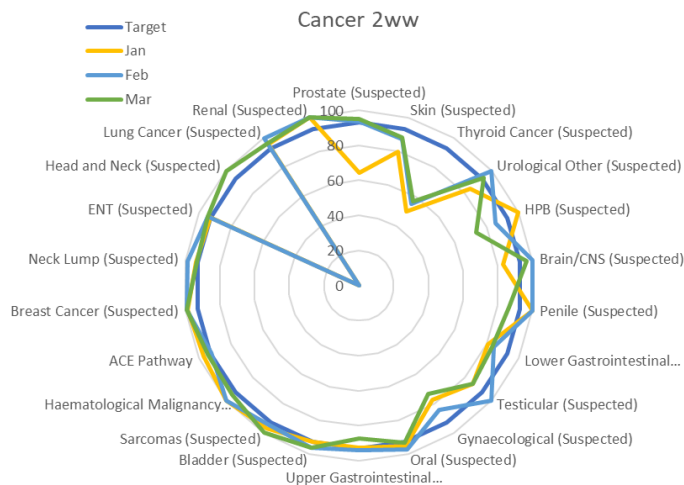
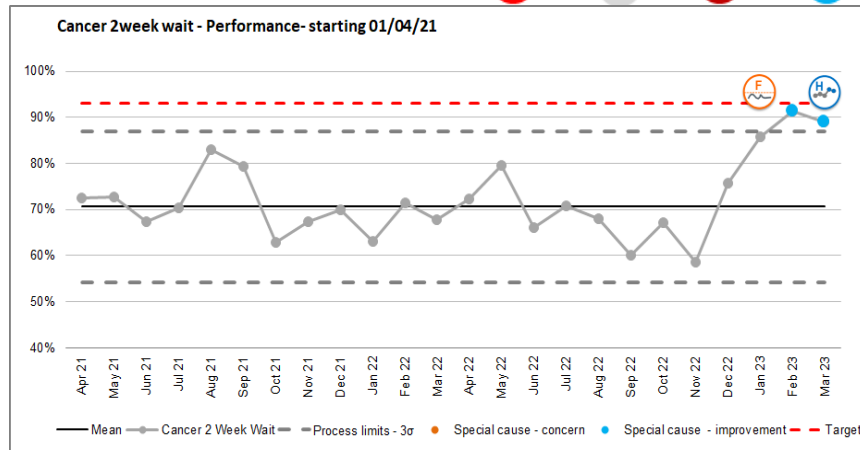
# Cancer 2 Week Wait

Reporting Month: March 2023

Executive Owner: Clare Smith (Chief Operating Officer)

Management/Clinical Owner: Elizabeth Barron (ADOP)

Sub Groups: F&P Committee



## Background / target description:

- 93% of GP referrals are seen for their first OPA or test within 14 days

## What does the chart show/context:

- 2ww delivery in March 2023 was 89% which is an improvement from the February position of 85.9%
- LTHT ranked 60 of 133 Trusts for 2ww delivery. LTHT also ranked 2<sup>nd</sup> out of 12 against peer for March 2023 (latest available data), last month we were 3<sup>rd</sup> of 12 against peer group

## Underlying issues:

### Demand:

- Referrals remained steady since December 2022 at just under 1000 per week, which is around 50 per week higher than at the same time in 2022. Referrals did spike about 1000 towards the end of April

### Capacity:

- The number of patients waiting outside 14 days at 7<sup>th</sup> May is 303. Pathways with highest number outside of 14 days are skin, Lower GI, Gynae and Urology
- There has been some disruption due to Industrial Action and Easter Leave which will be seen in the April position but cancer activity has been prioritised and improvement actions to recover are being taken across affected CSU's with a focus on ensuring that improvement is sustainable
- Due to the industrial action patients in some areas are being seen on day 14, just meeting the 2WW target. Work is underway to reduce waits in these areas back towards day 7 to increase resilience. This is particularly important given the potential for further industrial action being planned. Particular focus is being given to Upper and Lower GI.
- Skin – the team maintained their improved delivery of 2ww throughout February and March 2023. However, a dip in performance was seen in April due to operation pressures and sickness. Service back up to predicting 80% currently in May.

### Actions:

- Continued monitoring of impacts of industrial action to continue, and CSU's to prioritise available capacity when necessary to cancer patients
- Review of pathways and work to implement optimal pathways – will be commencing in Gynae during May in collaboration with the ICB and other external stakeholders
- Work in Gynae to address increase in referrals into the 2WW pathway possibly driven in part by GPs referring via this route rather than using the routine pathways for some patients.

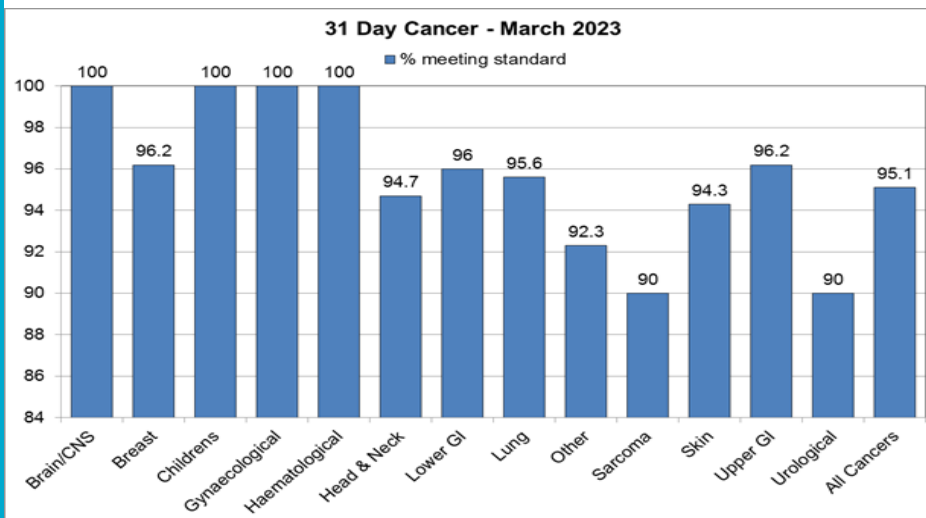
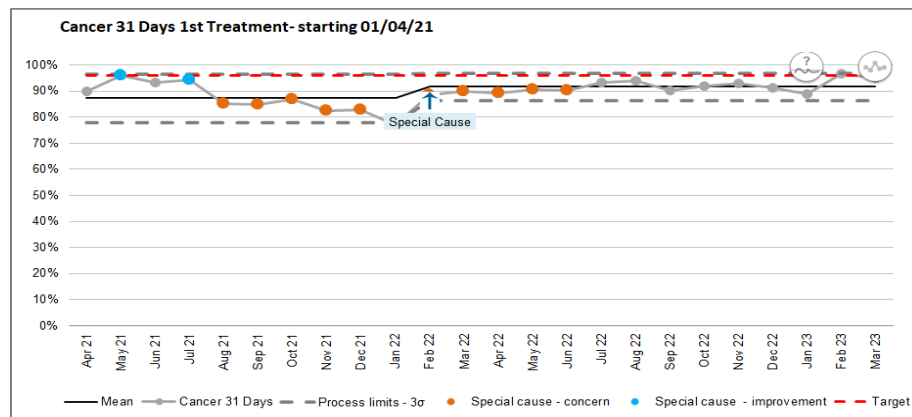
# Cancer 31 Days

Reporting Month: March 2023

Executive Owner: Clare Smith (Chief Operating Officer)

Management/Clinical Owner: Elizabeth Barron (ADOP)

Sub Groups: F&P Committee



## Background / target description:

- 96% of patients receive their first definitive treatment (FDT) within 31 days.
- 94% of patients receive their subsequent surgery within 31 days

## What does the chart show/context:

- For 31-day 1st definitive treatment, position for March was 95.1%, a slight reduction from February position of 96.5% (achieved target) but an improvement from January 2023 which was 88.8%
- LTHT ranked 63 of 135 Trusts in peer comparison for 31-day first treatment. Among the peer group of 13 Trusts LTHT undertook the fourth highest volume of treatments and ranked 2 out of 13 in terms of performance - (latest available data)
- Waits for radiotherapy and chemotherapy continue to be within national standards, it is waits for surgery that are longer
- The chart below shows March 2023 31-day FDT by cancer type

## Underlying issues:

- High volumes of 2WW referrals remained throughout this year across Breast, Gynae, Head and Neck, Lower GI, and Urology (Prostate & Bladder), and continue to impact on the ability of the CSUs to achieve the CWT
- Higher referral rates and industrial action have impacted on activity levels for 31-day delivery throughout February, March and April. There is an expectation that the 31 FDT standard will continue to maintain at 90%+

## Actions:

- Cancer patients continue to be prioritised for surgery and radiotherapy, with those most clinically urgent addressed first
- Recovery of the skin position includes ongoing validation of the waiting list, changes to coding, additional OP and MOPs capacity. Capacity continues to be accessed in the independent sector, with plans to utilize this until the end of June
- Timely validation of potential breaches to mitigate or avoid breaches as appropriate

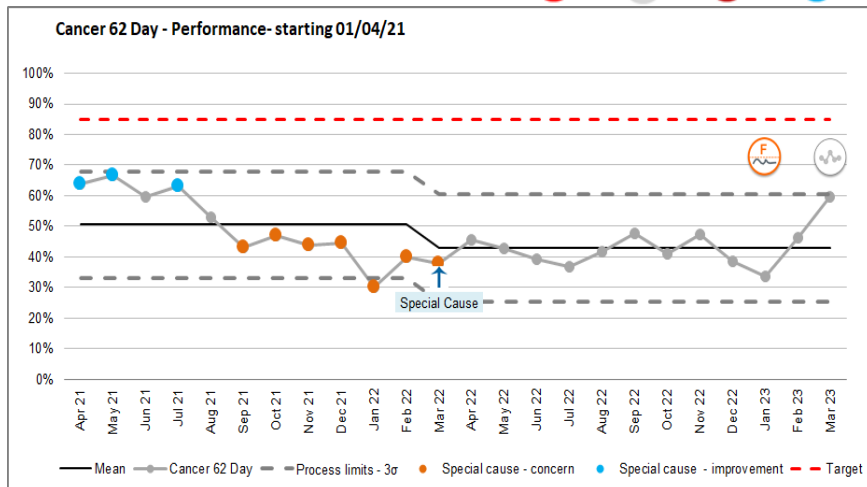
# Cancer 62 Days

Reporting Month: March 2023

Executive Owner: Clare Smith (COO)

Management/Clinical Owner: Elizabeth Barron

Sub Groups: F&P Committee



## Background / target description:

- 85% of patients receive their first definitive treatment for cancer within 62 days of a GP referral for suspected cancer
- 62 day backlog for 2023/24 planning guidance is to reduce to 248 by March 2024

## What does the chart show/context:

- March 2023 reported an improvement in performance of 59.8% from 46.3% in February
- In March LTHT ranked 91 out of 133 reporting Trusts for 62-day delivery and 6 of 13 against peer group (latest available data). In February we were 9<sup>th</sup> out of 13
- The volume of the 62-day backlog increased slightly at the end of March to 237 from 229 at the end of February

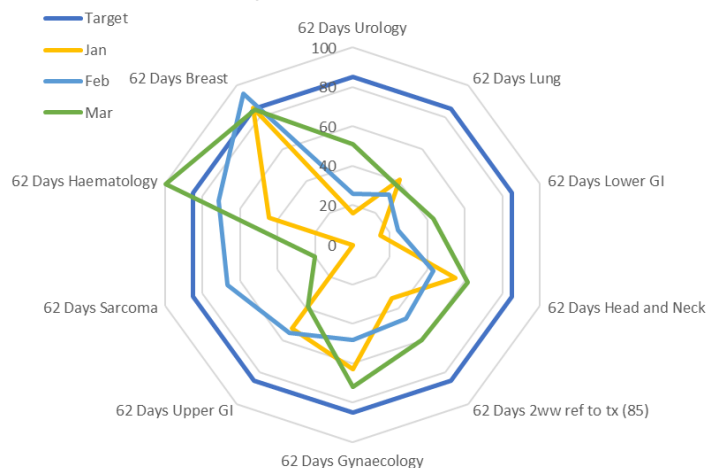
## Underlying issues:

- The backlog position at the end of March 2023 was due to a sustained effort from the CSU's to bring the backlog down. The improvement was noticed and acknowledged locally and nationally as a real achievement after the challenges presented in 2022.
- April has seen a rise in the backlog due to impact of industrial action which was predicted. CSUs have signed up to and agreed local internal trajectories to reduce this further by the end of March '24. With this year seeing a predicted increase due to summer demand for Skin before reducing to a lower year end position
- Pathology & Radiology continue to work with the CSU's and will be included as significant stakeholders in the pathway work ready ongoing and about to commence

## Actions:

- Pathway work is being included in the cancer transformation work and formalised project plans are being established for both existing ongoing groups and new work starting in the next few weeks for optimal pathways and PSFU
- Lung – the KPO team will work with the CSU's, looking at the surgical element of the pathway for this group of patients
- Work continues with the Cancer Alliance to look at introducing FIT testing for all Lower GI referrals, with the aim of a new pathway being implemented with the GP's in the Summer – this will reduce referrals into an already stretched service
- Work continues with the cancer alliance to work with WYAAT providers to improve IPT referrals as delays continue to be a concern in delaying treatment for some patients. These form a proportion of pathways in the LTHT 62 day backlog

62 day 2ww referral to treatment





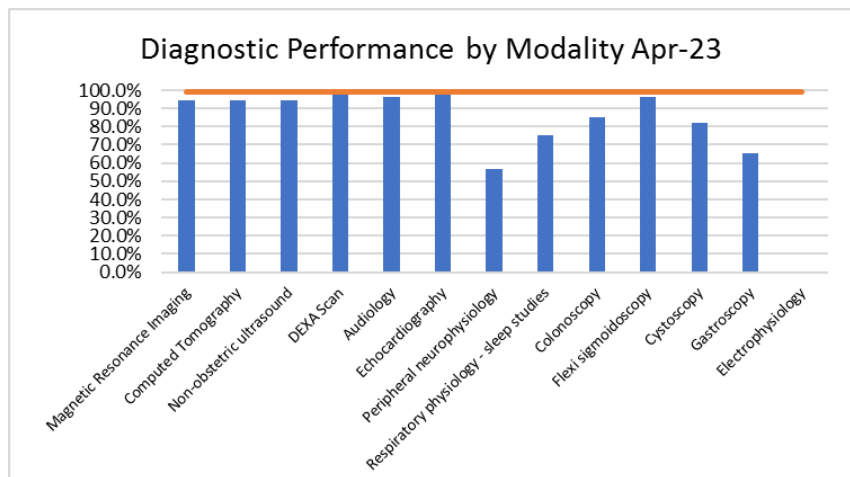
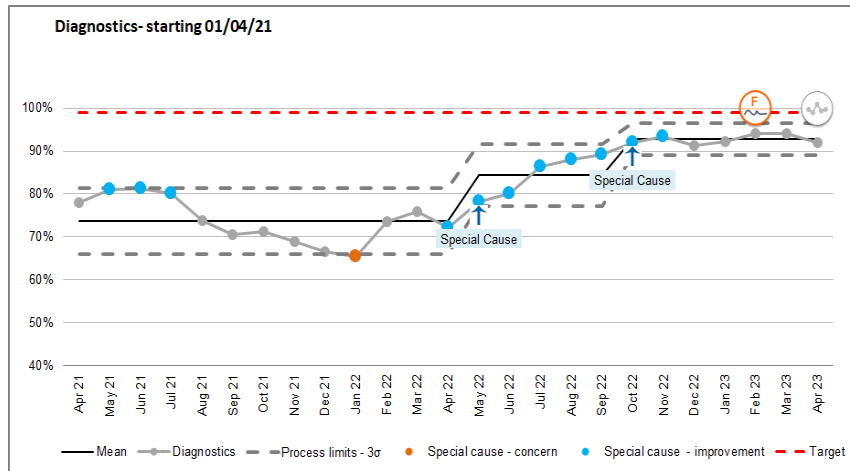
# Diagnostic Waits

Reporting Month: April 2023

Executive Owner: Clare Smith (Chief Operating Officer)

Management/Clinical Owner: Ruby Ali (ADOP)

Sub Groups: F&P Committee



## Background / target description:

- 99% of patients wait no more than 6 weeks for a routine diagnostic test
- 2023/24 national planning priority is to deliver 95% by March 2024.

## What do the charts show/context:

- Delivery in April 2023 was 92.1%, a slight deterioration on previous months. The waiting list size for April 2023 month end was 14,938, in line with pre-pandemic levels
- LTHT ranked 33 out of 158 Trusts and 2 out of 15 in the Peer group for diagnostic performance in March 2023 (latest available data)

## Underlying issues:

- MRI has recovered most of the long waits, except those patients who are waiting for a GA, where theatre capacity is limited
- CT & MRI have continued to see increased demand
- Neurophysiology have seen a deterioration in performance. Options for recovery are currently being explored
- Respiratory Physiology have seen a deterioration in performance over recent months, recovery plans have been requested
- Children's diagnostic services are heavily reliant on theatre capacity due to many patients requiring GA for diagnostic test

## Actions:

- MRI – use of In-Phase (insourcing company) continues along with MRI van at SJUH to maintain current activity levels (which exceed 19/20). Refurbishment work at Seacroft Hospital will deliver MRI through the Leeds CDC (expected in October 2023)
- CT – mobile van at CAH continues to support recovery. Will also be supported by the Leeds CDC from October 2023
- Corporate team liaising with theatres to review long waits for 6 weeks diagnostics, and additional capacity for modalities/specialties requiring theatre provision. Actions have included looking to re-provide lost sessions due to scheduling on audit days, additional lists to recover the adults & paediatric backlog
- Current focus on ensuring that cancer diagnostics are prioritised. Potential for some impact on 6ww performance to ensure clinical prioritisation is undertaken
- Ongoing focus to clear the >13 weeks waiters which increased in April from 143 March 2023, to 177. The bulk of the waits sit in Radiology and Children's CSUs respectively. Recovery plans have been submitted to ascertain what is needed to achieve and maintain a zero over 13 week position by March 2024.
- Additional peds Saturday diagnostic sessions have been arranged to manage the 13 week risks. 1-2 sessions are expected to run each month until March 2024.
- Theatres are using LIM to identify and remove waste and test improvements to support delivery of increased GA MRI capacity. The first observation session was held on 10 May 2023

# Length of Stay

Reporting Month: April 2023

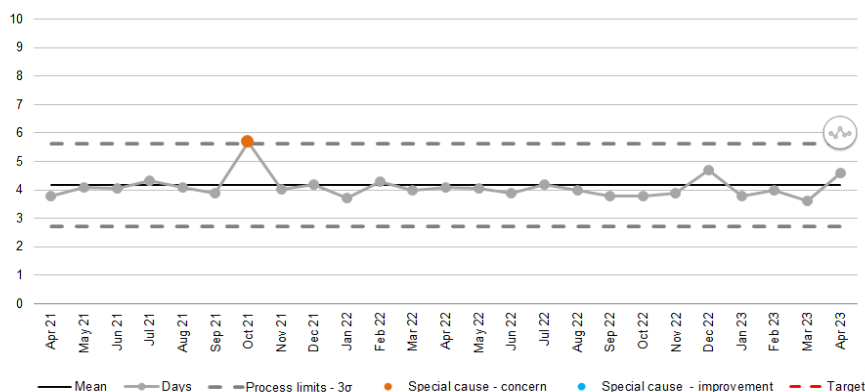
Executive Owner: Clare Smith (Chief Operating Officer)

Management/Clinical Owner: Steve Bush (MD Ops)

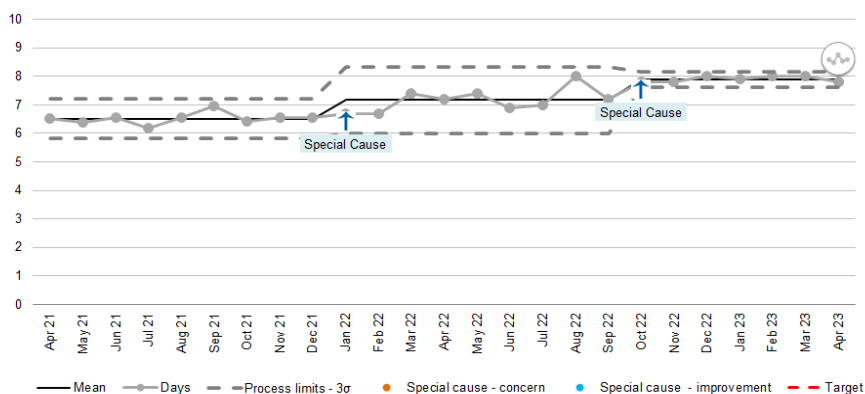
Sub Groups: None

**Elective Length of Stay- starting 01/04/21**

Baseline calculated on first 12 values



**Non-Elective Length of Stay- starting 01/04/21**



## Background / target description:

- Elective and non-elective LOS run charts from April 2020 to April 2023

## What does the chart show/context:

- Elective LOS remains at under 5 days for April 2023
- Non-elective LOS remains at 8 days or below since October 2022

## Underlying issues:

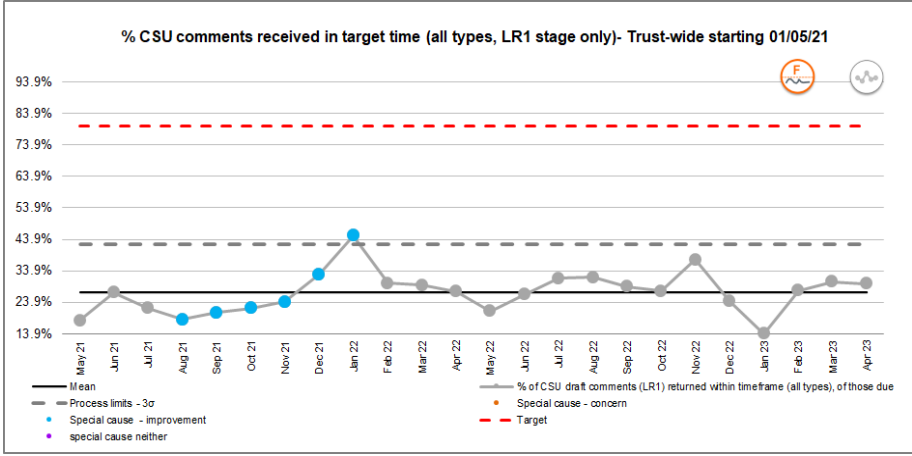
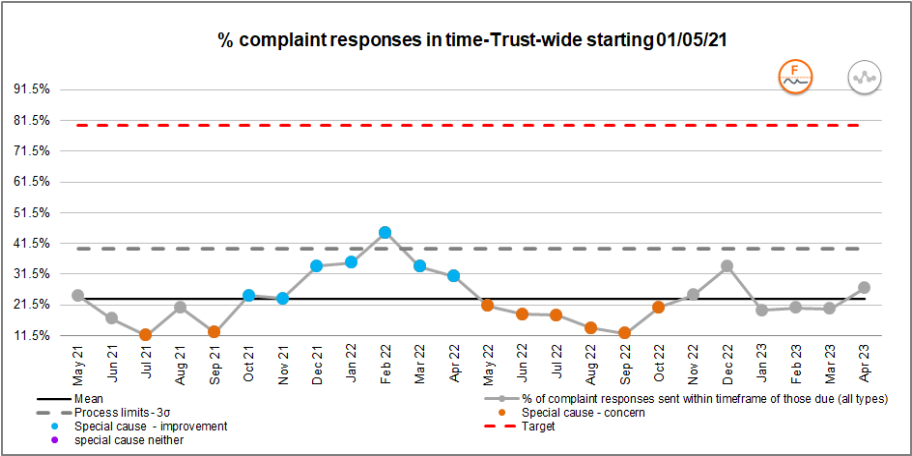
- LTHT have hosted the running of 2 no reason to reside wards (60 patients) previously managed by Villa Care. These are longer staying patients and have been included in LTHT data since November 2022
- Non-elective admissions into the main bed base from A&E have decreased by 3.5% for April 2023 in comparison to April 2022
- 48.2% of non-elective patients had a length of stay of 0-3 days in April 2023. Non-elective and short stay admission reductions correlate with increased activity in medical SDECs
- Increased waits for social worker assessments, community bed availability and packages of care are increasing the LOS of the patients who no longer have a reason to reside
- Long waiting R2R patients are complex, with challenging medical care needs or a combination of medical and complex social care needs

## Actions: linked to annual commitments for reducing LOS by 0.5 days, delivery of access standards and efficiency and productivity.

- Planned Care programme is focussing on day case as norm. Case mix opportunity was sent to all areas with scope for improvement. BADs data set describes the opportunity by specialty. Performance is 80.3% with six months of consecutive improvement which is the highest LTHT has ever delivered
- Pre-optimisation developed to improve patient outcomes for surgery and reduce LOS including enhanced frailty pre-assessment and optimisation
- Further review of short stay patients 0-3 days LoS identifying ways to avoid these admission through currently available pathways and the development of virtual monitoring wards to support new alternative to admission pathways – including “hot gall bladder”
- Longest length of stay with NR2R inpatients review as a city approach in place
- City focus on increasing the use of the virtual ward across elderly and respiratory care to support early discharge and reduce length of stay
- Business Case being written by the city regarding use of digital monitoring to support earlier discharge
- City “Home First strategy” launched in May planning for an increase in patients to be discharged home or to another place of care safely and at the point they no longer require acute hospital intervention
- External review of LoS has been commissioned and in progress. Report expected in two months



**Reporting Month: April 2023/24**  
**Executive Owner:** Helen Christodoulides (Interim Chief Nurse)  
**Management/Clinical Owner:** Krystina Kozłowska (Head of Patient Experience)  
**Sub Groups:** Quality Assurance Committee



**Background / target description:**

- The Trust Complaint Response Time Standard requires 80% of complaint responses to be completed within the initial timeframe agreed with the complainant (either 20, 40 or 60 working days).
- Improvements in complaint response timeliness are supported by a Complaints Improvement Programme (CIP).
- National complaint handling guidance states responses must be provided within 6 months. This standard has been achieved for 94% of Trust complaints responded to over the past 12 months.
- The top complaint subjects continue to reflect common themes in line with the national picture.

**What do the charts show/context:**

- The first chart shows Trust-wide performance for the percentage of first stage (LR1) complaint responses that met completion target, of the total number due to be sent out to complainants that month.
- The second chart shows the percentage of CSU comments which were returned to the complaints team by CSUs on time, out of the total number of comments due to be returned each month. The target for comments is earlier than the target for completed responses, to allow time in the process to complete letter drafting and quality assurance checks. This chart is a good indicator of CSU performance.
- The latest data for April 2023 for both metrics shows normal (common cause) variation that is consistently falling below target.

**Underlying issues:**

- As this target is above the process limits, the process cannot achieve target based on current performance data. The 12 month average for all target timeframes being sent out in time was 21%. Focusing on the three target times, this broke down to 25% for 20 w/day, 22% for 40% and 20% for 60 w/day timeframes.

**Actions**

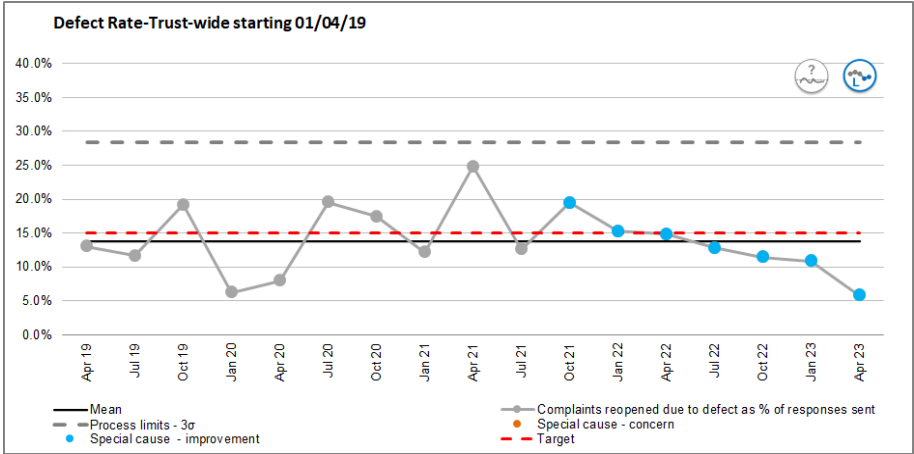
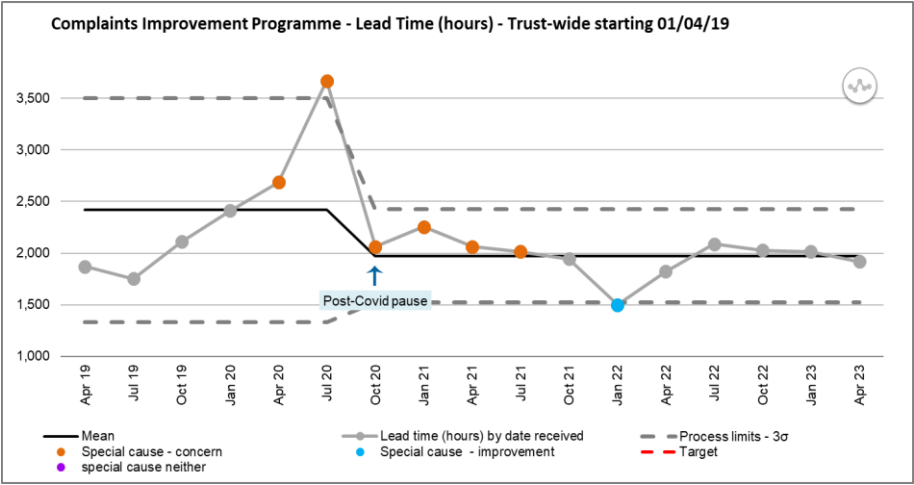
- Work has taken place within the complaints improvement programme to encourage CSUs to develop internal processes that ensure comments are received by the complaints team in good time. A number of CSUs have developed internal tracking processes to support this.

Reporting Month: Q1 – 2023/24

Executive Owner: Helen Christodoulides (Interim Chief Nurse)

Management/Clinical Owner: Krystina Kozłowska (Head of Patient Experience)

Sub Groups: Quality Assurance Committee



### Background / target description:

- The Complaints Improvement Programme aims to improve the experience of complainants and patients, specifically focusing on the timeliness and quality of complaint responses.
- Lead time is the median number of days taken from the date a complaint is received to the response being sent out. This is converted to hours by multiplying the number of days to hours, to represent the time the complainant is waiting for a response.
- Defect rate is the % of first stage complaint responses sent out to the complainant which were reopened for a defect reason. Defects are reopened due to a poor or incomplete previous response, disputed information and/or factual errors.

### What do the charts show/context:

- The chart shows Trust-wide performance for complaint response lead time from Q1 2019/20 to Q1 2023/24 (data available up to 04/05/2023).
- The latest data shows normal variation in the complaint response lead time.
- The defect rate is showing a special cause for improvement due to a reducing trend over the last seven months.
- The CIP continues to work with CSUs in cohort four.
- The heat map also shows an improvement in the range of Lead Time.

### Underlying issues:

- Lead time is showing normal variation. Of the 634 first stage (LR1) responses sent in the twelve months to the end of April 2023, 143 (23%) have been sent within the initial timeframe agreed with the complainant. This continues to be below the Trust target of 80%.

### Actions

- In 22/23 complaints were: 28% multi CSU, 54% single CSU and the remaining 18% mixed sector complaints. Cohort 4 of the CIP commenced in February 2023 and includes non-bed holding CSUs, including the Corporate teams. Work with these CSUs is focussing on supporting CSUs to return draft comments within target times and streamlining the drafting and Executive review process stages.
- In addition to addressing timeliness and quality, the CIP has also introduced a focus on supporting CSUs to record and monitor actions arising from complaints. There have been 249 actions logged in 2022/23.

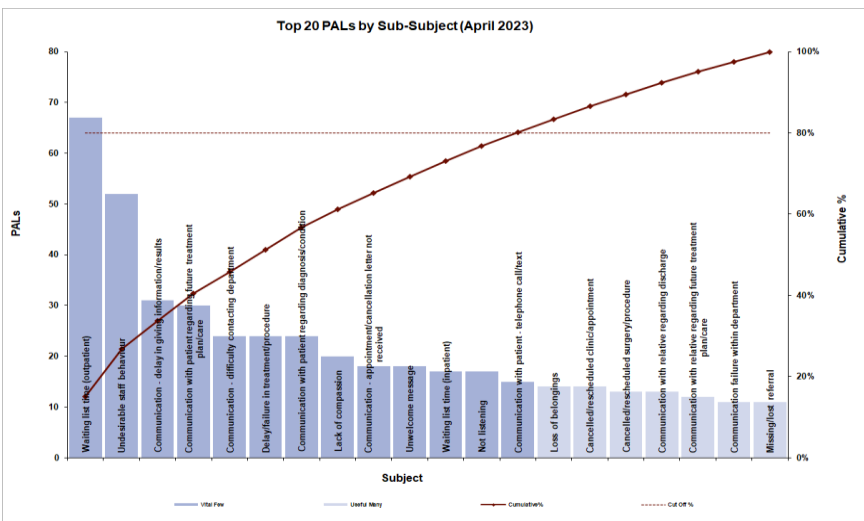
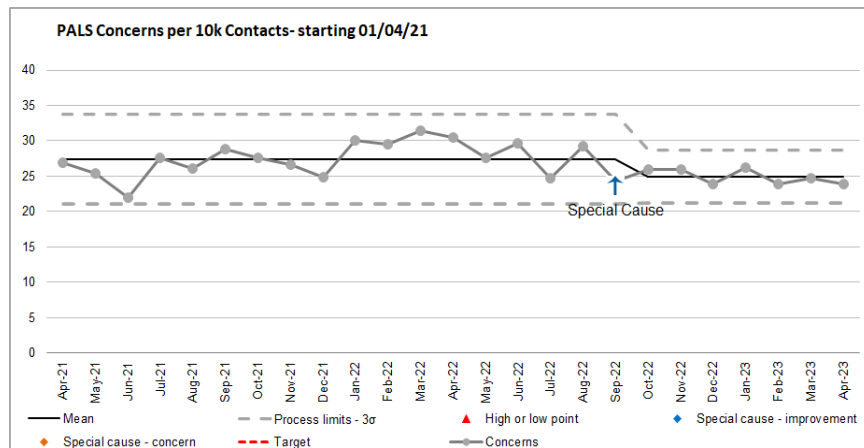
Reporting Month: Q1 – 2023/24  
Reporting Month: April 2023

Executive Owner: Helen Christodoulides (Interim Chief Nurse)

Management/Clinical Owner: Krystina Kozłowska (Head of Patient Experience)

Sub Groups: Quality Assurance Committee

Target	Trajectory	Assurance	Variation
NA	NA	R	CC



## Background / target description:

The graphs show the number of PALS concerns raised for every 10,000 patient contacts and the topics associated with those concerns.

## What does the chart show/context:

- The rate of PALS raised shows common cause variation around a decreased mean.
- Concerns are predominantly related to communication and treatment.
- Waiting list times for outpatients continues to be the number one reason for PALS raised. A number of the other most frequently raised subjects relate to appointment and treatment delays; waiting list times (outpatient and inpatient); delay/failure in treatment procedure and cancelled procedures or appointments. This is reflective of current operational pressures.
- Concerns regarding staff interaction (formerly coded as 'staff attitude') feature in four of the top 20 themes.
- Patients experiencing difficulty contacting departments continues to feature; this was the fifth most frequently raised concern in April 2023.

## Underlying issues:

- Difficulty in getting through to wards and departments continues to be a significant concern. From a review of PALS responses to this concern from CSUs this appears to be influenced by low staffing, staff working from home and telephone lines provided in patient letters being unmanned or out of date.
- A number of new staff interaction sub-theme concerns were introduced as part of the Quality Improvement Collaborative's work to understand better what patients mean when they complain about poor staff interactions. Of the new sub-subjects recorded, undesirable staff behaviour and lack of compassion were the most frequently raised sub-subjects in April 2023.

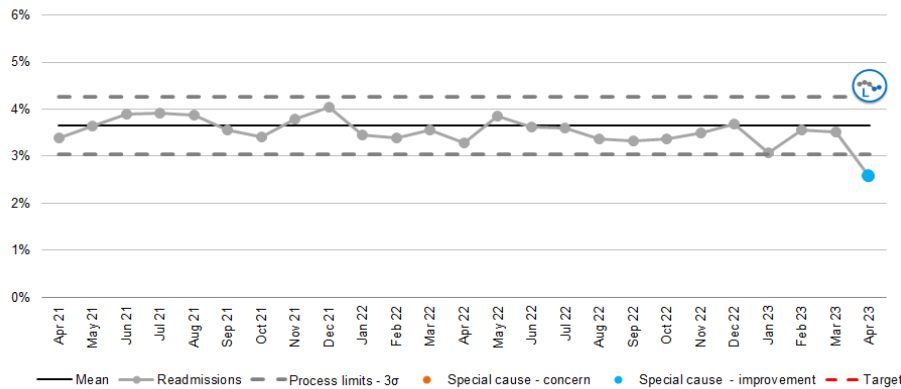
## Actions:

- CSU level data relating to difficulty contacting departments is now included in the Patient Experience Assurance Programme. This enables CSUs to report actions they are taking to address this in their services.
- CSU level data relating to staff interaction has been shared with CSUs involved in the staff interaction QI task and finish group. The intention is for the data to support improved CSU understanding of where the greatest challenges lie, to enable targeted interventions for improvement to be progressed where needed.

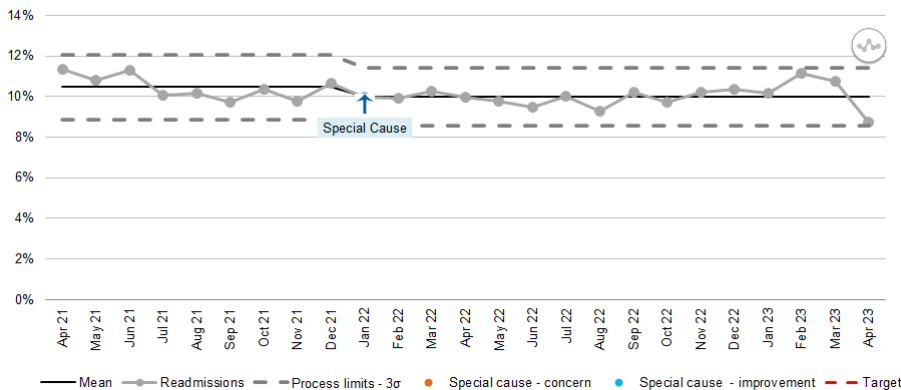
## Reporting Period: April 2023

**Executive Owner:** Clare Smith (Chief Operating Officer)  
**Management/Clinical Owner:** Jo Wood, (ADOP)/Steve Bush MD Ops  
**Sub Groups:** None

Readmissions within 30days following an Elective Spell- starting 01/04/21



Readmissions within 30days following a Non-Elective Spell- starting 01/04/21



### Background / target description:

- Readmission rates within 30 days for elective and non-elective patients are monitored monthly
- Readmission rates are measured to assure ourselves that patients are not being discharged from hospital prematurely or without adequate community support

### What does the chart show/context:

- Elective readmission rates are below the lower process control limit at 2.57% for April 2023
- Non-elective readmission rates are at the lower process control limit. The readmission rate for April 2023 is 8.73%

### Actions:

- Medical and elderly SDEC estate work to be completed by October 2023 to enable footprint for maximum admission and readmission avoidance
- Review of patient pathways that could be delivered as acute clinic rather than admission or readmission including the headache pathway, neurology clinic, acute gall bladder and paracetamol overdose
- Geriatrician 8am to 8pm presence across the Emergency Department and Same Day Emergency Care to support admission and readmission avoidance
- Primary Care Access Line service continues to develop including ambulance calls direct to PCAL and review of the stack (the ambulance service list of patients who need to be brought to A&E) to enable alternatives to admission or readmission
- Community partners to enhance care pathways options including access to community services in addition to LTHT care pathways avoiding admission
- Unplanned care programme includes a suite of actions agreed with Health Watch to focus on the discharge experience, patient information and advice on discharge including contacts for advice and support for patients who feel they need ongoing medical care
- Strengthening the utilisation of virtual ward to support early discharge and adaptation to self-management in a person's own home

Reporting Period: January-22 to December-22

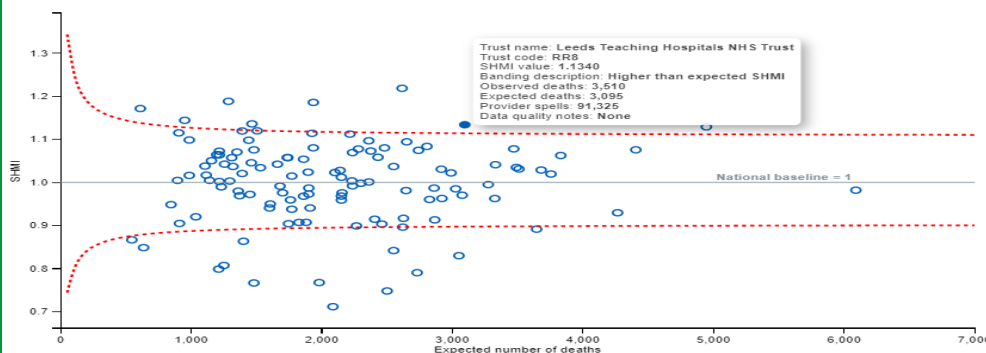
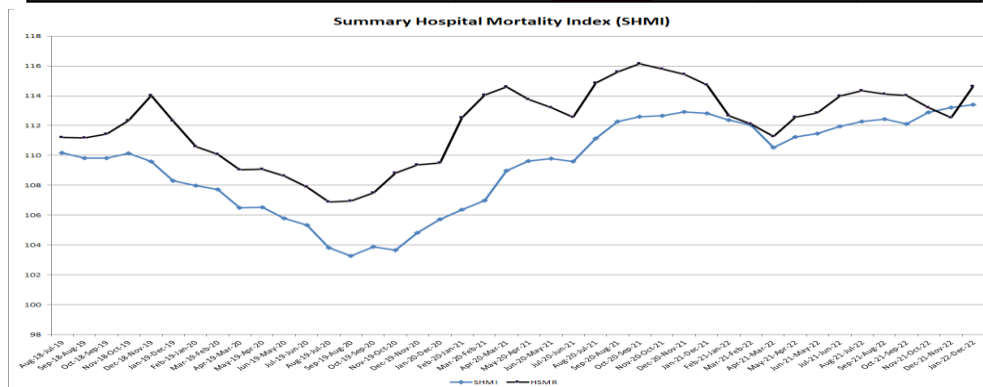
Executive Owner: Dr Hamish Mclure (Interim Chief Medical Officer)

Management/Clinical Owner: John Adams (Medical Director Governance & Risk)

Sub Groups: Quality Assurance Committee



Trust level Mortality, Jan-22 to Dec-22	Spells	Value	Observed Deaths	Expected Deaths	95% Confidence Interval
SHMI published banding (95% CL with over-dispersion)	91,325	113.4	3,510	3,095	89.76-111.41
HSMR	56,965	114.6	2,454	2,141.00	110.1-119.2



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**Background / target description:** There are two national Trust-level risk adjusted measures of mortality; the Summary Hospital Mortality Indicator (SHMI) and the Hospital Standard Mortality Rate (HSMR). These are used by NHSi and the CQC to inform the mortality alert process, and are calculated using a twelve month rolling average.

**What does the chart show/context:** The Trust SHMI for January 2022 – December 2022 was 113.4 a further increase on the previous publication and “Higher than Expected”.

**Underlying issues:** Both SHMI and HSMR use calculations based on diagnostic categories to standardise mortality rates. Whilst this is a well established process, it makes no account of disease severity and we would expect that LHT as a tertiary referral centre and Major Trauma Centre that admits the sickest patients from around the region would have a higher mortality rate than many local hospitals and the national average. The HSMR rate is released in advance of the SHMI and we anticipate SHMI will track a similar trajectory.

**Actions:** The Mortality Improvement Group will continue to monitor SHMI in terms of both absolute value, comparison with peer organisations and changes in the diagnostic group breakdown. The Group uses a step-wise investigation response outlined by NHS Digital to review any areas of statistical outlier and this on-going comprehensive review process, in addition to a deep dive undertaken earlier this year have subsequently failed to reveal any problems in care. We continue to seek assurance through statistical analysis, coding reviews, and case note analysis. The Trust have strengthened the learning from deaths framework and have a robust screening process in place, the Structured Judgement Review (SJR) methodology is used to identify learning and provide assurance on quality of care. The escalation process has also been revised to enable greater oversight of any concerns highlighted through SJRs and this will be updated in the Mortality Review Policy in November 2022. A central SJR system is currently being piloted and is scheduled for Trustwide implementation in early 2023 for greater oversight of learning themes and to provide further assurance from the SJR process.

# Patient Safety Incident Investigations (PSIRP)

**Reporting Period: 2022/23 ytd.**

**Executive Owner:** Dr Hamish Mclure (Interim Chief Medical Officer)

**Management/Clinical Owner:** Craig Brigg (Director of Quality)

**Sub Groups:** Quality Assurance Committee

National Priorities Incident Type	April 2022 to March 2023
<b>Maternity and neonatal incidents</b> which meet the 'Each Baby Counts' and maternal deaths criteria. These must be referred to HSIB for a HSIB-led PSII.	7 (HSIB)
<b>Child deaths</b> to be referred to the local Child Death Overview Panel. A PSII may also be indicated where there is reason to believe that one or more patient safety incidents/ problems in care could have contributed to the death.	5
<b>Deaths of persons with learning disabilities</b> to be referred to the local LeDeR reviewer. If a trust wishes to complete its own internal mortality review, the LeDeR initial review process is recommended; documentation is available.	0
<b>Safeguarding incidents</b> to be referred to the local safeguarding lead.	1
<b>Incidents in screening programmes</b> to be referred to the local Screening Quality Assurance Team.	0
<b>Incidents meeting the Never Events criteria 2018 (see Never Events List Feb 22)</b>	4
<b>Incidents meeting the 'Learning from Deaths' criteria</b> ie: a death clinically assessed as more likely than not due to problems in care. (This clinical assessment will have been conducted as part of a local LfD plan, or following concerns about care or service delivery).	11
<b>Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrists' mortality review guidance</b> and which have been determined by case record review to be more likely than not due to problems in care.	0
<b>Suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.</b>	0
<b>National priority total</b>	28
<b>Local Priorities - Incident Type</b>	LTHT actual 2022/23
<b>Emergent incidents</b> which justify a heightened level of response because the consequences for patients, families and carers, staff or organisations are so significant and the potential for learning is so great.	2
<b>Pressure Ulcers</b> - Thematic review of deterioration of MASD to category 2 pressure ulcer (review of 20 incidents)	1
<b>Medication</b> - Prescribing incidents concerning Enoxaparin occurring at LGI	2
<b>Obstetric Incident</b> - Postpartum Hemorrhage in excess of 1.5L requiring transfer to theatre or activation of major hemorrhage protocol	2
<b>Treatment</b> - Thematic review of failure to recognize the deteriorating patient (review of 20 incidents)	0
<b>Communication</b> - Enhanced care plans which are ineffective or not followed to prevent harm to patients including Mental Health (excluding patient falls)	0
<b>Local priority total</b>	7
<b>Grand Total</b>	35

## Background / target description:

LTHT is committed to identifying, reporting and investigating patient safety incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. Incidents that require the highest level of patient safety investigation are now identified and reported in accordance with NHS Patient Safety Incident Response Framework (PSIRF). They are patient safety incidents that occur as categorised by a number of national and local patient safety priorities.

## What does the chart show/context:

The number of incidents reported against each of the categories of the Trust's Patient Safety Incident Response Plan, where a Level 3 Patient Safety Incident Investigation (PSII) is being undertaken.

## Underlying issues:

Four never event incidents were reported in Quarter 3 2022/23.

## Actions:

Specific incidents will be identified from the Datix record for investigations to commence against the PSIRP local priorities. An updated version of the NHS Patient Safety Incident Response Framework was published by NHS England in August 2022. The new requirements and investigation tools released have been reviewed by the LTHT PSIRF Programme Board and a plan is in place to make the changes required to LTHT incident management processes prior to the national implementation date in Autumn 2023. Progress reports, including actions taken continue to be provided to Quality Assurance Committee and Quality, Safety & Assurance Group.



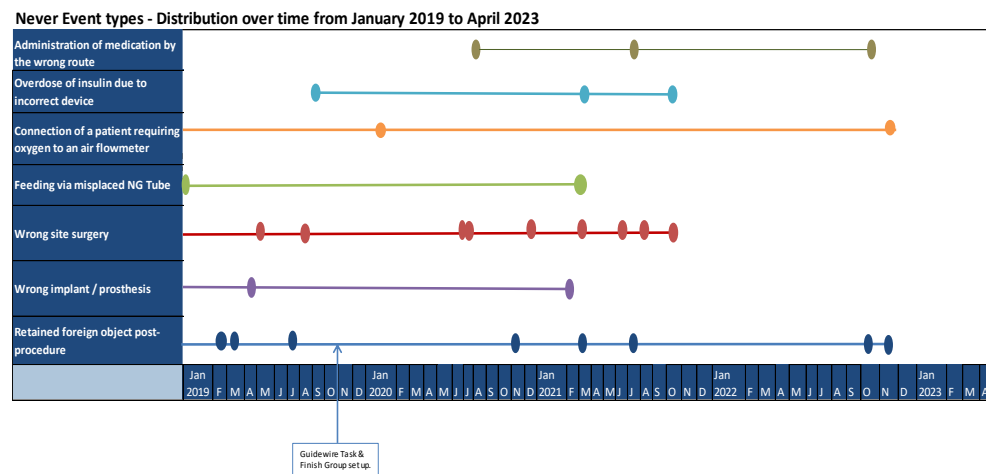
# Never Events

Reporting Period: 2022/23 ytd.

**Executive Owner:** Dr Hamish Mclure (Interim Chief Medical Officer)

**Management/Clinical Owner:** Craig Brigg (Director of Quality)

**Sub Groups:** Quality Assurance Committee



Never events by Type April 2021 to March 2023 by financial quarter

	Qtr 1 21/22	Qtr 2 21/22	Qtr 3 21/22	Qtr 4 21/22	Qtr 1 22/23	Qtr 2 22/23	Qtr 3 22/23	Qtr 4 22/23	Total
Wrong Site Surgery	1	2	1	0	0	0	0	0	4
Wrong Implant/Prosthesis	0	0	0	0	0	0	0	0	0
Retained Foreign Object Post Procedure	0	0	0	0	0	0	2	0	2
Administration of medication by the wrong route	0	1	0	0	0	0	1	0	2
Overdose of insulin due to abbreviations or incorrect device	0	0	1	0	0	0	0	0	1
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	0	0
Connection of a patient requiring oxygen to an air flowmeter	0	0	0	0	0	0	1	0	1
Total	1	3	2	0	0	0	4	0	10

## Background / target description:

Never Events are defined as patient safety Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

## What does the chart show/context:

The number of Never Event incidents reported to commissioners each quarter via the national Strategic Information System (StEIS). There were no new Never Event incidents reported in Quarter 4 2022/23. Four never event incidents were reported in Quarter 3 2022/23. Each of the incidents occurred in Never Event categories previously reported in LTHT.

## Underlying issues:

The most commonly occurring Never Events are related to failures in established checking procedures. This reflects the national profile in line with the report published by NHSE.

## Actions:

All Never Event incidents are subject to a Level 3 Patient Safety Incident Investigation (PSII). Investigations have completed and action plans are in place to prevent recurrence of these incidents. Never Event incidents are notified to commissioners and the CQC. Learning from Never Events are subject to review at the WYAAT shared learning group chaired by LTHT.

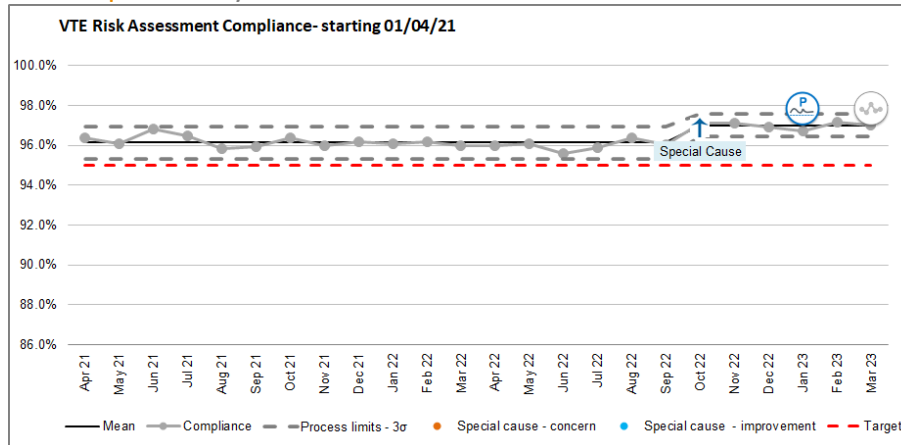
# Venous Thromboembolism Risk Assessment

**Reporting Period: March 2023**

**Executive Owner:** Dr Hamish Mclure (Interim Chief Medical Officer)

**Management/Clinical Owner:** John McElwaine (Associate Medical Director)

**Sub Groups:** Quality Assurance Committee



**Background/target description:** To Ensure a 95% VTE risk assessment completion rate

The target is for 95% of VTE risk assessments to be completed within 24 hours of admission. The Trust has historically struggled to meet this.

**What does the chart show/context:**

The Trust met the 95% target in 2021/22, for the third consecutive year

**Underlying issues:**

- Continued focus work is required to maintain Trust position
- There is a dip in compliance when junior staff rotate

**Actions:**

- Monthly review by clinical owner
- Special cause for Neurosciences- Our data suggests they are responsible for Nuffield ward 1, which does not use PPM+, and therefore has 15% of the Trust's "failure to assess VTE risk"
- Highlighting importance of VTE at junior doctor induction
- Work with CSUs that are below target, and those with negative trajectories
- Work with individual wards to utilise Safety huddles & ward rounds for VTE review
- Associate Medical Director has shared local processes from areas that are consistently achieving the target with triumvirate teams from CSUs that are struggling to achieve the target

CSU	Mar 23	YTD (2022-23)
Abdominal Medicine and Surgery	95.4%	95.0%
Adult Critical Care	98.3%	94.7%
Cardio-Respiratory	97.8%	96.9%
Centre for Neurosciences	94.7%	91.3%
Chapel Allerton Hospital	99.7%	99.5%
Childrens	94.6%	90.8%
Head & Neck	96.9%	97.4%
Institute of Oncology	97.6%	97.9%
Leeds Dental Institute	100.0%	100.0%
Non LTHT Activity	-	100.0%
Not Known	0.0%	81.3%
Operations Centre	100.0%	94.4%
Radiology	90.5%	96.4%
Research and Innovation	100.0%	99.9%
Specialty & Integrated Medicine	96.3%	96.8%
Theatres & Anaesthesia	96.9%	95.1%
Trauma and Related Services	97.1%	96.0%
Urgent Care	96.8%	97.3%
Womens	94.7%	95.0%
<b>Trust</b>	<b>97.0%</b>	<b>96.5%</b>



## Reporting Period: April 2023

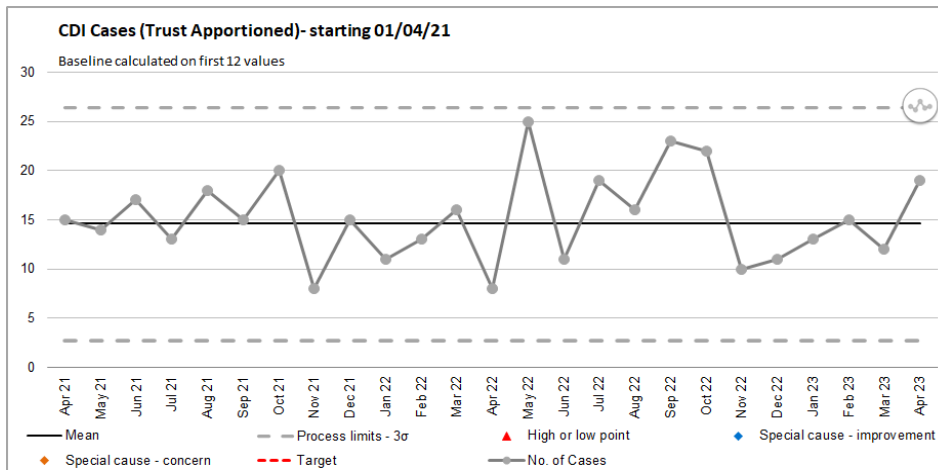
**Executive Owner:** Helen Christodoulides(Chief Nurse/DIPC)

**Management/Clinical Owner:** Gillian Hodgson (Deputy Director of Infection Prevention and Control(DIPC)

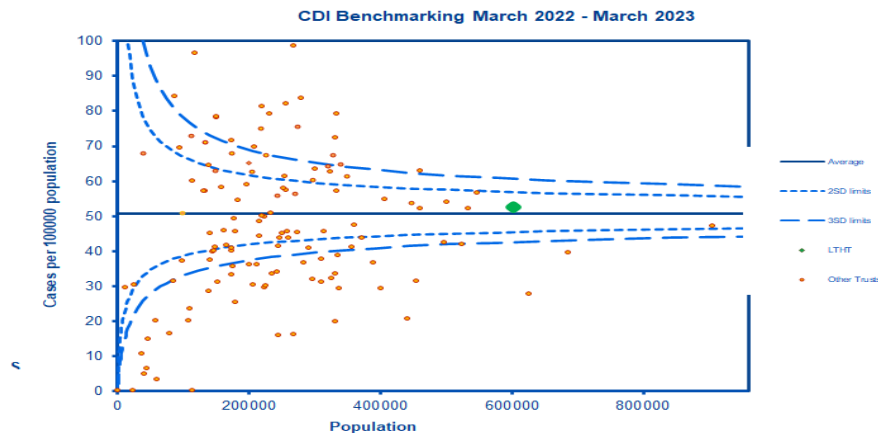
**Sub Groups:** Quality Assurance Committee

Target	Trajectory	Assurance	Variation
NA	NA	R	CC

Month	CDI - Hospital Onset Healthcare Associated (HOHA) (actual)	CDI - Community Onset Healthcare Associated (COHA) (actual)	CDI (Subtotal)	CDI (National objective)
Apr-23	15	4	19	TBC



Data as at 09/05/23



### Background / target description:

The NHS Standard Contract 2023/24 - Minimising *Clostridioides difficile* (CDI) and Gram-negative Bloodstream Infections has not yet been received by the organisation.

### What does the chart show/context:

The first chart shows Trust apportioned CDI cases from April 2021 to April 2023 and shows continued variation with an increase above the mean for the first time in 6 months.

The second chart with date range March 2022 to March 2023 shows LTHT position is close to the national average when compared to other peer organisations.

### Underlying issues:

The underlying issues continue to include competing priorities for isolation rooms, operational challenges to delivering Hydrogen Peroxide Vapour (HPV) for environmental decontamination and antimicrobial stewardship.

### Actions:

A 'rapid bundle' approach to support wards with high frequency of CDI cases is being tested, this includes additional antimicrobial stewardship, cleaning, IPC audit and educational support. Development of a robust clinical IPC/AMS leadership Model including a new Medical AMS lead role and delivery of workstreams to support the IPC standards and Antimicrobial stewardship elements within the HCAI annual commitment utilising LIM Methodology.

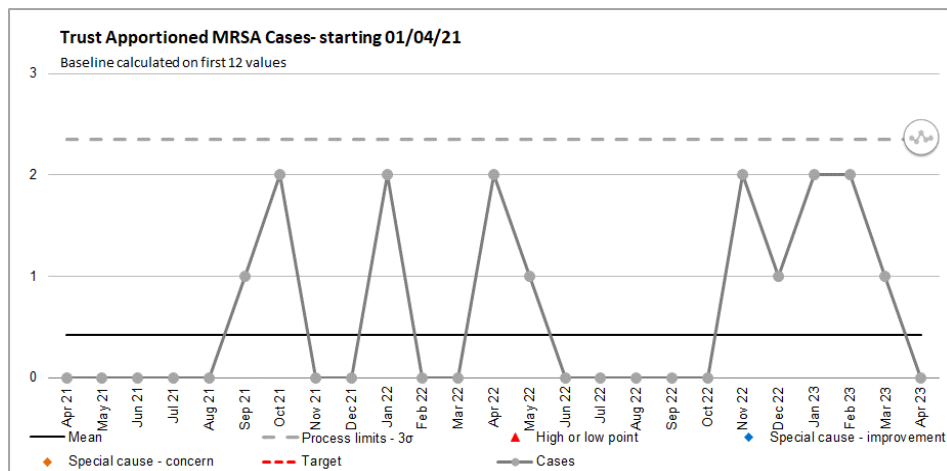
## Reporting Period: April 2023

**Executive Owner:** Helen Christodoulides (Chief Nurse/ Director of Infection Prevention and Control)

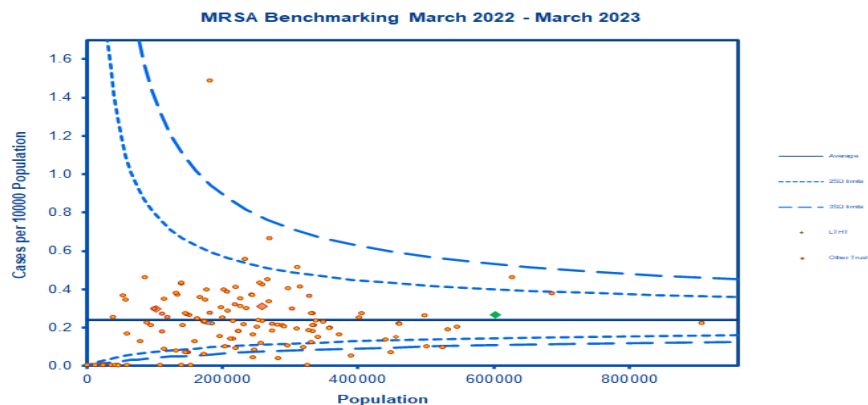
**Management/Clinical Owner:** Gillian Hodgson (Deputy DIPC)

**Sub Groups:** Quality Assurance Committee

Target	Trajectory	Assurance	Variation
Y	NA	R	CC



Data as at 09/05/23



### Background / target description:

The National 'zero tolerance' approach to MRSA bloodstream infections continues. A post infection review (PIR) takes place for all cases of MRSA bloodstream infections recorded at the Trust.

### What does the chart show/context:

The first chart with a date range April 2021 to April 2023 shows that LTHT recorded no cases in April and has fallen below the mean for the first time in 6 months. At the time of writing this update, it has been 70 days since the last recorded case at LTHT. The second chart with date range March 2022 to March 2023 records our position nationally shows that LTHT is tracking above the national average.

### Underlying issues:

Surgical site infection, screening of additional sites and checking of sensitivities for the correct decolonisation to be prescribed or changed continue to remain key issues.

### Actions:

A Quality & Safety Matters Briefing: Keeping Patients Safe from MRSA Bloodstream Infection was distributed trust wide In April. CSU's that have recorded an MRSA Bacteraemia have attended the Operational Infection Control Group (OIPC) to identify themes and trends following the Post Infection Reviews. A number of workstreams have been identified following this which will form part of the CSU HCAI annual commitment response.

## Reporting Period: April 2023

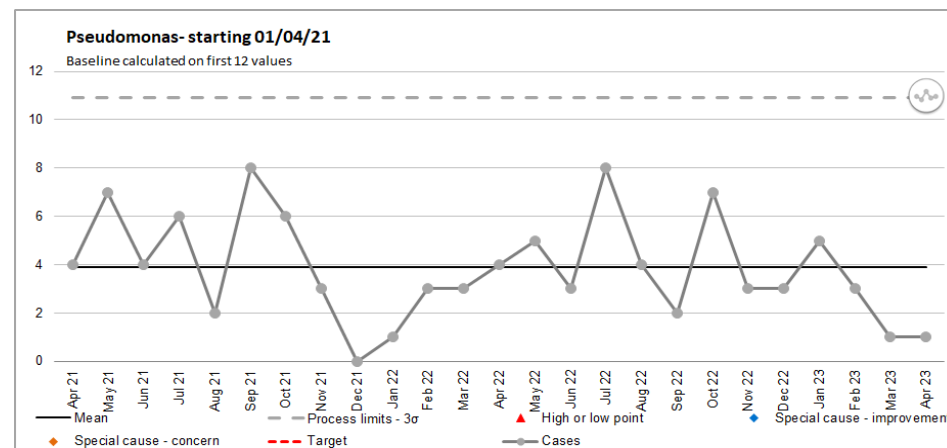
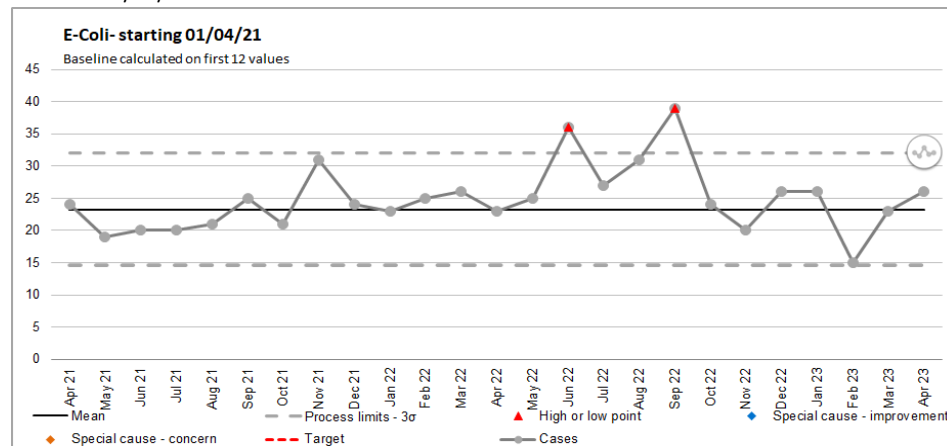
**Executive Owner:** Helen Christodoulides (Chief Nurse/ Director of Infection Prevention and Control)

**Management/Clinical Owner:** Gillian Hodgson (Deputy DIPC)

**Sub Groups:** Quality Assurance Committee

Target	Trajectory	Assurance	Variation
Y	Y	R	CC

Data as at 09/05/23



### Background / target description:

The NHS Standard Contract 2023/24 - Minimising *Clostridioides difficile* (CDI) and Gram-negative Bloodstream Infections has not yet been received by the organisation.

### What does the chart show/context:

The chart with a date range of April 2021 to April 2023 shows LTHT's position which demonstrates variation around the mean.

### Underlying issues:

The root cause of infection differs between CSU's and overlaps with *Klebsiella* spp. infections.

### Actions:

A multi resistant Gram-negative bacillus group established pre pandemic recommenced in April 2023, the core members include laboratory, IPC, clinical research and pharmacy colleagues.

Development of workstreams to support the IPC standards and Antimicrobial stewardship elements within the HCAI annual commitment utilising LIM Methodology.

### Background / target description:

The NHS Standard Contract 2023/24 - Minimising *Clostridioides difficile* (CDI) and Gram-negative Bloodstream Infections has not yet been received by the organisation.

### What does the chart show/context:

The chart with the date range April 2021 to April 2023 shows LTHT has demonstrated a reduction in cases, continues on a downward trend below the mean plateauing.

### Underlying issues:

There are no current underlying issues. Early indication suggest the Trust's current approach to water safety may be having an impact.

### Actions:

Water safety walkabouts in augmented care areas continue and clinical areas are being asked to develop their own water assurance processes monthly. Development of workstreams to support the IPC standards and Antimicrobial stewardship elements within the HCAI annual commitment utilising LIM Methodology.

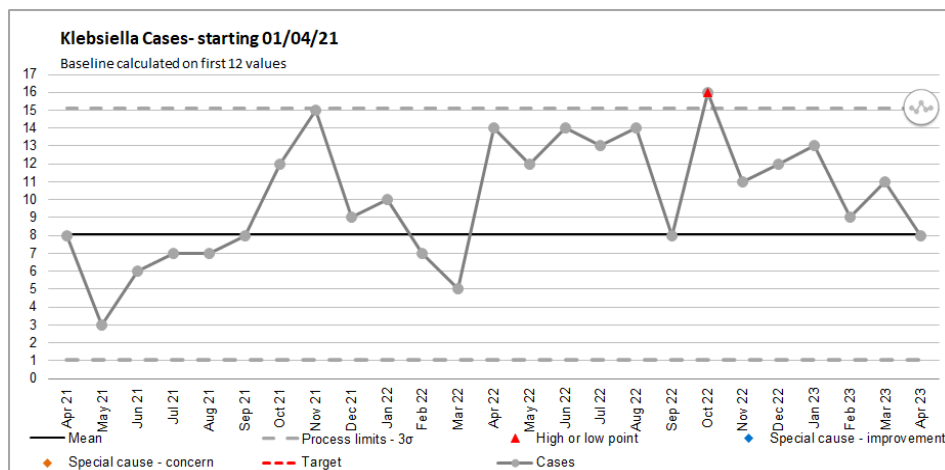
## Reporting Period: April 2023

**Executive Owner:** Helen Christodoulides Chief Nurse/ Director of Infection Prevention and Control)

**Management/Clinical Owner:** Gillian Hodgson (Deputy DIPC)

**Sub Groups:** Quality Assurance Committee

Target	Trajectory	Assurance	Variation
Y	Y	R	CC



Data as at 12/05/23

### Background / target description:

The NHS Standard Contract 2023/24 - Minimising *Clostridioides difficile* (CDI) and Gram-negative Bloodstream Infections has not yet been received by the organisation .

### What does the chart show/context:

The chart with the date range of April 2021 to April 2023 shows LTHT's position which demonstrates a slight decline but remains on the mean .

### Underlying issues:

The root cause of infection differs between CSU's and overlaps with E. coli infections. Current investigation findings suggest prophylaxis on insertion of catheter may have a role.

### Actions:

The role of prophylaxis around catheterisation to be discussed at the Invasive Devices group. Investigation analysis of Gram-negative bacteraemia includes evidence that device related infection, urinary catheters and intra vascular access devices are a concern.

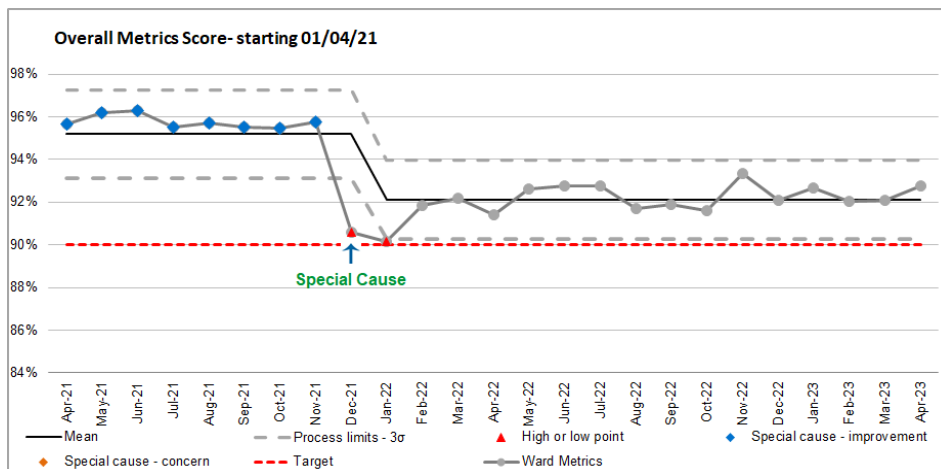
Development of workstreams to support the IPC standards and invasive device management elements within the HCAI annual commitment utilising LIM Methodology

Reporting Period: April 2023

Executive Owner: Helen Christodoulides (Chief Nurse)

Management/Clinical Owner: Katie Robinson (Associate Director of Nursing)

Sub Groups: Quality Assurance Committee



Indicators	Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
<b>Safe</b>													
Overall Metrics Score **	>=90	92.6%	92.8%	92.8%	91.7%	91.9%	91.6%	93.4%	92.1%	92.7%	92.0%	92.1%	92.8%
Falls	N/A	186	179	212	181	195	209	212	232	212	210	224	216
Falls Resulting in Moderate Harm and Above	=0	4	9	8	6	7	10	11	16	11	8	9	14
Falls Assessment (Metrics)	>=90	90.9%	90.7%	89.2%	88.4%	89.1%	89.3%	91.0%	88.4%	90.7%	89.7%	89.8%	91.1%
Pressure Ulcers (Grade 2) (developed)	=0	82	48	69	76	60	60	52	76	69	61	54	76
Pressure Ulcers (Grade 3 & 4) (developed)	=0	7	0	4	8	1	2	3	6	0	0	5	4
Pressure Ulcers (U) and Deep Tissue Injury (developed)	=0	5	9	3	12	6	12	9	12	8	9	6	10
Pressure Area Care (Metrics)	>=90	92.5%	91.5%	91.5%	91.1%	88.8%	89.0%	92.3%	91.3%	90.5%	90.8%	89.5%	89.9%
<b>Caring</b>													
Mixed Sex Accommodation Breaches	=0	267	242	214	242	195	225	245	191	202	178	239	163

Target	Trajectory	Assurance	Variation
Y	NA	P	CC

## Background / target description:

The Perfect Ward dashboard is a standardised framework for monitoring, reviewing and evaluating data, based against patient safety and experience indicators. The expected Trust standard is above 90%. The ward Healthcheck metrics which feeds into the Perfect Ward is an audit of wards and departments across a range of key areas reflecting the standards of care.

## What does the chart show/context:

The run chart illustrates a small increase in the Trust average Healthcheck metrics score for April 23 to 92.8% when compared to March, this continues to be above the mean and remaining above the Trust standard of 90%. This small increase is reflective of education regarding metric standards.

## Underlying issues & Actions (by exception):

The amendments include;

- The falls metrics scores have achieved the Trusts expected standard of 90% in April 23, and is comparable with a reduction in falls. The improvement is due to work of the falls collaborative regarding Lying and Standing BP and promotion of the falls interventions.
- The pressure ulcer metrics score for March and April 23 has reduced to below the expected standard of 90%. This decrease in metrics scores is reflected in the increase of pressure ulcers due to patient acuity and staffing mix.
- Reporting of Mixed Sex Breaches widened to include further areas such as HASU, CCU, HOBs areas in addition to ACC in May 22. The number of reported of mixed sex breaches reduced by 76 in April 23. This is due to a standardised approach for reporting of justified or unjustified breaches been introduced and compliance of reporting improved. There has been no PALS complaints regarding mixed sex breaches.

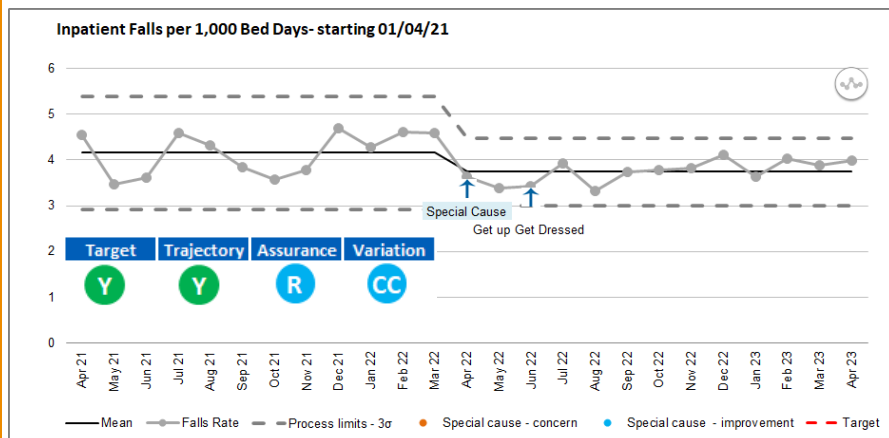
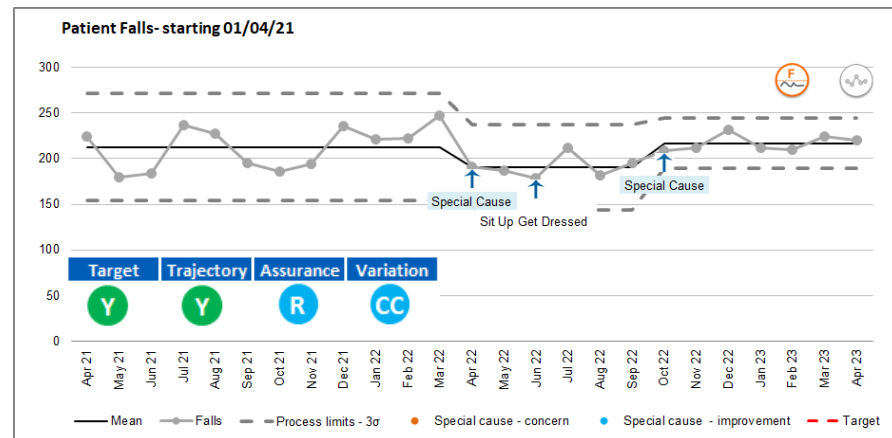
# Harm Free Care - Falls

**Reporting Period: April 2023**

**Executive Owner:** Helen Christodoulides (Chief Nurse)

**Management/Clinical Owner:** Katie Robinson (Associate Director of Nursing)

**Sub Groups:** Quality Assurance Committee



## Background / target description:

The prevention of falls is a Trust patient safety priority for 2022/23.

## What does the chart show/context:

During March and April 23, 440 patient falls were reported, of which 16 resulted in moderate harm or above. All are investigated using an RCA or Stop the Line method. In April 23 the falls rate increased above the mean but remained within the control limits, winter pressures are a contributing factor for the increase.

The Trust has maintained a reduction in the rate of falls for Q1 2023, noting that the rate of falls per 1,000 bed days in April has risen above the mean. Contributing factors for the increase in falls are associated with the increase admissions, staff shortages, increased length of stay and increase in patients requiring enhanced care.

## Actions:

- The Trust 'Falls Collaborative' remains active along with the Trust Falls Prevention Group. The falls QI bundle is currently scaled up Trust wide and continue to trial new interventions and review its progress.
- The escalation process for accessing Rescue kit has been agreed and the flowchart is ready to be launched.
- Approval for the purchase of a new falls rescue kit, expected to be completed within the current financial year and will be launched alongside the escalation process above.
- To continue sharing learning from falls RCA's through the circulation of Lessons Learnt bulletins Trust wide.
- Deputy Chief Nurse meets with local teams to review actions where falls with moderate harm are deemed to be avoidable.
- The Patient Safety team to support ED with quarterly Falls Prevention & Quality Improvement Review visits to ensure improvement action plans are reviewed regularly and support plans put in place.
- A Specialist Review Framework document has been trialled and feedback from three CSUs obtained. The document and investigation process is being reviewed in line with the induction of the Patient Safety Framework.
- The patient safety team are providing training and education to ward staff.

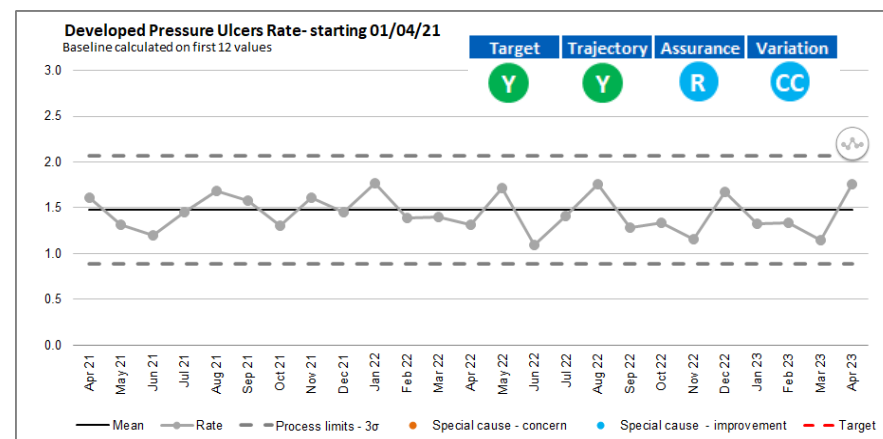
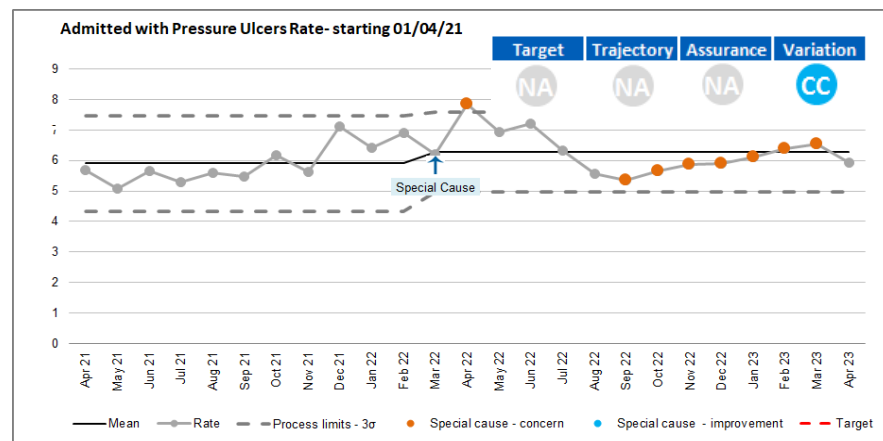
# Harm Free Care - Pressure Ulcers

Reporting Period: April 2023

**Executive Owner:** Helen Christodoulides (Chief Nurse)

**Management/Clinical Owner:** Katie Robinson (Associate Director of Nursing)

**Sub Groups:** Quality Assurance Committee



**Background / target description:** The prevention of hospital acquired pressure ulcers remains a Trust patient safety priority for 2023/24.

## What does the chart show/context:

During March and April 2023, 155 hospital acquired pressure ulcers were reported, of which 21 resulted in moderate harm or above. These are all being investigated using the Stop the Line, RCA process, or the new PSIRF template, depending on the severity of harm.

The Trust continues to see month on month variation in pressure ulcer numbers, either just above or below the mean per 1000 bed days. Year end the Trust achieved a 0.6% reduction in hospitals acquired pressure ulcers for 2022/23.

Admitted with pressure ulcers remain within the upper and lower control limits. As part of the citywide work, LHT have made changes to how staff report admitted with pressure damage and these are now embedded across the Trust.

Pressure ulcer numbers remain above pre pandemic levels, with contributing factors including increased admissions and bed occupancy, staff shortages, increased length of stay and patients requiring enhanced care/acuity.

## Actions:

- The pressure ulcer collaborative continues to meet monthly, promoting the tests of change across a number of wards as part of the PU bundle.
- The tissue viability team continue to promote closer links with CSU's and wards as part of project work, particularly where there has been an increase in pressure ulcers to promote collaborative working.
- Deputy Chief Nurse continues to meet with local teams to review the actions from PU investigations where lapses in care and with moderate harm or above were identified.
- Level 1 eLearning for pressure ulcer training compliance is currently at 82% (green) and 84% (green) for level 2.
- The Trust Pressure Ulcer and Tissue Viability Strategic group receive assurance from CSU's throughout the year regarding their internal pressure ulcer reduction action plans. These are presented to the group on a rolling monthly programme.
- As part of the City wide work to standardise PU training, across the system. The eLfh online eLearning PU training package is now available across the Trust.
- Agreement from Oncology to pilot the new patient safety incident reporting framework (PSIRF) for PU's from 1<sup>st</sup> June with plans to roll out Trust wide later in 2023/24.



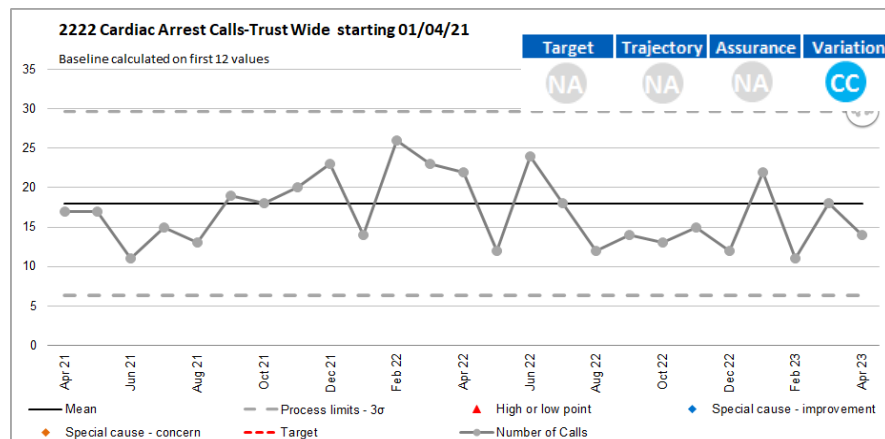
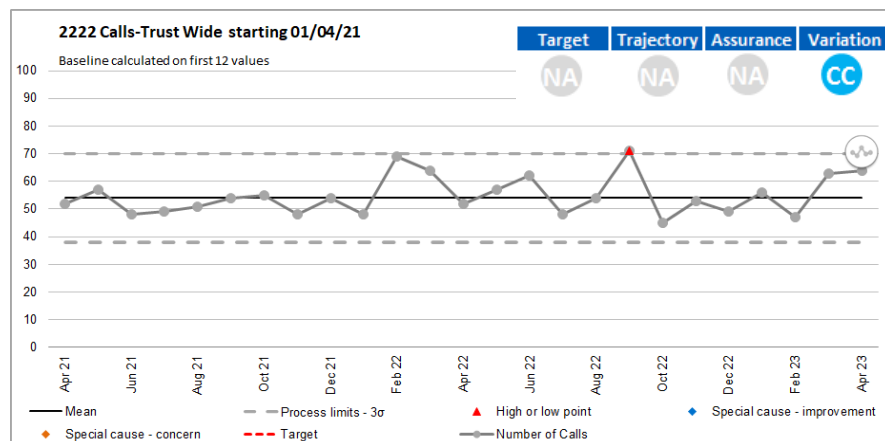
# Responding to Risk – 2222 Calls

Reporting Period: April 2023

**Executive Owner:** Dr Hamish Mclure (Interim Chief Medical Officer)

**Management/Clinical Owner:** Dr Anna Winfield (Specialist in Elderly Medicine and Quality Improvement) /Dr Ali Cracknell (Consultant for Older People and Associate Medical Director for QI)

**Sub Groups:** Quality Assurance Committee



**Background:** In June 2014 14 collaborative wards were identified to utilise the model for improvement as a framework for testing new interventions to reduce avoidable deterioration.

In June 2015 five key successful interventions developed and tested by these teams formed an “intervention bundle” and this bundle was tested at scale across the 14 Collaborative wards. This “intervention bundle” has proven across the Collaborative wards to reduce harm, and improve the quality and reliability of our care.

By November 2015 analysis showed a significant step reduction in 2222 calls on these wards, with earlier response to deterioration and earlier identification of patients approaching end of life.

From 2016 onwards the work has been scaled up CSU by CSU.

**What does the chart show/context:** Both charts show a statistically significant reduction in 2222 calls (16% Improvement) and Cardiac arrest calls (31% Improvement) across the Trust. These improvements have been sustained.

**Underlying issues:** The early identification of the Deteriorating Adult has led to an unintended consequence of a reduced confidence when attending Cardiac Arrests. This has been addressed through additional training where required.

**Actions:** Work will continue to focus on the CSU’s with the largest number of 2222 calls.

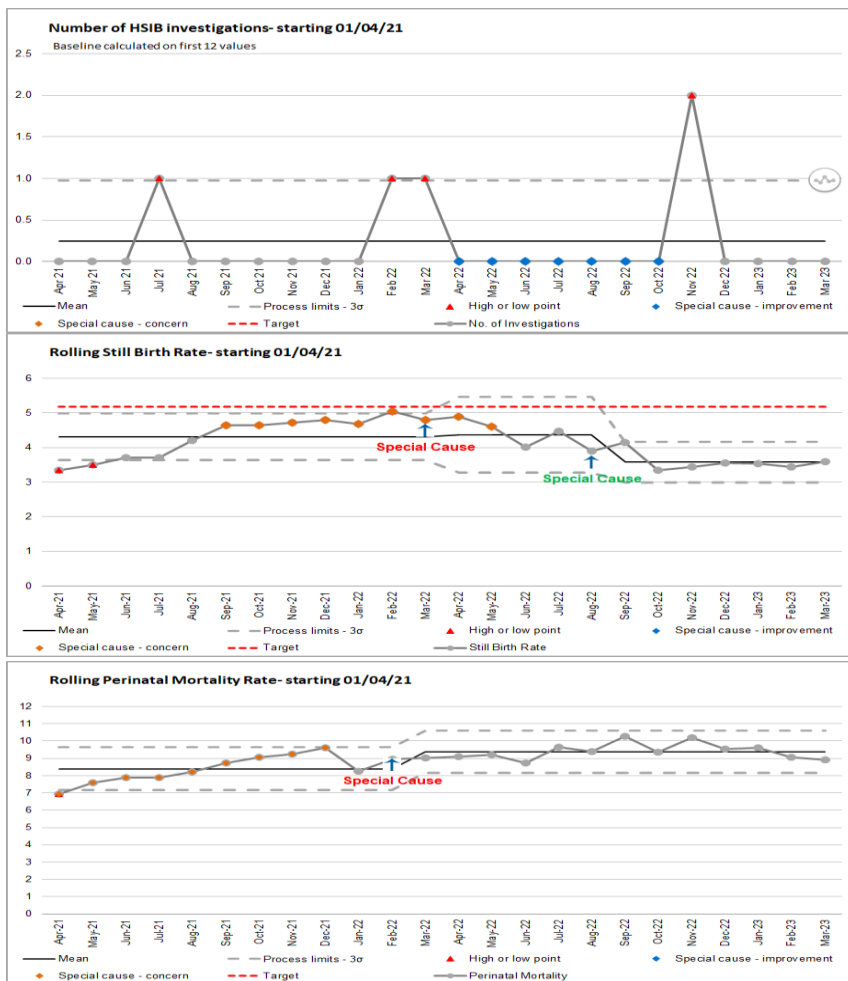


## Reporting Period: March 2023

**Executive Owner:** Helen Christodoulides (Chief Nurse)

**Management/Clinical Owner:** Susan Gibson (Director of Midwifery)

**Sub Groups:** Quality Assurance Committee



### March 2023

#### HSIB referrals

1 new case referred to HSIB in March 2023 associated with a NND in community, this case is also under coronial review.

#### Neonatal deaths

There have been 5 neonatal deaths in the reporting period:

- 1 had known congenital abnormalities,
- 1 TOP born with signs of life
- 1 SUDIC as per HSIB referral above
- 1 extreme prematurity
- 1 severe placental insufficiency and growth restriction.

#### Stillbirths

There have been 4 stillbirths in March 2023.

- 1 significant complications from 20 weeks gestation
- 1 inutero transfer of critically ill mother from outside of region with associated fetal loss
- 1 presented with reduced fetal movements, initially normal fetal monitoring and then reattended and IUD confirmed.
- 1 presented for admission for IOL for GDM and IUD noted on arrival

There is no statistically significant change in the stillbirth rate. However the rolling stillbirth rate has demonstrated a downward trend since January 2022.

All of these cases will be fully reviewed through the PMRT process by a multidisciplinary team and actions developed accordingly.

#### Moderate Harms

There were 40 moderate harm incidents reported in March. All cases have been reviewed and Duty of Candour letters have been sent. The common incidents remain postpartum haemorrhage, unexpected admission to the neonatal unit and Obstetric Anal Sphincter injury.

**Serious incidents** – There have been no other serious incidents identified March 2023.

# Patient Environment – Patient Catering

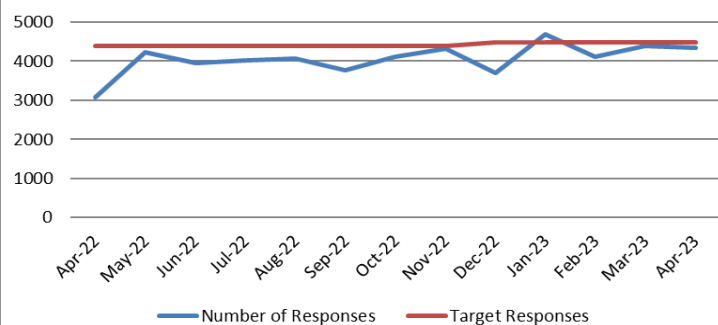
Reporting Month: May 2023

**Executive Owner:** Craig Richardson (Director of Estates & Facilities)

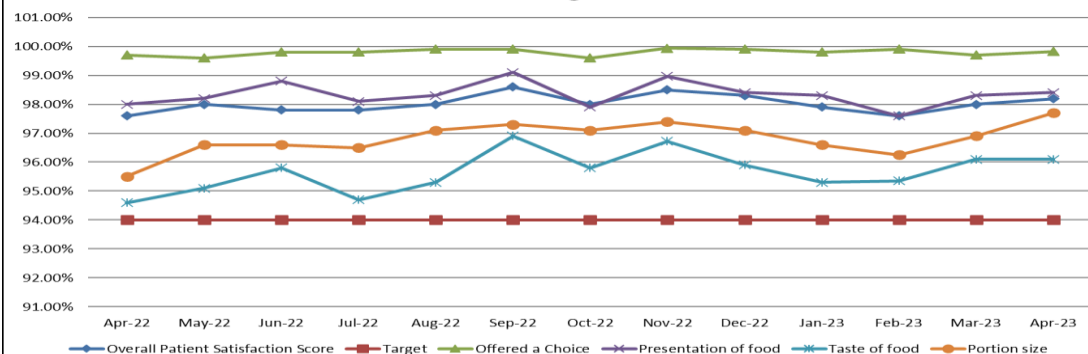
**Management/Clinical Owner:** Chris Ayres (Associate Director Facilities Operations)

**Sub Groups:** N & HC SG

## Survey Response Rate



## Patient Catering Satisfaction



### Background:

We proactively seek feedback directly from our patients with regards to the service we offer, particularly around the standard of service, choice range and quality. We routinely receive over 3500 patient satisfaction surveys each month across our hospitals (SJUH, LGI & Chapel Allerton) regarding the patient meal experience..

### What does the chart show/context:

The response rate has dipped slightly under the target across all combined areas (4341 Vs target of 4494), the satisfaction scores have increased in most areas or remained overall the same, the second graph shows that we are still exceeding the target for Patient satisfaction across 12 different service review areas. The survey asks 12 different questions covering: offered a choice, healthy options, presentation of food, taste, temperature, portion size, ease of ordering, menu style, meal times, attitude of staff and overall satisfaction of the service. These separate questions are used to calculate the above overall score which is shown as an average across all questions.

**Underlying issues:** On going post COVID related supplier issues, with regards to the delivery and manufacture of chilled ready to eat items continue and has resulted in numerous short notice changes to the food items supplied to Patients. The main frozen delivery meals provider over the last 2 months has also encountered significant problems resulting in high level of short notice substitution of items. The nutritional requirements and quality of product has never been compromised or reduced during this time. Whilst there is a high degree of satisfaction with the patient catering service, there remains a pre-conceived perception of hospital food.

**Actions:** Continue to proactively monitor patient satisfaction and react to unfavourable menu items as required. Continue to work with suppliers and manufacturers to proactively drive up patient satisfaction, in respect of taste and quality, to match the delivery and range of food scores that we achieve.

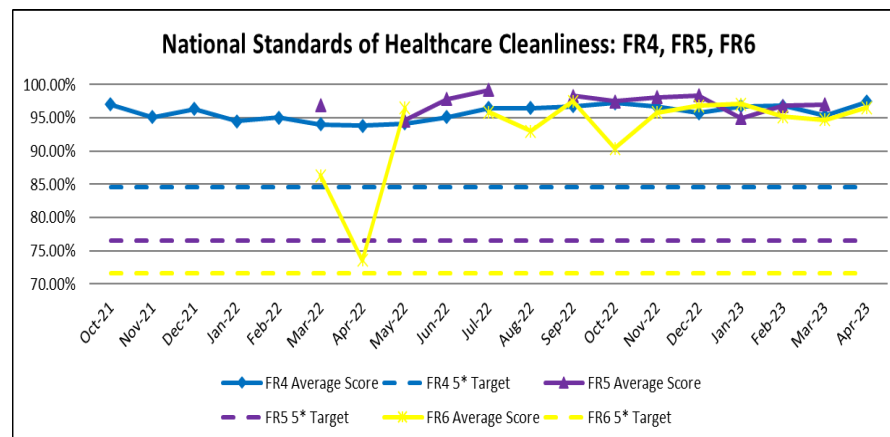
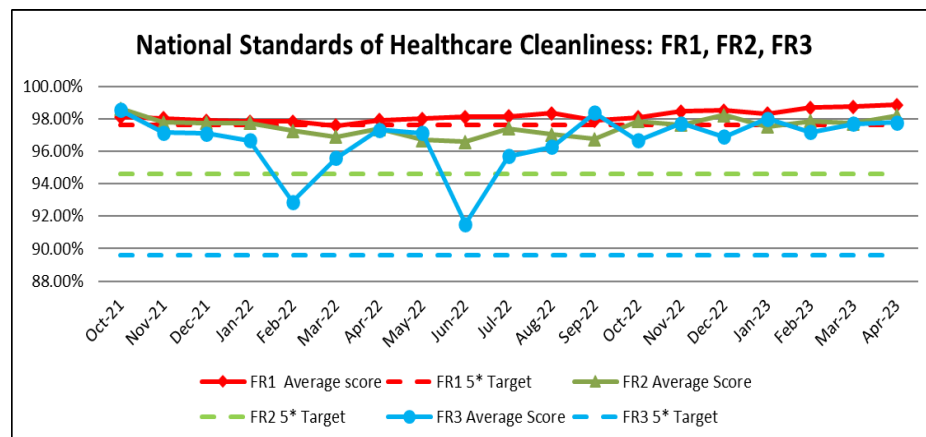
# Patient Environment - Cleaning

**Reporting Month: May2023**

**Executive Owner:** Craig Richardson (Director of Estates & Facilities)

**Management/Clinical Owner:** Chris Ayres (Associate Director Facilities Operations)

**Sub Groups:** HCAI and IPCC



**Background: Cleaning:** A range of independent measures are used to ensure the provision of a clean and safe environment. The National Standards of Healthcare Cleanliness (NSoHC - 2021) have been fully implemented within the required time frame. Risk ratings are now calculated across 6 risk categories FR1 to FR6, as well as a percentage cleanliness score. Areas are given a star rating between 1 star (poor) and 5 star (excellent).

(FR1 (e.g. HDU/ Theatres) are audited twice a month, FR2 (e.g. All General Wards) are audited monthly, FR3 (e.g. Departments) are audited every 2 months, FR4 (e.g. OP Clinics) are audited quarterly, FR5 (e.g. Low risk departments i.e. Medical Physics) are audited every 6 months and FR6 (e.g. Very low risk departments; i.e. Medical Records) are audited annually.)

**What does the chart show/context:** In previous reporting periods and in line with NSoHC scheduling, all FR1 to FR6 areas have been audited. The Trust remains above the national targets in all functional risk areas.

**Underlying issues:** The standard of cleaning has remained high throughout the year with additional cleaning requirements remaining in place due to localised infection outbreaks. The NSoHC have been in place excess of 12 months, with the audit results showing a positive improvement. Final phases of the NSoHC have been implemented and the Trust collaborated with Sheffield to successfully complete the external cleaning audit. Resources remain under pressure from surges in activity and fluctuating infection rates in the community.

**Actions:** Continue to flex cleaning resources, methodologies and frequency to meet the ever changing demand. Continue to deliver the final elements of NSoHC, comprising additional services to implement as part of final stages of the new standards; wall washing and 'pop up' / enhanced cleaning teams, to deal with localised infection outbreaks. In May, to implement new HPV technology 'ProXcide' for swifter bed space turn around for red cleans.

# Patient Environment - Portering

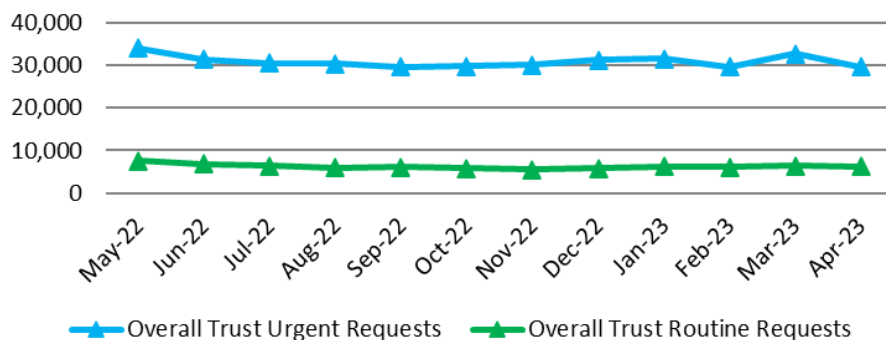
Reporting Month: May 2023

**Executive Owner:** Craig Richardson (Director of Estates & Facilities)

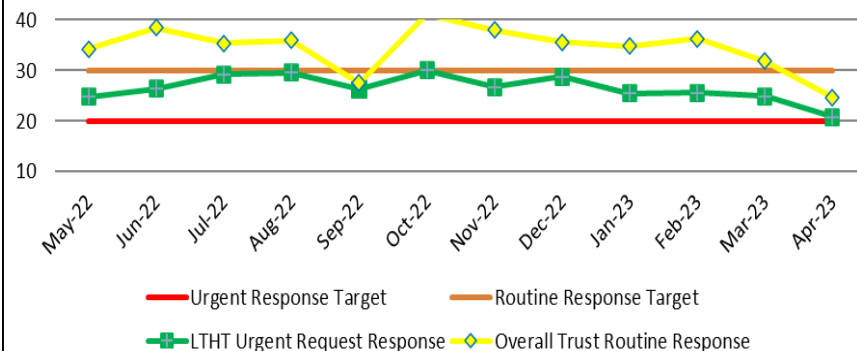
**Management/Clinical Owner:** Chris Ayres (Associate Director Facilities Operations)

**Sub Groups:** HCAI and IPCC

## Patient Movement



## Portering Response Times



**Background:** This graph summarises the patient movement related activity which the Trust porter teams respond to.

### What does the chart show/context:

Activity in this reporting period has remained relatively unchanged, with the demand on services remaining high due to surges in activity. To support activity some patient movements are carried out directly under the instruction of clinical area, such as in Radiology, removing the need for them to be recorded via the porter management system, with direct deployment within department. This does mean that these movements are not included in the above data set. Overall response times remain constant and have improved modestly in month.

### Underlying issues:

Ad hoc short notice requests as the Trust reacted to the changing position regarding patient flow. There continues to have been unexpected spikes in activity in month, due to ED department attendances. Staffing has improved, but the challenge in effective attendance management remains.

### Actions:

Porter activity is flexed as required to support the need for rapid discharge and to support patient flow.

Reporting Month: May 2023

**Executive Owner:** Craige Richardson (Director of Estates & Facilities)

**Management/Clinical Owner:** Peter Aldridge (Associate Director Estates Operations)

**Sub Groups:** PPRG, RMC



**Background:** This graph summarises the security related activity that the teams respond to.

**What does the chart show/context:** Both physical and non-physical assaults on staff have seen an decrease. Additional resource continues to be deployed within the ED's on both sides of the city which is assisting in reducing the impacts and longevity of incidents. Interviews for a Violence Prevention and Reduction Co-ordinator are taking place in May 23. Revised DATIX reports are now produced monthly and a key role of the VPR Co-ordinator will be to carry out a thematic review and identify root causes of incidents. There has been an increase in patient/staff welfare checks, which is in part as a result of our drive to provide a "safe and secure environment" for patients, visitors and colleagues which is positive as the Team deliver a responsive service to staff welfare. ASB incidents have seen a continued increase and interactions with partner agencies continue. Other Incidents show an increase, these incidents include fire calls, assisting in car parking operations and lost property issues. Of the other incidents MISPERs are included and work with CSU's continues on this issue. Vehicle crime remains low, and there has been a drop in thefts.

**Underlying issues:** Analysis of security activity data continues so resources can be deployed in a proactive manner. Wide stakeholder work continues internally to address the violence and aggression issues and partnership work with external agencies continues to address ASB. Security Teams have an increased presence in "hot spot areas".

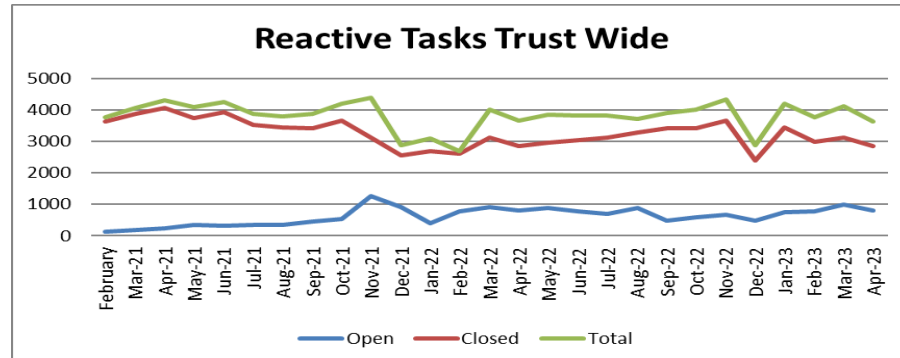
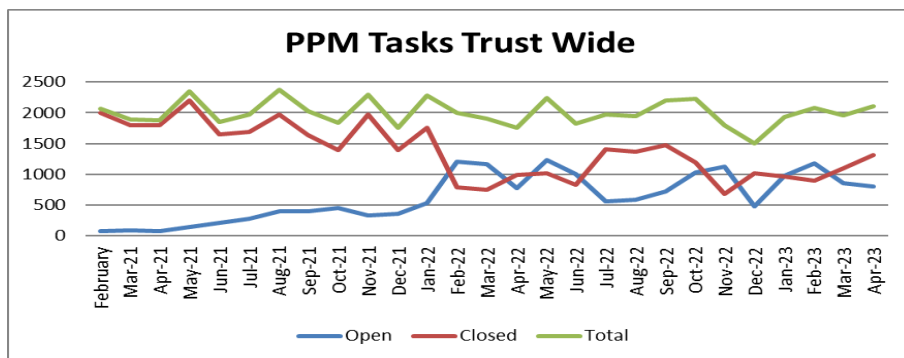
**Actions:** Work continues with our "challenging behaviours collaboration" to seek a reduction in assaults. Our focus on data and metrics provides further assurance and governance from the violence prevention and reduction steering group. Team working with corporate nursing colleagues continues in order to reduce missing patient calls.

Reporting Month: May 2023

**Executive Owner:** Craig Richardson (Director of Estates & Facilities)

**Management/Clinical Owner:** Peter Aldridge (Associate Director Estates Operations)

**Sub Groups:** Estates & Facilities F&P



## Background:

The graphs show the number of planned preventive maintenance (PPM) and reactive maintenance (logged on helpdesk) tasks completed and those awaiting completion by month. There are no Estates issues that are impacting on the ability to deliver clinical services.

## What does the chart show/context:

The total number of PPM's is not the same each month as the frequency of PPM's is not uniform across the year. There continues to be an increase in PPM's closed off. Reactive maintenance usually follows a similar trajectory each month however, there has been a slight decrease in the number of reactive tasks logged. The number of open jobs remains constant.

## Underlying issues:

All clinical areas of the Trust continue to be under pressure and accessing these areas remains a challenge, as does the need for the workforce to be flexible in terms of responding to changes to the estate at short notice. The teams have provided a response to reset and recovery, unprecedented system pressures, CQC inspections, service changes, capital commitments, HoTF, GSC completion and BtLW challenges. Being responsive to recovery actions is at times challenging, as it restricts the ability to focus on PPM and reactive tasks.

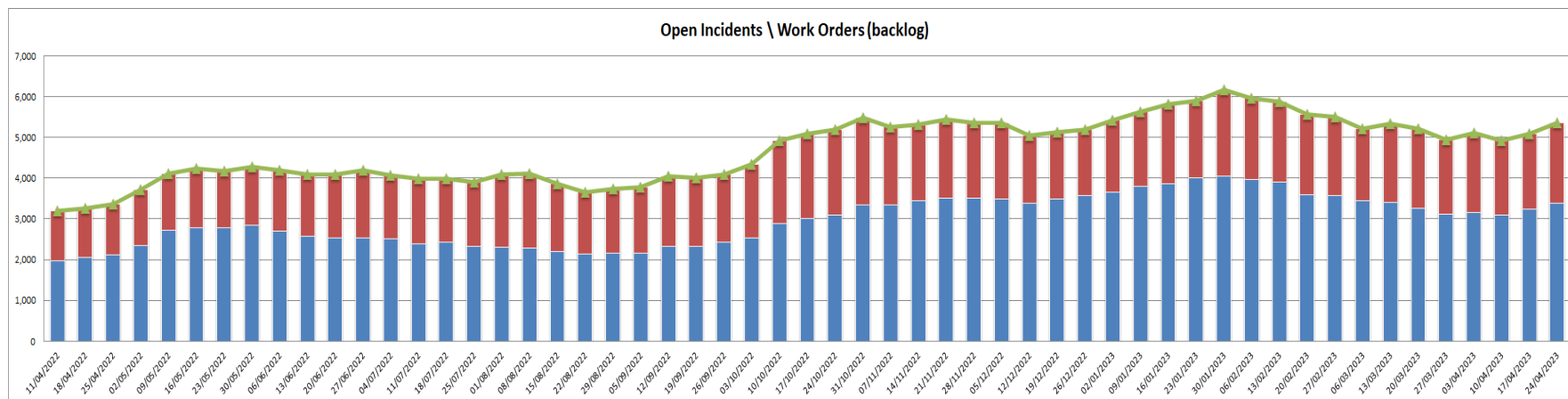
## Actions:

- The team will continue to focus on PPM and reactive maintenance and will flex resources to balance increased activity and outstanding tasks. Trailing combined roles at peripherals and cross trade working – continues and remains under review.
- Continue to work to address issues with the estates management system (K2) as some jobs are potentially sitting in the system that have been completed or duplicated – LIM methodology workshop has held in April to focus on this issue – findings now being implemented
- Continue to work on the Workforce Strategy to focus on deployment of resources, high vacancy numbers at SJUH is affecting reactive/PPM tasks and compliance

# Service Delivery (Backlog)

Reporting Month: April 2023

Sub Groups: DIT Committee



## Background/Description:

Backlog refers to the number of outstanding or unresolved Incidents and Work Orders. When demand outstrips the ability to service these requests, there will be an increase in the overall backlog number.

## What does the chart show:

The overall backlog trend is increasing.

## Underlying Issues:

The legacy hardware and software issues within the End User Compute environment is a key driver in the backlog. It is anticipated that completion of the EUCMP will have a positive impact on the backlog and future trend. There has also been an increase in System Administration and accommodation requests to support estates changes and operational requirements.

## Actions:

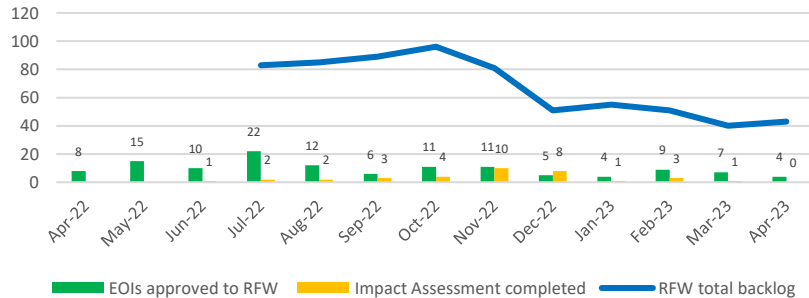
Weekly review sessions are now in place across key resolver teams to understand demand drivers and identify improvement opportunities. The EUCMP now includes a weekly operational review of the impact of the programme on BAU ticket numbers.



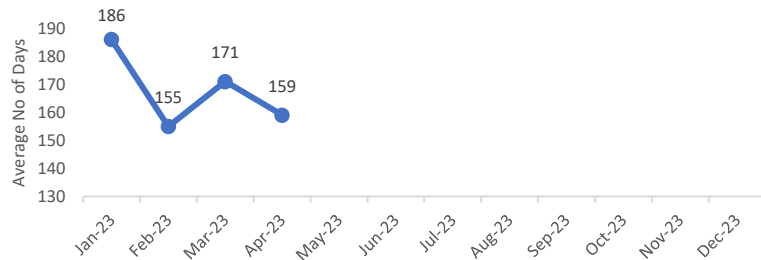
## Reporting Month: End of April 2023 position

The Project Delivery Lifecycle tracks Projects through a 7 Stage Process from Expression of Interest (EOI) to Project Closure on successful delivery.

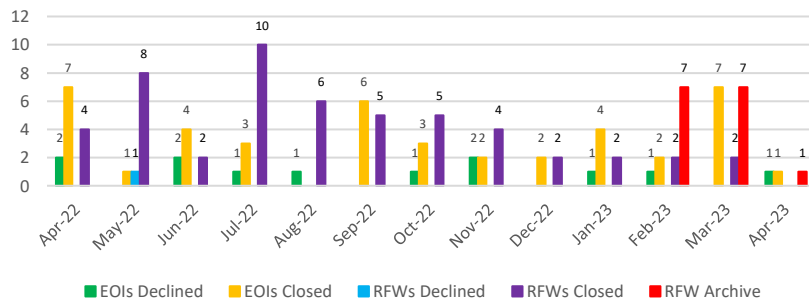
### VOLUME OF RFWs WHICH HAVE BEEN ASSESSED



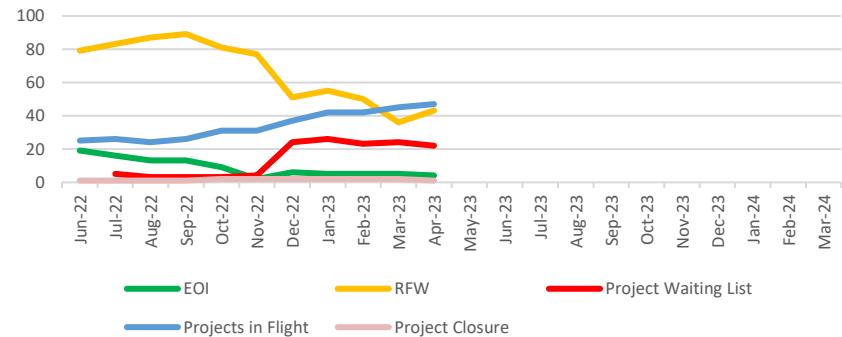
### AVERAGE LENGTH OF TIME FOR AN RFW TO BE ASSESSED AS AT START OF MONTH



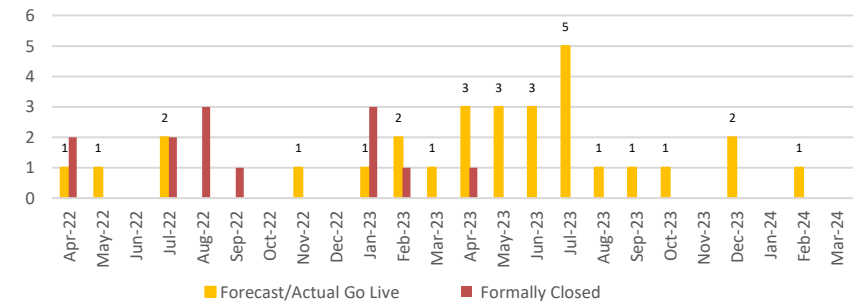
### VOLUME OF EOI/ RFWs WHICH HAVE NOT PROGRESSED



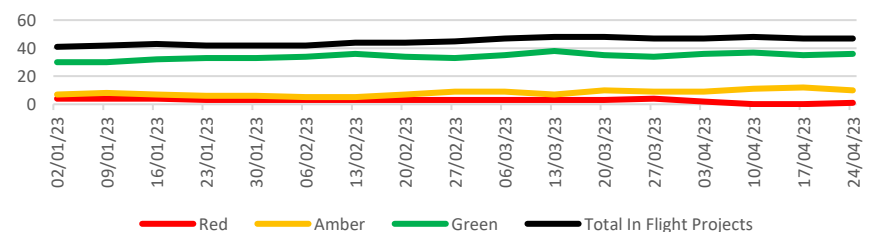
### NUMBER OF PROJECTS PER STAGE - TREND



### VOLUME OF PROJECTS FORMALLY CLOSED, BASELINE & FORECASTED/ACTUAL GO LIVE DATES



### INFLIGHT PROJECTS WEEKLY RAG STATUS TREND



### RED AMBER AND GREEN PROJECTS



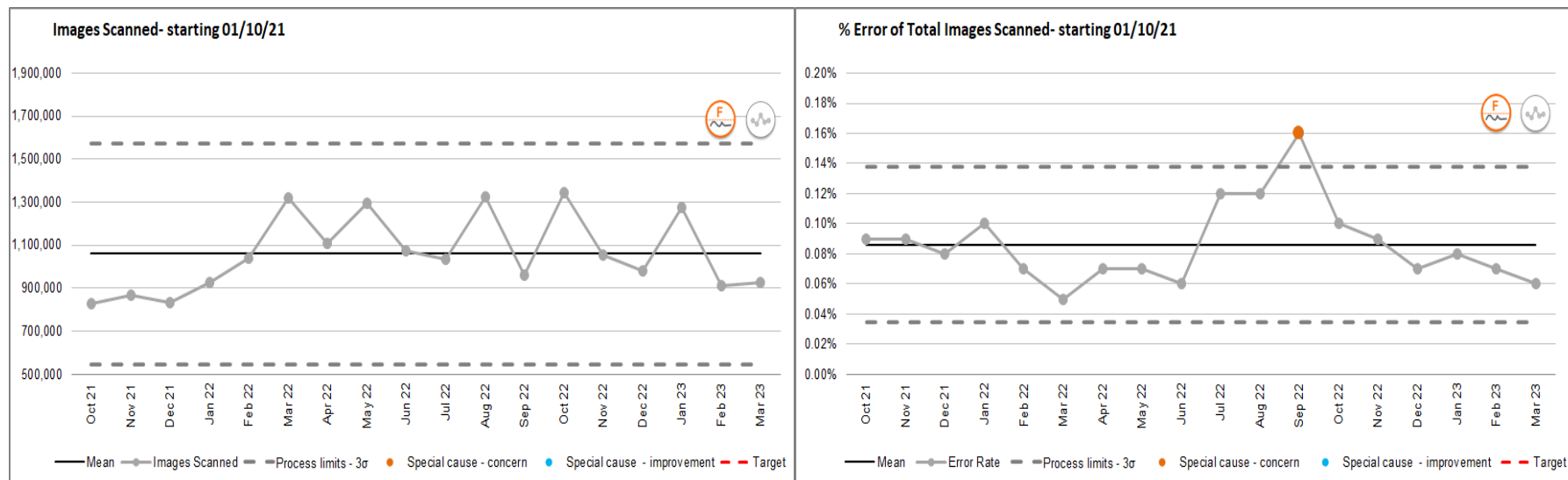
#### Red Projects

Delivery against forecast go live dates may be delayed.

**DM121 – Regional Maternity System** - Certificate work pending completion by DIT Technical Services. Once this is complete on-boarding documentation for YHCR can be finalised.

# Medical Records – Images Scanned

Reporting Period: March 2023  
Sub Groups: DIT Committee



**Background / target description:** Clinic Pulls and Email requests used to be the core business of the library and now hardly requested due to the health records being available on PPM+. Focus is on scanning back log and reducing scanning errors

## What does the chart show/context:

Difference in how the Library works with records now being available on PPM+ so records no longer required in paper form. Due to digitisation our quality process have evolved over time.

There was slight variation on how some team members were documenting/recording errors.

The errors have arisen due to a combination of factors i.e. human errors occurred during the prep/scanning process, Allergy alert missed, mixed patients and errors from wards.

**Underlying Issues:** None.

**Actions:** None

# Workforce Planning

Reporting Period: March 2023

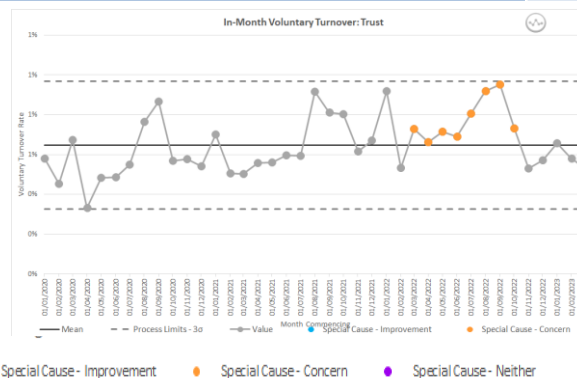
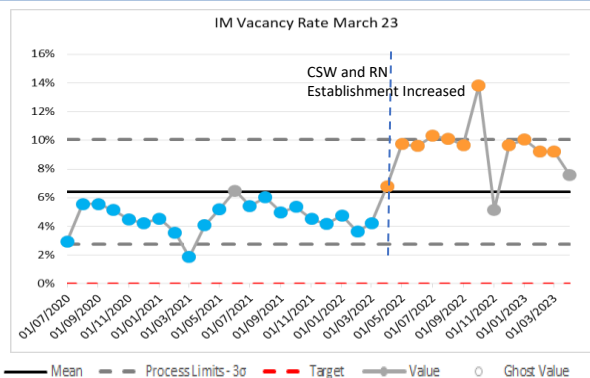
Executive Owner: Jenny Lewis (Director of HR & Organisational Development)

Management/Clinical Owner: Jo Buck (Deputy Director of HR)

Sub Groups: Resource Management Group

- Indicates score against the national benchmark average
- ↑↓ Indicates score against the previous year's result
- \*no rating if no significant statistical change*

Measure	21/22 Score	21/22 Target	22/23 Target	Score
All CSUs put in place governance to ensure that workforce planning activities are discussed and reviewed resulting in a clear action plan.	N/A	N/A	100% of CSUs have an action plan by 31.8.22	100%
Reduce Agency Spend	£28.8M	£16.8m	< 21/22	£30.4m
Registered nursing workforce trajectory on plan		Achieve Nursing Trajectory	Achieve Nursing Trajectory	Refer to graph (next slide)*
Reduction in number of vacancies	3.9%	Improvement on last year	Improvement on last year	8.6%
Voluntary Turnover	7.67%	Within SPC measures	Within SPC measures	0.54% (in-month) 8.4%(rolling)
National Level of Attainment (% of staff deployed via e-roster)	N/A	N/A	78%	78%
National Level of Attainment (% of staff deployed via e-Job Plan)	N/A	N/A	45%	45%
Improve Staff Survey Response to the question 3i "there are enough staff at this organisation for me to do my job properly"	● 30% ↓	Improve + maintain above average	Improve + maintain above average	● 28.1 ↓



## Background:

All CSU workforce plans have been submitted and reviewed by our ADOPs and Deputy HR Director. HR Business Partners (HRBPs) will continue to support the CSUs in progressing their action plans to address retention, operational workforce challenges aligned to service and financial priorities.

## Updates:

- Agency spend is highlighted as red, This is due to the continuation of the No Reason to Reside wards, the transfer of wards previously managed by Villa Care and the Trust's winter plan. International nurse recruitment in 2023/24 will support a reduction in agency spend.
- The increase in vacancies from 3.9% in March 2022 to 8.6% in March 2023 is as a result of nursing establishment increases from April 2022 (RN by 150 WTE and CSW by 221 WTE).

## Actions:

- Vacancies continue to be managed through CSU vacancy control linked to workforce plans.
- Further work on staff retention will be undertaken by CSUs as part of their A3 Plans to support the 7 commitments for 2023/24.

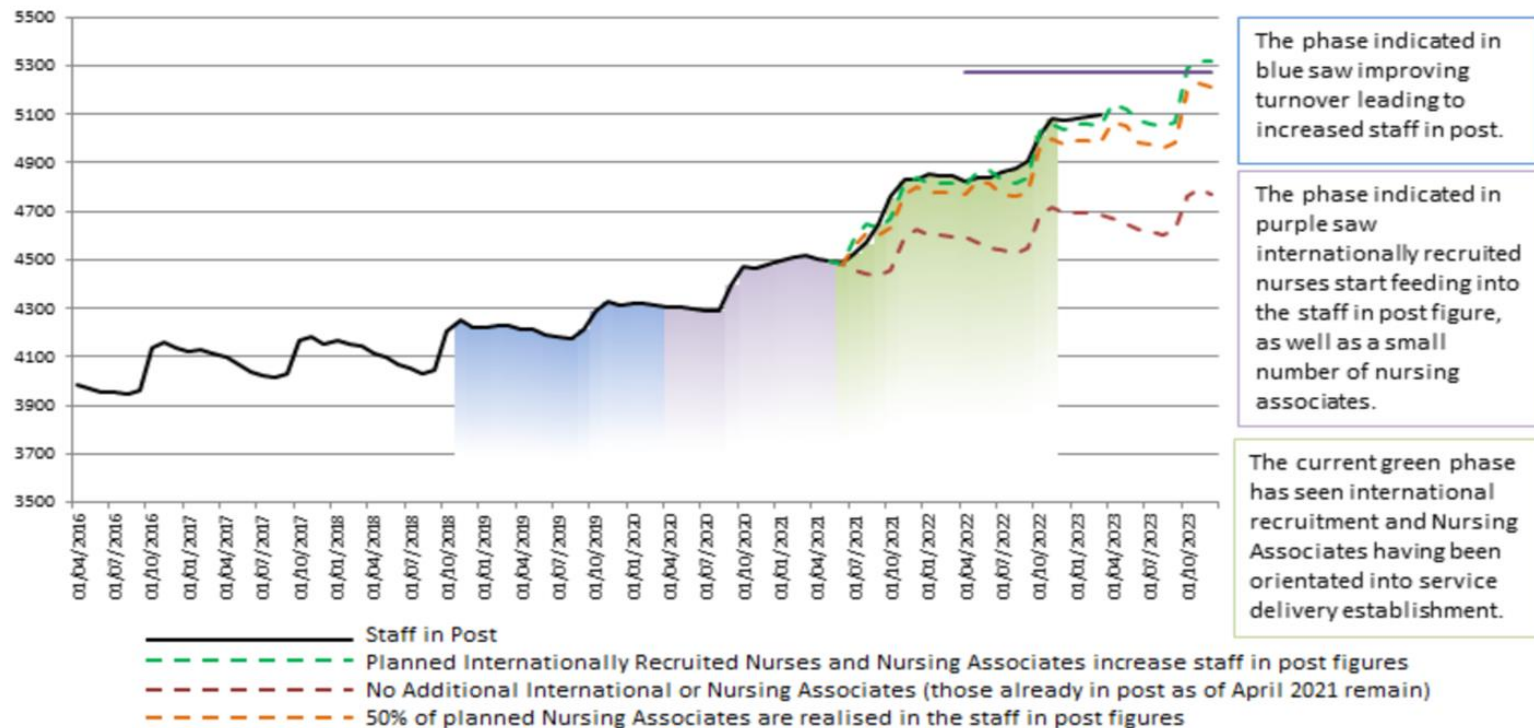
# Scenario Planning to increase RN/RNA Workforce

Reporting Period: March 2023

Executive Owner: Lisa Grant (Chief Nurse)

Management/Clinical Owner: Helen Christodoulides

Sub Groups: Resource Management Group



## What does the chart show/context:

- The March 2023 RN/RM vacancy is 524.05 WTE, turnover is 6.09%.
- 725 WTE internationally trained nurses now in post; 611 WTE of these nurses are now UK Nursing and Midwifery Council (NMC) registered.
- The remaining 114 WTE internationally trained nurses will gain UK NMC registration by September 2023.
- Additional 93 WTE internationally trained nurses are recruited to arrive by July 2023.
- 134 new RN, RMs and POPs in recruitment pipeline as of March 2023.

# Scenario Planning to increase CSW Workforce

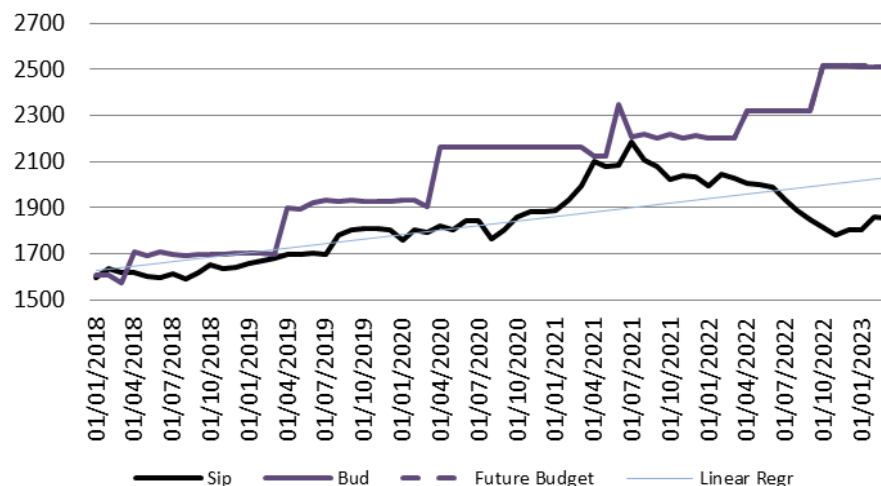
Reporting Period: March 2023

Executive Owner: Lisa Grant (Chief Nurse)

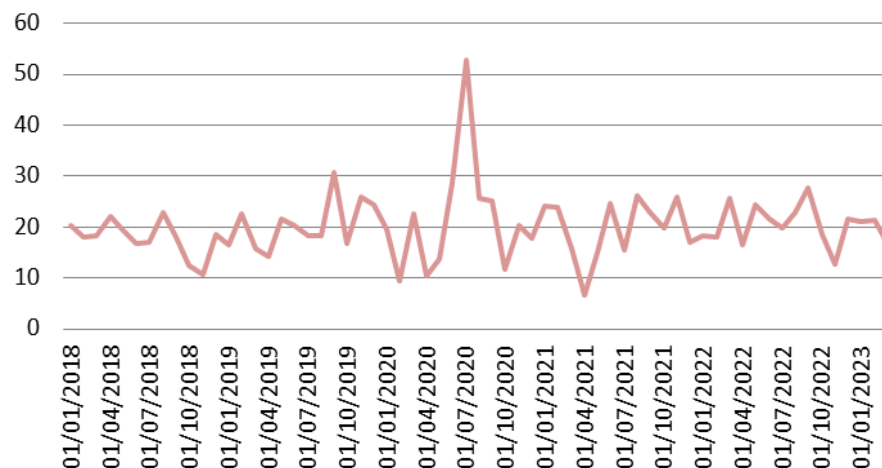
Management/Clinical Owner: Helen Christodoulides

Sub Groups: Resource Management Group

**CSW Staff in post**



**CSW Leavers (FTE)**



## What does the chart show/context:

- March 2023 vacancy position of 491 WTE; the current CSW turnover rate is 10.68%.
- 140 (Head count) CSWs started in Trust in March 2023 and will be reflected in April 2023 data.
- 127 WTE CSWs in the recruitment pipeline as of March 2023 (excludes new to care).
- LHT, in collaboration with NHSE/I, have developed a New to Care trainee CSW role with significant success. The new pathway supports people who are new to care without qualifications or experience and who don't meet UK Apprenticeship Criteria.
- 260 (Head count) New to Care CSWs started in post between December 2022 and March 2023.
- A further 120 New to Care CSWs are recruited to start training in June and July 2023.

# Clear Performance Expectations

**Reporting Period: March 2023**

**Executive Owner:** Jenny Lewis (Director of HR & Organisational Development)

**Management/Clinical Owner:** Jo Buck (Deputy Director of HR), Chris Carvey (Deputy Director of HR)

**Sub Groups:** Executive Directors

● Indicates score against the national benchmark average  
 ↓↑ Indicates score against the previous year's result  
 \*no rating if no significant statistical change

Measure	21/22 Score	21/22 Target	22/23 Target	Score
All available Agenda for Change staff receive an appraisal	90%	90%	90%	92%
All medical staff receive an appraisal	97.4%	94%	94%	98%
Do you feel this appraisal discussion has been helpful and valuable? (AfC Appraisals completed on training interface)	90%	90%	90%	90%
All new staff complete corporate induction	99%	90%	90%	97%
All new staff complete a local induction	82%	90%	90%	79%
Number of Conduct cases open for more than 90 days (excluding cases beyond our control)	9	< 10	< 10	3
Number of starts on Management/Leadership development programmes	1859	1000	2000	1075
Staff Survey Question 3A: "I always know what my work responsibilities are"	86.6% ↑	Improve on last year	Improve + maintain above average	● 86.2%
Staff Survey Question 21c: "Appraisal helped me agree clear objectives for my work"	32.4%	N/A	Improve + maintain above average	● 30.7% ↓

## Background:

There has been a 3% decrease in local induction compliance which is below the required standard. The decrease in local induction compliance is due to large intake of Clinical Support Workers and International Nurses over the past 2 months.

## Updates:

- The Medical Appraisal figures are the final year-end figures as at the 31st March 2023. Only 17 appraisals remain incomplete without a reason.
- 2023 AfC Appraisal Season commenced on 1st April; data will be available for 2023/2024 AfC Appraisals in August 2023.
- An appraisal update will be provided to Workforce Committee in May 2023.

## Actions:

- The appraisal admin team are currently undertaking an end of year audit with CSUs to find the reasons for the 17 Medics who have not completed, with a view to taking to the RO to decide on next steps.
- Low local induction compliance will be brought back to required standards through BAU admin processes and in collaboration with Senior HR Business Partners/ CSU management teams.

## Reporting Period: March 2023

**Executive Owner:** Jenny Lewis (Director of HR & Organisational Development)

**Management/Clinical Owner:** Jenny Lewis (Director of HR & Organisational Development)

**Sub Groups:** WYAAT HRD Group, LSWB, Academy

Measure	21/22 Score	21/22 Target	22/23 Target	Score
As a partner in the WYAAT network deliver workforce aspects of service transformation projects				
As a lead partner, build the Leeds Health and Care Academy's portfolio and reach through LTHT expertise, and increase access to the Academy's shared learning across the LTHT workforce	190	300	1,015	
<ul style="list-style-type: none"> <li>Quarterly assurance reviews of the Academy portfolio and performance through the Academy Portfolio Delivery Group</li> <li>Joint LTHT and Academy staff development programmes accessed by colleagues across the full Leeds Health and Care Sector</li> <li>An increase in LTHT staff accessing Academy learning and development in 2022/23 to 5% of the workforce (1,015)</li> </ul>				
				394
Ensure delivery of LTHT priority collaborative workforce projects under the 2022 One Workforce Programme:	-	-	-	3.2 Developing
<ul style="list-style-type: none"> <li>3.2 Leeds City Resourcing Group (was Winter Workforce Readiness)</li> <li>5.1 Narrowing Inequalities through Health and Care Careers</li> <li>6.1 Team Leeds Hearts and Minds</li> </ul>				5.1 On Target
				6.1 On Target

### WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS (WYAAT)

#### Updates:

- Community Diagnostic Centres (CDC): International Recruitment staff numbers to be submitted to NHSE by 21st April.
- Elective Recovery: Theatre workforce subgroups initiating job role standardisation, TIF 2 workforce assessments being undertaken. HEE funding success of £30k to support school careers promotion for roles in surgery – currently in design stage followed by implementation in Q3.
- Endoscopy: Capital business case for BHT going through approval stage. Workforce groups in planning stage.
- Yorkshire Imaging Collaborative: Practice Educators recruitment commenced. Trust Career Champions to provide exemplars for website. New homework stations received and delivered to staff.
- WYAAT Senior Leadership programme launched. First cohort of 15 now received mentors and placements to begin in May.
- Neurology Transformation: workforce data completed. Initial lead nurse focus group to take place and prioritise plan.
- Non-Surgical Oncology: workforce transformation workshops using HEE STAR model to take place during April/May.

### LEEDS HEALTH & CARE SYSTEM

- In 2022/23 we almost doubled the number of LTHT staff accessing collaborative learning opportunities through the Academy compared to 2021/22, with 371 staff taking part. These include apprenticeship programmes, Health and Wellbeing Champions training, Better Conversations training, digital workshops and peer mentoring.
- In addition, 200 LTHT staff have signed up to the new city-wide Leeds Learning Portal. Using the portal will enable more staff to access the breadth of opportunities offered through the Academy, and is being actively promoted through the Learning Prospectus, social media and organisational communications. This includes the Skills Booster license package, with over 60 EDI, health and wellbeing and leadership learning packages to the health and care workforce and reducing system-wide costs and duplication.
- In 2023/24 we anticipate a continued increase in staff accessing learning and development opportunities through the Learning Portal and continued strong partnership across our teams.
- The Leeds City Resourcing Group have reviewed their impact within each of the six workstreams over Q3/Q4, which has enabled the group to review and agree the collective priorities moving forward.





# Free From Discrimination

Reporting Period: March 2023





Executive Owner: Jenny Lewis (Director of HR & Organisational Development)

Management/Clinical Owner: Chris Carvey (Deputy Director of HR)

Sub Groups: EDI Strategic Group

● Indicates score against the national benchmark average  
  Indicates score against the previous year's result  
*\*no rating if no significant statistical change*

Annual Reporting Dates apply to WDES / WRES / Staff Survey and Gender Pay  
 • WDES & WRES data collected in July 2022 and submitted to NHSE August 2022  
 • Staff Survey collected Oct /Nov 2022 and published March 2023  
 • Gender Pay Gap data captured March 2022 and published March 2023

Measure	21/22 Score	21/22 Target	22/23 Target	Score
BAME - Overall Improvement against WRES indicators	self-assessment	Improvement	Improvement	Insignificant
Likelihood of white shortlisted applicants being appointed compared to BME shortlisted applicants	1.71	0.8-1.2	0.8-1.2	1.98
BAME - Relative likelihood of BME colleagues entering a formal disciplinary process (Specific WRES measure)	1.12	<1.2	<1.2	1.06
Disability - Overall Improvement against WDES indicators	Self-assessment	Improvement	Improvement	Insignificant
Likelihood of non-disabled shortlisted applicants being appointed compared to disabled applicants (Specific WDES measure)	1.14	0.8-1.2	0.8-1.2	1.14
Disability - Relative likelihood of Disabled colleagues entering a formal capability process (Specific WDES measure)	0	< 1.2	< 1.2	3.75
LGBTQ+ - Improve the following staff survey question scores:				
Q14b Experienced harassment, bullying or abuse from managers	12.1% 	Improvement	Improvement	● 8.9%
Q14c Experienced harassment, bullying or abuse from other colleagues	22.4% 	Improvement	Improvement	● 18.2% 
Q15 Organisation acts fairly: career progression (LGBTQ+ Improvement)	61.1%* 	Improvement	Improvement	● 59.9%
Q16b Experienced discrimination from manager/team leader or other colleagues (LGBTQ+ Improvement)	11.3%	Improvement	Improvement	● 7.6%
Staff - Achieve NHSE/I trajectory for BAME representation at band 8a+	76	87	96	98
Staff - Improve Gender Pay Gap (Mean)	21.3%	Improvement	Improvement	19.7%
Staff - ESR records with one or more unidentified protected characteristic	24.3%	10%	10%	22.3%
Staff - Number of people belonging to a protected group participating in positive action programmes	74	146	104	112
Number of staff that have been part of an Inclusive Conversation	N/A	N/A	16,000	288

## Updates:

- There has been a slight improvement in both the ratios of BAME staff and disabled staff progressing through shortlisting with both now within target.
- Our target for BAME staff in Band 8a has also been achieved as has the number of staff accessing positive action programmes.
- The Inclusion Conversation figure recorded on ESR has reduced, linked to staff turnover and not a decline in activity as identified on the last report.

## Actions:

- Identify the meaningful metrics aligned to this priority and identify targets for 2023/2024.

Reporting Period: March 2023

**Executive Owner:** Jenny Lewis (Director of HR & Organisational Development) & Hamish Mclure (Interim CMO)

**Management/Clinical Owner:** Stuart Haines (General Manager, Corporate Medical CSU)

**Sub Groups:** Learning Education & Training Committee

● Indicates score against the national benchmark average  
 ↓↑ Indicates score against the previous year's result  
 \*no rating if no significant statistical change

Measure	21/22 Score	21/22 Target	22/23 Target	Score
<b>Learner Satisfaction Scores</b>				
• Under graduate (medical staff only)	85%	75%	85%	86%
• Post graduate (medical staff only)	79%	75%	80%	76%
• Apprenticeships	82%	75%	85%	-
Apprenticeship levy spend	£2.2m	£3m	£3m	£0.27m
Staff accessing CPD and internally approved Education, Training and Development activity	2695	2000	2000	1416
Relative likelihood of white staff accessing non-mandatory or CPD training compared to BME staff (Specific WRES measure)	1.19	0.8-1.2	0.8-1.2	1.17
Mandatory Training Compliance	89%	90%	90%	91%
Staff attending Inclusive Conversations Training	N/A	N/A	25	19
Staff Survey Question 22c: "I have opportunities to improve my knowledge and skills"	73%	N/A	Improvement on 21/22 score	● 73.4%
Staff Survey Question 22d "I feel supported to develop my potential"	56.9%	N/A	Improvement on 21/22 score	● 57.8%
Staff Survey Question 22e: "I am able to access the right learning and development opportunities when I need to"	59.4%	N/A	Improvement on 21/22 score	● 60.3%

\* Measure of students supported by Organisational Learning – work is underway to develop a measure of all student experience

\* Learner experience 21/22 targets a combined target of all three aspects

#### Updates:

- There has been a 2% increase in mandatory training compliance, which reflects seasonal patterns as staff prepare for their appraisals.
- The apprenticeship levy income for 2022/2023 IQPR target for this year of £3m which has been surpassed, therefore reflective of the new 2023/2024 financial year is on track at £0.27m.
- Encouragingly, there is an improvement shown in the 2022 Staff Survey data within the 'We Are Learning' People Promise theme, with individuals feeling there are opportunities to develop and that they are supported to do this.

#### Actions:

- Whilst there has been no additional Inclusive Conversation facilitators trained, discussions have been reviewed with CSUs (where all CSU Tri Teams have had an Inclusive Conversation) via the HRBPs to identify facilitators to roll out in their teams, including the distribution of the Amplifying Voices, Mending Divides book.
- Continue to build the internal network of coaches, to build on the provision of career coaching and mentoring. Aswell as continuing to promote the Line Management Fundamentals Toolkit and resources to equip and enable managers with supportive career and development plans with their teams.

## Reporting Period: February 2023

Executive Owner: Jenny Lewis (Director of HR & Organisational Development)

Management/Clinical Owner: Jo Buck (Deputy Director of HR)

Sub Groups: Health & Wellbeing

Measure	21/22 Score	21/22 Target	22/23 Target	Score
Sickness Absence – Improve Overall Sickness Rate and Long Term Sickness Rates	5.6% (Overall) 3.3% (Long term)	Improvement	Improve on 21/22	5.8% 3.34%
Increase the number of Mental Health First Aiders within the Trust	396	250	600	726
Increase the number of contacts to Mental Health First Aiders within the Trust	1,455	N/A	Increase of 20% on 21/22 1,746	5586
Increase the Number of Health and Wellbeing Champions within the Trust	202	250	600	325
Total number of LTH appointments to OH Total number of DNAs to OH	- -	N/A	Reduction in DNAs	3971 YTD 441 YTD
Percentage of frontline staff receiving vaccinations as reported by NHSE/I <ul style="list-style-type: none"> <li>Flu</li> <li>Covid</li> <li>COVID non-BAME</li> <li>COVID BAME</li> </ul>	<ul style="list-style-type: none"> <li>53.76%</li> <li>N/A</li> <li>95%</li> <li>90%</li> </ul>	90% N/A N/A N/A	90% N/A N/A N/A	<ul style="list-style-type: none"> <li>49%</li> <li>53.1%</li> <li>N/A</li> <li>N/A</li> </ul>
<b>Staff Survey Health and Wellbeing Questions:</b>				
* Staff Survey Question 11D “In the last three months have you ever come to work despite not feeling well enough to perform your duties?”	● 47.1%* ↓	Improvement and maintain above average	*Improvement and maintain above average	● 46.5% →
• Staff Survey Question 9D “My immediate manager takes a positive interest in my health and well-being”	68.1%	Improvement and maintain above average	*Improvement and maintain above average	● 69.0% →
• Staff Survey Question 11A “The organisation takes positive action on health and well-being”	59.5%*	Improvement and maintain above average	*Improvement and maintain above average	● 58.7% →

# Health and Wellbeing (continued)

Reporting Period: March 2023

Executive Owner: Jenny Lewis (Director of HR & Organisational Development)

Management/Clinical Owner: Jo Buck (Deputy Director of HR)

Sub Groups: Health & Wellbeing

## Background:

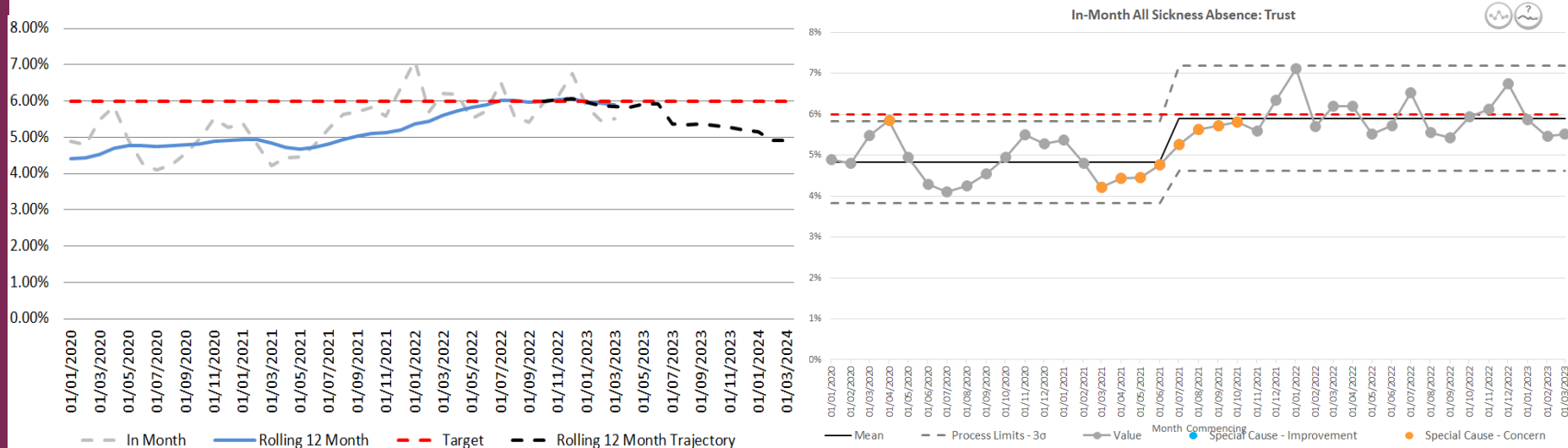
- Between the periods March 2021 and October 2021, we saw special cause concern for in-month sickness absence. This was largely due to increased levels of Covid related sickness absence.
- Covid related sickness absence was between 1.3% and 1.6% during this time frame. As of January 2023, the Covid related sickness absence figure is now 0.4% and we anticipate this will continue to fall throughout 2023/24.

## Updates

- Work continues to deliver the health and wellbeing training; this will now be delivered in house to achieve our target.
- Waiting times have improved for management referrals to Occupational Health, which are now an average of a four week wait.

## Actions:

- Regular assurance meetings are taking place between managers in CSUs and the HR Advisory team. The focus is to reduce the number of people breaching any of the sickness absence thresholds whilst maintaining a Personalised People Management approach.
- To support delivery of the 2023/24 winter vaccination programme a new staff immunisation post has been agreed, they will be responsible for the planning and delivery of this work, ensuring sufficient capacity and accessibility to meet staff need.
- Work continues on the capacity and demand review in OH to ensure resources are directed where they are most needed organisationally.





# Most Engaged Workforce









Reporting Period: March 2023

Executive Owner: Jenny Lewis (Director of HR & Organisational Development)

Management/Clinical Owner: Chris Carvey (Deputy Director of HR)

Sub Groups: Staff Engagement Group

● Indicates score against the national benchmark average  
  Indicates score against the previous year's result  
 \*no rating if no significant statistical change

Measure	21/22 Score	21/22 Target	22/23 Target	Score
Overall staff engagement score in the annual staff survey	● 6.9 	Improvement Maintain above average position	Improvement Maintain above average position	● 6.8 
Quarterly Pulse Survey – Improve Staff Engagement <b>Involvement</b> Sub-group score	6.64	N/A	Overall annual Improvement	-
Staff engagement score for BME colleagues	7.2	Maintain at or above overall score	Maintain or Improve	7
Staff engagement score for female colleagues	7.0	Maintain at or above overall score	Maintain or Improve	6.9
Staff engagement score for disabled colleagues (WDES Measure)	6.5	Improvement	Improvement	6.4
	0.4	Reduce Gap to <0.5	Reduce Gap to <=0.2	0.4
Staff engagement score for LGBTQ+ colleagues	6.7	Improvement	Improvement	6.5
	0.2	Reduce Gap to <0.5	Reduce Gap to <=0.1	0.3
NHS Staff survey response rate	● 59% 	Above average for benchmark group	Above average for benchmark group	● 37% 
Staff Survey Questions – <i>Getting the Basics Right</i>				
• 3h “I have adequate materials, supplies and equipment to do my work”	● 52.9% 	Improve on last year	Improve on last year	● 45% 
• 6d “I can approach my manager to discuss flexible working”	65.7%	N/A	Improve on last year	67.9%
• 13d “The last time you experienced physical violence at work, did you or a colleague report it?”	● 62.8% 	Improve on last year	Improve on last year	● 62.6%
• 8b “The people I work with are understanding and kind to one another”	69.8%	N/A	Improve on last year	● 69.3%
• 7b “Team Members often meet to discuss team effectiveness”	56.3%	N/A	Improve on last year	59.7% 

# Most Engaged Workforce

**Reporting Period: March 2023**

**Executive Owner:** Jenny Lewis (Director of HR & Organisational Development)

**Management/Clinical Owner:** Chris Carvey (Deputy Director of HR)

**Sub Groups:** Staff Engagement Group

## Background:

1. Deteriorating Staff Engagement considered within Goal Deployment. In-year goal agreed: 'Improve Retention', an update will be provided to Workforce Committee in May 2023.
2. New Flexible Working Steering Group initiated
3. New violence and Aggression resources and process drafted, for approval at the next Challenging Behaviours Steering Group, an update will be provided to Workforce Committee in May 2023.

## Updates:

### In-Year Goal: Improve Retention

- Deteriorating Staff Engagement considered within Goal Deployment. In-year Trust goal agreed: 'Improve Retention'.
- Corporate CSU A3 Improvement Plans in development – to aid specific focus.
- CSU A3 Improvement Plans to align to workforce plans, to be supported, holistically, by HR Centres of Excellence.
- A3 Improvement Plans to be completed by the end of April, ready for immediate implementation.

### The January National Quarterly Pulse Survey is now closed.

- National Quarterly Pulse Survey Staff Engagement Score continues to deteriorate and track below the LTH NHS Staff Engagement Score. Awaiting April's results.
- Results will be made available to all teams, to utilise to inform their ongoing improvement conversations.

### Flexible Working Steering Group

- The new Trust Flexible Working Steering Group has commenced.
- Group aim: to work alongside 4 pilot areas (Midwifery/Infectious Diseases/Chapel Allerton/Cardio-Respiratory), to identify specific challenges, and work to find solutions.
- Learning will form case studies and identify methods for increasing scale and spread across the organisation, alongside corporate support.
- Identified as an 8-month project.

### Wrap around support following an experience of violence or aggressions at LTH

- New supporting resources, communication materials and corporate processes are drafted,
- Suggested amends and approval to be gained at the next Challenging Behaviours Steering Group (June)
- Launch planned for July.

# Friends and Family – ED

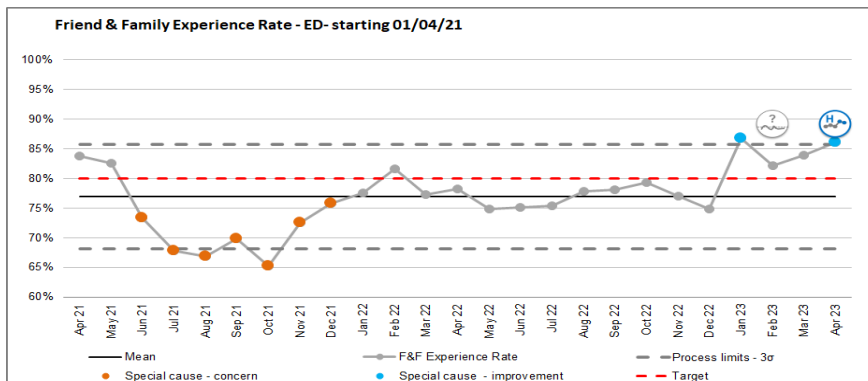
Reporting Month: April 2023

Executive Owner: Helen Christodoulides (Interim Chief Nurse)

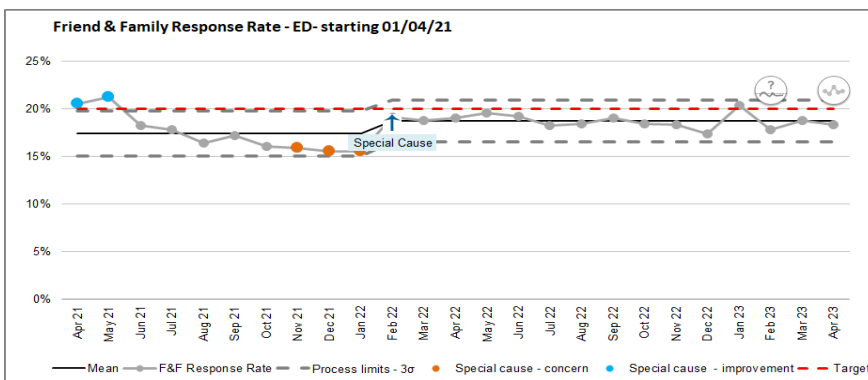
Management/Clinical Owner: Krystina Kozłowska (Head of Patient Experience)

Sub Groups: Quality Assurance Committee

Target	Trajectory	Assurance	Variation
Y	NA	R	CC



Target	Trajectory	Assurance	Variation
N	NA	R	CC



## Background / target description:

- ED have internal FFT targets to achieve a 20% response rate and an 80% positive experience rate.

## What do the charts show/context:

- The charts show FFT response and positive experience rates for ED.
- Whilst experience rate is not consistently meeting target over the past 25 months, the latest data is showing a special cause for improvement.
- Response rate shows common cause variation, not consistently meeting target. This was marginally below the target of 20% in February 2023.

## Underlying issues:

- The top three positive themes arising from feedback for April 2023 include staff attitude, clinical treatment and implementation of care.
- Negative themes arising from the feedback in the same period also included staff attitude and clinical treatment, in addition to waiting times.

## Actions:

- The FFT team were involved in a recent ED Away Day to highlight the importance of offering every patient the opportunity to feedback on their ED experience.
- The team recently met with Matrons across both ED sites to discuss how to increase awareness and improve response rates for FFT. Agreed actions include:
  - the FFT team to carry out 'Walk Arounds' on both sites to ensure that FFT is being appropriately promoted in public areas and to also ensure that staff are aware of the importance of gaining patient feedback;
  - new FFT Champions to be recruited in the department to ensure that FFT is being offered to every patient at every opportunity in a method that suits the patient.



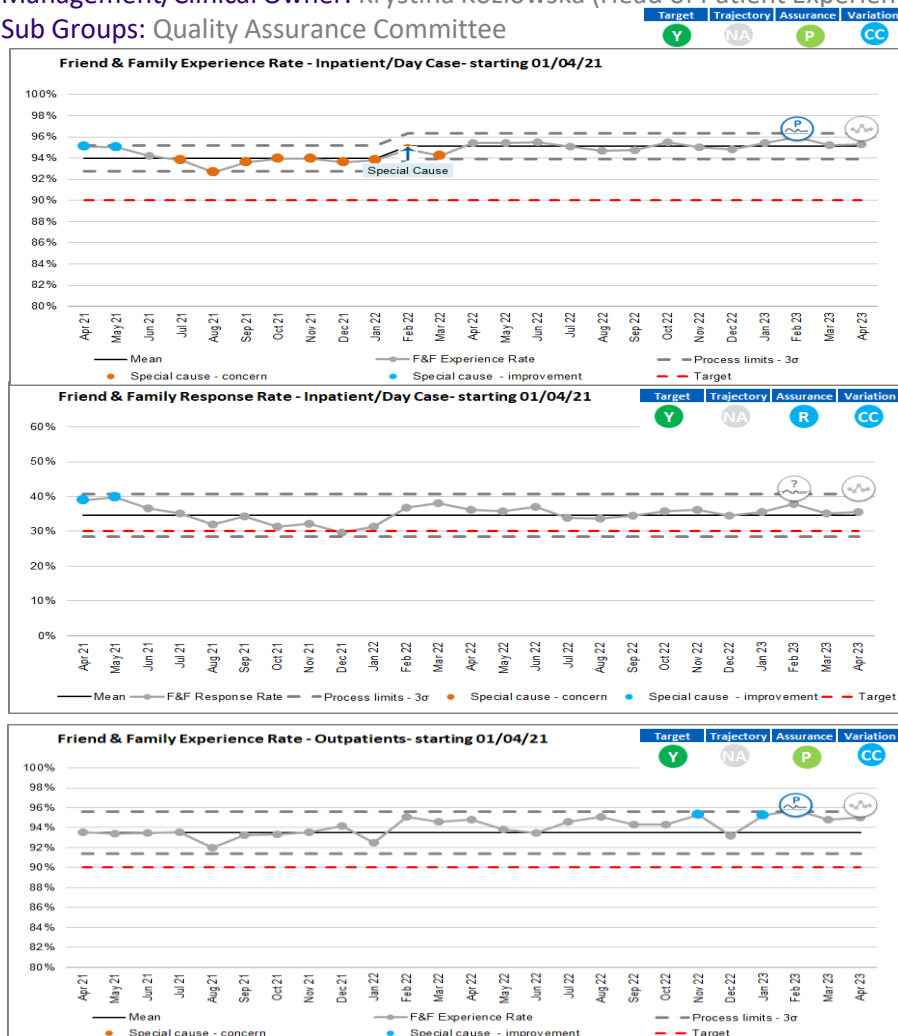
# Friends and Family – Inpatient/DC & Outpatients

Reporting Month: April 2023

Executive Owner: Helen Christodoulides (Interim Chief Nurse)

Management/Clinical Owner: Krystina Kozłowska (Head of Patient Experience)

Sub Groups: Quality Assurance Committee



## Background / target description:

- Inpatient / Day Case services have an internal FFT target to achieve a 90% positive experience rate and 30% response rate.
- Outpatient services have an internal target to achieve a 90% positive experience rating, with no response rate required.

## What does the chart show/context:

- The charts show FFT response and positive experience rates for Inpatient/Day Case and positive experience rates for Outpatients.
- Inpatient /Day Case experience rates shows common cause variation consistently above the target of 90%.
- Inpatient /Day Case response rates shows common cause variation consistently above the target of 30%.
- Outpatients experience rates shows common cause variation consistently above the target of 90%.

## Underlying issues:

- Texts continue to be sent to discharged inpatients, however it is known they are not accessible to everyone.
- Postcards are available again for patients who do not have access to digital methods to ensure that leaving feedback is as accessible as possible .
- A trial is taking place in Children's CSU of bedside stickers promoting the FFT QR code to encourage uptake of surveys at any time in a patient journey.

## Actions:

- Self Serve, a survey tool aligned to the FFT contract, continues to be well received. This month, a new survey has been created and applied to various inpatient wards to gain feedback about the technology patients have access to. Feedback will be used in support the delivery of the new Children's Hospital Build.
- Additional Self Serve questions have also been applied to all TRS inpatient surveys to raise awareness of the Daisy/Iris Awards with patients and to encourage nominations.

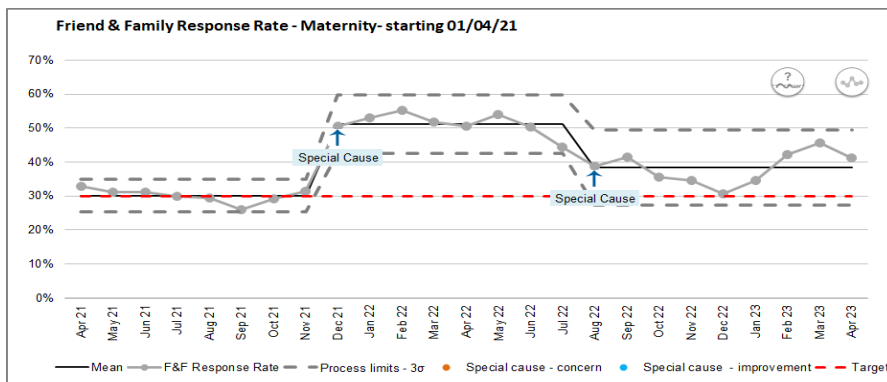
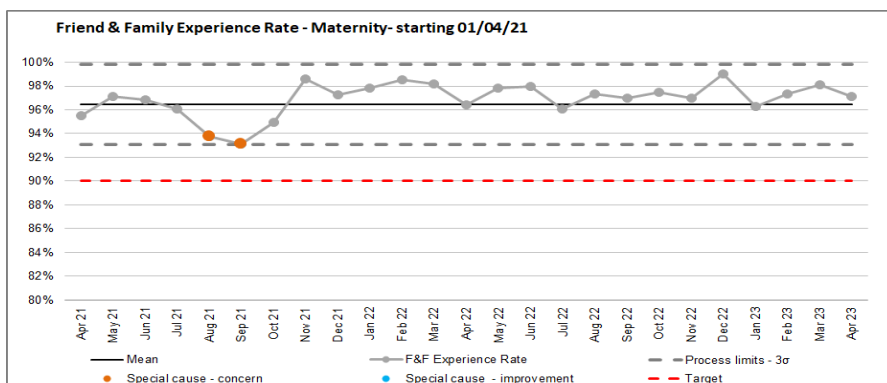
# Friends and Family – Maternity

Reporting Month: April 2023

Executive Owner: Helen Christodoulides (Interim Chief Nurse)

Management/Clinical Owner: Krystina Kozłowska (Head of Patient Experience)

Sub Groups: Quality Assurance Committee



## Background / target description:

- Maternity services have an internal target to achieve a 30% response rate and a 90% positive experience rate.

## What does the chart show/context:

- The charts show FFT response and positive experience rates for Maternity services.
- Experience rates show common cause variation consistently above the target of 90%.
- Response rates now show common cause variation following a special cause for concern in November and December 2023.

## Underlying issues:

- The previously reported downturn in maternity response rate was in part due to antenatal community patients having not been included in October 2022 figures, due to an external technical error. The FFT team and external partners have taken action to address this and are continuing to work with the CSU to monitor the position.
- The FFT team and CSU have been continuing to work on capturing a greater range of experiences relating to antenatal and postnatal / postnatal community-based maternity care, to ensure experiences across the whole pathway are understood.

## Actions:

- The FFT team continue to progress a project with the Trust interpreting team and the Trust's interpreting providers, Language Line Solutions, to find a way to offer limited English speaking patients the opportunity to leave feedback in their own language. This is being piloted in Maternity services, with a view to rolling the principle out Trust wide if it is successful.
- All four FFT maternity touch points – antenatal, birth, postnatal ward and postnatal community are now set up with the texting service.

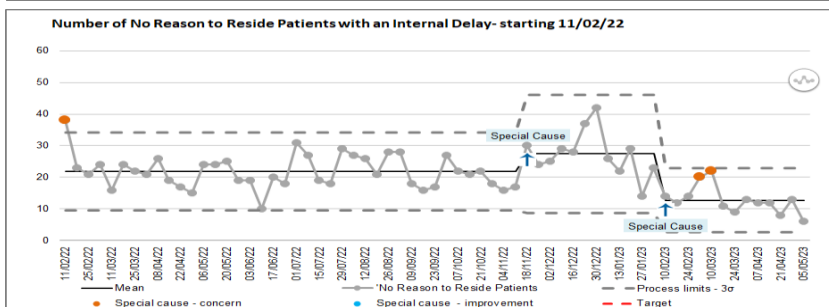
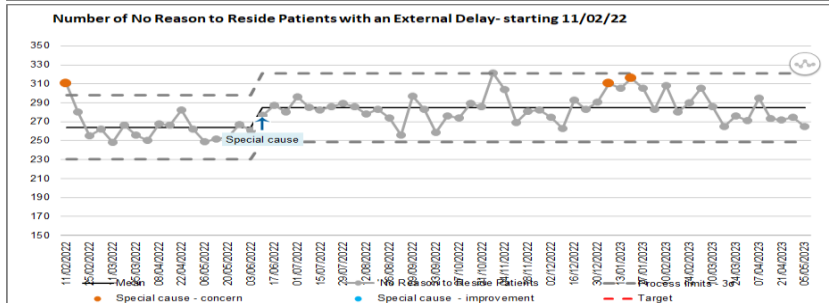
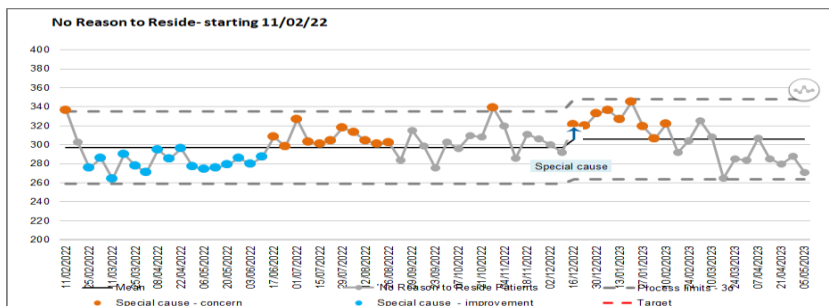
# No Reason to Reside

Reporting Month: April 2023

**Executive Owner:** Clare Smith (Chief Operating Officer)

**Management/Clinical Owner:** Dawn Marshall (Associate Director of Nursing)

**Sub Groups:** None



## Background / target description:

- Reason to Reside patients are those assessed by a multi-disciplinary team as requiring acute medical intervention
- No reason to reside patients are those assessed by the MDT as medically optimised and no longer requiring an acute hospital bed for their on-going care

## What does the chart show/context:

- There were 288 patients without a reason to reside on the last Friday in April 2023.
- Of these there were 275 patients without a reason to reside who had an external delay and there were 13 patients without a reason to reside that had an internal delay.
- Of the 288 patients:
  - 8 patients (2.8%) had a length of stay of up to 2 days,
  - 198 patients (68.8%) had length of stay of between 3 and 49 days,
  - 57 patients (19.8%) had a length of stay between 50 and 99 days and
  - 25 patients (8.7%) had a length of stay of over 100 days.
- 35.07% of patients were awaiting availability for assessment and start of care at home (Pathway 1)
- 15.63% of patients were awaiting availability of rehabilitation/reablement/recovery bed in community hospital or other bedded setting (Pathway 2).
- 39.93% of patients were awaiting availability of bed in a residential or nursing home that is likely to be a permanent placement (Pathway 3)
- LHT placed 9 out of 10 peers and 119 out of 121 acute trusts for the number of patients remaining in hospital who no longer meet criteria to reside for April 2023

## Issues:

- Depleted social work workforce leading to protracted waits for social work allocation and assessment
- A reduction in discharge to assess bed availability due to withdrawal of central funding at the end of March 23
- A lack of availability of beds for patients with dementia/complex needs
- In the absence of Home for assessment community capacity the system is heavily reliant on beds.

## Actions:

### Internal:

- LHT has agreed a target of maintaining less than 20 patients who are assessed as no reason to reside with an internal delay. This has been achieved consistently for 7 weeks.
- The discharge collaborative leads on two improvement initiatives, to increase the number of patients discharged before 3pm and promote better MDT conversation to improve patients experience of discharge.
- Standard way of working for the discharge workforce to provide consistency of role across the organisation.

### External :

- The Leeds Transfer of care hub is now established on the SJUH site. The hub will receive the referrals for all patients who require support on discharge and manage patients on the appropriate discharge pathway
- In partnership with adult social care a weekly meeting is in place to review patients with an extended length of hospital stay
- Home for Assessment pathway introduced in collaboration with system partners.
- Testing new ways of working with Hospital social work colleagues to increase efficiency and effectiveness, recruitment of additional social workers is ongoing.
- The system programme has been integrated within the city intermediate care redesign programme, the diagnostic phase is completed, the structure and project groups have now been agreed. This is now rebranded as the Home first programme and the design and test period commenced.

# CQUIN Tracker

Reporting Period: 2022/23

**Executive Owner:** Dr Hamish Mclure (Interim Chief Medical Officer)  
**Management/Clinical Owner:** Craig Brigg (Director of Quality)  
**Sub Groups:** None

National - PSS CQUINs 2022/23: IQPR Update 9th May 2023

There are 8 PSS CQUINs, 4 are in-scope for the Trust and eligible for the financial incentive scheme.

	CQUIN	Value	Year-end Target	Quarter 1 Performance	Quarter 2 Performance	Quarter 3 Performance	Quarter 4 Performance	Annual Performance
1	PSS1: Achievement of revascularisation standards for lower limb Ischaemia	£1,375,000	Achieve ≥ 60% Fail <40%	66.7%	40.0%	Published result: N/A Numerator value <5	Awaiting Q4 data to be published	Q1 to Q3 50%
2	PSS2: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	£1,375,000	Achieve ≥ 75% Fail <65%	Progress update submitted	Progress update submitted	Progress update submitted	Progress update submitted	
3	PSS3: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	£1,375,000	Achieve ≥ 60% Fail <40%					81.7%
5	PSS5: Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines	£1,375,000	Achieve ≥ 98% Fail <74%	Q1 data is not included in the final year calculation to give extra time to improve data quality	94.7%	93.6%	97.2%	95.1%
PSS Total		£5,500,000						

National - ICB CQUINs 2022/23: IQPR Update 9th May 2023

There are 15 CCG CQUINs, 9 are in-scope for the Trust and we had to select 5 to be eligible for the financial incentive scheme.

\*The 5 are highlighted in yellow.

	CQUIN	Value	Year-end Target	Quarter 1 Performance	Quarter 2 Performance	Quarter 3 Performance	Quarter 4 Performance	Annual Performance
*CCG1: Flu vaccination for frontline healthcare workers								
1	*CCG1: Achieving 90% uptake of flu vaccination by frontline staff with patient contact	£1,710,602	Achieve ≥ 90% Fail <70%					49.0%
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+								
2	CCG2: Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment		Achieve ≥ 60% Fail <40%	72.0%	60.0%	61.3%	52.0%	61.3%
*CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions								
3	*CCG3: Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded	£1,710,603	Achieve ≥ 60% Fail <20%	44.0%	64.0%	64.0%	68.0%	60.0%
*CCG4: Compliance with timed diagnostic pathways for cancer services								
4	*CCG4: Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	£1,710,602	Achieve ≥ 65% Fail <55%	Collation & validation of data. Summary of Compliance: 29.3% (Partial compliance agreed with ICB)	Collation & validation of data. Summary of Compliance: 24.9% (Partial compliance agreed with ICB)	Collation & validation of data. Summary of Compliance: 29.3% (Partial compliance agreed with ICB)	Collation & validation of data. Summary of Compliance: 29.7% (Partial compliance agreed with ICB)	28.3%
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle								
5	CCG5: Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle		Achieve ≥ 70% Fail <45%	Proposal in Q1	0.0%	5.7%	2.2%	2.9%
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery								
6	CCG6: Ensuring that 60% of major blood loss surgery patients are treated in line with NICE guideline NG24		Achieve ≥ 60% Fail <45%	Proposal in Q1	66.3%	74.5%	73.3%	71.4%
*CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service								
7	*CCG7: Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message	£1,710,603	Achieve ≥ 1.5% Fail <0.5%	3.5%	3.3%	4.0%	Awaiting Q4 results to be published	Q1 to Q3 3.6%
CCG8: Supporting patients to drink, eat and mobilise after surgery								
8	CCG8: Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending		Achieve ≥ 70% Fail <60%	Proposal in Q1	72.0%	92.0%	80.0%	81.3%
*CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients								
9	*CCG9: Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis	£1,710,602	Achieve ≥ 35% Fail <20%	4.0%	29.7%	45.9%	41.8%	29.3%
CCG Total		£8,553,012						

# 2022/23 I&E Position

**Reporting Month: Mar 2023**

**Executive Owner:** Simon Worthington (Director of Finance)

**Management/Clinical Owner:** Jonathan Gamble (Deputy Director of Finance)

For the financial year 2022/23 the Trust achieved its planned surplus of £7.6m, subject to audit - the sixth consecutive year of a surplus. The position accounts for technical adjustments including gains on disposal of assets, asset impairments following a professional revaluation conducted by an independent qualified valuer and the accounting impact of centrally procured consumables for the Covid-19 response.

**Income:** NHS England and Clinical Commissioning Groups funded an additional £93.3m in 2022/23 when compared to 2021/22. The majority of this relates to funding for inflation, including the recent agenda for change pay offer (offset with expenditure), activity growth funding and winter surge funding partially offset by a decrease in Covid-19 funding. In addition to the fixed funding arrangement in 2022/23 the Trust received funding through the Elective Recovery Framework (ERF) of £41.2m. Income in respect of donations was £19.8m and was received from a number of charities and organisations who generously support our services by funding equipment purchases, research activity, specialist staffing or environmental enhancements. The Leeds Hospitals Charity has continued to raise funds on our behalf and worked closely with our staff to raise the profile of our services. Other income has increased by £32.7m compared to 2021/22 and includes increases in Education & Training funding and Research & Innovation income.

**Expenditure:** Total operating expenditure has increased by £72.9m after allowing for asset impairments and centrally procured Covid-19 related consumables. If technical adjustments are excluded the increase in operating costs is £120m. Employment costs are the most significant area of increase, £103m, since 2022/23. This includes an increase of 332 whole time equivalent (wte) staff of which 331 wte (4.4%) relate to medical and nursing staff, 77 wte (2.2%) to allied health professionals and scientific and technical professionals and 70 wte (11.1%) relate to other staff. Healthcare assistants and other support staff have decreased by 146 wte (3.2%). The recent agenda for change pay award offer accounts for £35.2m of the increase and is largely offset by income. Drug costs account for a further £19m of the year on year increase in expenditure.

**Waste Reduction Programme (WRP):** To achieve its surplus the Trust ended the year delivering waste reduction and mitigations of £119.3m, which is significantly higher than in previous years.

# 2023/24 I&E Position

**Reporting Month: Apr 2023**

**Executive Owner:** Simon Worthington (Director of Finance)

**Management/Clinical Owner:** Jonathan Gamble (Deputy Director of Finance)

**Sub Groups:** Financial Planning & Reporting

In April the Trust reported a deficit of £5.0m, which was £0.5m adverse to the NHSE/I plan. Income to date is £142.5m which is £4.8m adverse to plan. Pass through drugs & devices income is £3.5m below plan which is offset in expenditure. Expenditure to date, £147.5m, is £4.3m favourable to plan.

Pay expenditure in the month is £88.7m, £1.9m adverse to the NHSE/I plan and includes £2.5m of estimated expenditure associated with the cost of covering industrial action. Non-pay expenditure is £58.8m in the month (including depreciation and finance costs) and is £6.2m favourable to the plan (£3.4m of this is offset with reduced pass through income).

The Trust has a balanced income and expenditure plan for the year. There are a number of significant risks to the delivery of a breakeven position, however, if no further risks materialise and the 23/24 waste reduction process is delivered a balanced position can be achieved.

# Capital & Cash Position

Reporting Month: Apr 2023

**Executive Owner:** Simon Worthington (Director of Finance)

**Management/Clinical Owner:** Martin Campbell Smith (Associate Director of Finance – Financial Services)

## Capital

### 2022/23

Capital expenditure of £133.5m for the financial year 2022-23 was a record amount for the Trust and was £3.8m ahead of the forecast target due to additional funding from ICB slippage. The Trust has continued to increase capital spend over the past 5 years.

### 2023/24

The Trust's capital expenditure forecast for 2023/24 is £116.9m. The programme is broken down as follows:

Programme	Forecast 2023-24 £000
Medical Equipment	9,147
Informatics	20,401
Building & Engineering	60,448
Building the Leeds Way	17,633
Leases	9,232
<b>Total</b>	<b>116,861</b>

Expenditure to 30 April 2023 is £1.6m which was £0.2m behind forecast driven primarily by delays with delivery of supplies for the Public Sector Decarbonisation Programme. Forecast outturn remains in line with the plan.

Capital expenditure forecasts are discussed with Programme Managers monthly together with orders raised and contracts awarded but yet to be fulfilled. Progress is formally monitored each month at the Capital Planning Group.

## Cash

### 2022/23

The Trust ended the financial year with cash of £91m which was in line with the latest Fundamental Review forecast (£90m). Receipts in month included £24m of PDC drawdowns to fund capital expenditure. There were significant payments to suppliers (£122m in total) with BPPC in March being 98% and the overall BPPC for the year 98% - the best performance against this measure in the history of the Trust.

### 2023/24

Cash at the end of April was £93m, an increase of £2m on the year end balance (£91m) and £8m ahead of the latest forecast (£85m). Total receipts for the month amounted to £164m including Q1 LDA funding from NHS England (ex HEE). Total payments in month were £162m comprising £83m for payroll and £79m for accounts payable. The favourable variance against fundamental review reflects lower levels of supplier payments in the month

Under the current finance regime the Trust continues to receive monthly block contract payments. Payments to our suppliers in April totalled £79m. Better Payments Practice Code compliance for the month was 97% (22/23 - 98%)

The Trust is not forecasting any requirement to borrow revenue cash to meet its obligations.

In accordance with national guidance, the pay award offers for 2023/23 and 2023/24 for agenda for change staff are due to be paid to employees in June. Additional cash will be received via NHS West Yorkshire ICB to cover the costs of the payments.



<b>Regulators</b>	<p><b><a href="#">Provider regulation</a></b> – NHS Improvement regulates NHS foundation trusts and trusts on their financial stability, operational performance, care quality, leadership, improvement capability and their ability to deliver strategic change. It does this through the Single Oversight Framework which combines powers previously exercised by Monitor and the NHS Trust Development Authority (TDA).</p> <p><b><a href="#">Quality regulation</a></b> – Quality regulation has risen up the agenda in recent years. As a result, the Care Quality Commission (CQC) has undergone significant reform. The CQC sets the fundamental standards of quality and safety for healthcare services and monitors and inspects providers to ensure standards are upheld. The CQC's five year strategy for 2016-21 sets out how its regulatory model will develop following the first inspection of all NHS providers.</p>
<b>NHS Improvement: Join the conversation on workforce (February 2019)</b>	<p>NHS Improvement launched five discussion pages on Talk Health and Care asking:</p> <ul style="list-style-type: none"> <li>• How can we better support our clinical workforce?</li> <li>• How do we ensure the NHS is a great place to work?</li> <li>• How do we develop compassionate, effective and diverse leaders in the NHS?</li> <li>• The future medical workforce: How do we get the balance right?</li> <li>• How can we enable the delivery of the NHS Long Term Plan by improving skills and education in using new technology?</li> </ul> <p>Each week they post new questions via <a href="#">workforce bulletin</a>. Share your views at: <a href="https://dhscworkforce.crowdcity.com/category/browse/">https://dhscworkforce.crowdcity.com/category/browse/</a></p>
<b>NHS Improvement Provider Bulletins</b>	<p>Further information on the NHS Provider Bulletins is available on the NHS Improvement Website at: <a href="https://improvement.nhs.uk/news-alerts/?articletype=provider-bulletin">https://improvement.nhs.uk/news-alerts/?articletype=provider-bulletin</a></p>
<b>Care Quality Commission: Inspections suspended (March 2020)</b>	<p>Routine inspections suspended in response to coronavirus outbreak.</p> <p>Further information and the full report is available on the CQC Website at: <a href="https://www.cqc.org.uk/news/stories/routine-inspections-suspended-response-coronavirus-outbreak">https://www.cqc.org.uk/news/stories/routine-inspections-suspended-response-coronavirus-outbreak</a></p>
<b>Care Quality Commission: The recovery challenges for NHS hospital services (September 2021)</b>	<p>The CQC's have published a report that looks at how NHS trusts are planning for people's care while tackling a backlog of treatment caused by COVID-19.</p> <p>Further information and the full report is available on the CQC Website at: <a href="https://www.cqc.org.uk/news/stories/recovery-challenges-nhs-hospital-services">https://www.cqc.org.uk/news/stories/recovery-challenges-nhs-hospital-services</a></p>
<b>Care Quality Commission: Latest News</b>	<p>The latest news articles published by CQC can be found on the CQC Website at: <a href="http://www.cqc.org.uk/search/site/news">http://www.cqc.org.uk/search/site/news</a></p>

Job Title	Abbreviation
General Manager	GM
Chief Operating Officer	COO
Associate Director of Operations	ADOP
Director of Nursing	DoN
Medical Director	MD
Chief Medical Officer	CMO
Head of Nursing	HoN

Sub Groups	Abbreviation
Finance & Performance	F&P
Quality Assurance Committee	QAC
Quality Safety & Assurance Group	QSAG
Clinical Effectiveness & Outcomes Group	CEOG
Patient Experience Sub-Group	PESG
Mortality Improvement Group	MIG
Quality Improvement Steering Group	QISG