The Leeds Teaching Hospitals NHS
NHS Trust

Annual Report and Accounts 2014/15

Incorporating the Annual Quality Account


hello my name is...

Contents

Statement from the Chair and Chief Executive

It has been an important year for the Trust. We have been busy strengthening our foundations and developing strong partnerships locally, nationally and internationally, which is putting us in prime position to achieve our vision of being the very best for specialist and integrated care in the UK.

We have grown in confidence over the year and the momentum and sense of what's possible for our organisation, our patients and the public visiting our hospitals in Leeds is becoming increasingly clear.

The Leeds Way

We have a dedicated and talented workforce who have been instrumental in helping us to shape our vision, values and goals over the last twelve months. With their input we have developed The Leeds Way which is now at the core of everything we do at our hospitals.

Launched in July 2014, The Leeds Way is about embedding a positive patient-focussed culture within the organisation, one in which everybody lives the five values we developed together through our behaviours at work. It means being patient-centred, collaborative, fair, accountable and empowered.

In the same month we launched Dr Kate Granger's inspirational #hellomynameis campaign at the Trust which is about delivering compassionate and patient-centred care and always treating people with dignity and respect. It links very closely with our values and we are delighted that over 7,000 of our staff had signed up to it in just eight months, with more joining every week.

We are passionate about The Leeds Way and believe that our values plus meaningful engagement with our people is the foundation for good quality care and positive experiences for our patients and will help us to continue to achieve our vision and goals.

Future plans

The Leeds Way is to be collaborative and this is the approach we used to develop our five year plan, by using our crowd sourcing platform Wayfinder to gather the views of all our partners and stakeholders, including staff, on whether they agreed with our future direction of travel. We received over 3000 suggestions and 39,500 contributions, as well as meaningful in depth discussions with our Clinical Service Units (CSUs).

Later in the year our CSUs developed their own Clinical Business Strategies. We were clear we wanted these to be clinically led and reflect the opportunities and challenges of all our clinical teams. They were presented to the Board in November 2014. In the latter half of the year we engaged with our staff on the most effective way for us to learn lessons so we can improve the safety and quality of the care we provide, and how to improve our intranet and public website.

Best place to work

Our people are absolutely fundamental to our success and once again this year we were delighted to see so many of them acknowledged locally and nationally for their many achievements.

If we are to achieve our vision we need to continue to retain and attract the best possible people to support us and so in 2014/15 we developed a dedicated recruitment website which has been designed to reflect The Leeds Way and will help us to bring more great people on board.

We continue to provide significant investment in professional and personal development for all our people too, whatever their role, as we believe that highly trained staff are vital in the delivery of exceptional treatment and care. We have over 150 apprenticeship programmes taking place across the Trust and have received numerous national and local accolades during the year for our ambitious work in this area.

We also continued to strengthen our top team over the year with the appointment of a new Director of Strategy and Planning, Simon Neville in May 2014, and a new Director of HR and Organisational Development, Dean Royles, in September 2014.

We appointed three new Non-executive Directors, Dr Bill Kirkup, Carl Chambers and Mark Ellerby. Carl was appointed to succeed Mark Abrahams, who stepped down from the Board early in 2015 at the conclusion of his term of office. We'd like to thank Mark for the valuable contribution he has made to the Trust, to welcome our new Directors and congratulate Caroline Johnstone on her appointment as Deputy Chair of the Trust.

We have a strong and diverse Trust Board who are absolutely committed to the success of the organisation and are very much involved in its governance at all levels. This was confirmed by a recent Board governance review commissioned by the Trust. We believe in a hands-on approach and each and every Board member undertakes regular walkabouts of our wards and clinical areas, hearing first hand from both staff and patients. This helps them to make more informed and effective decisions about the Trust. Patient stories are now a regular occurrence at each of our Board meetings too, enabling us to hear individual stories from patients in more depth and most importantly learn from them. You can view these stories on our website at www.leedsth.nhs.uk.

National context

In a national context the year started with the appointment of a new Chief Executive at NHS England, Simon Stevens. In his first day in office, he acknowledged that the next five years were going to be extremely challenging for the NHS, but that compassionate high quality care for all is as important as ever.

In October 2014 the NHS Five Year Forward View was launched which set out a vision for the future of the NHS focused on delivering better care and a better experience for patients, whilst also meeting the ongoing financial challenges that we all face.

We were reassured to see that our own five year plan, delivered to the NHS Trust Development Authority in June 2014, mirrored many of the themes set out in the NHS Five Year Forward View. It means we have a shared consensus of what good care looks like and how we can achieve it here in Leeds. You can read more about this in the report.

Partnerships

We have continued to build strong working relationships within the City which is absolutely fundamental to our success, particularly between leaders of health and social care providers. We are driving forward a number of projects, one example is the Inspiring Change programme to bring about the best possible health and social care services for the people of Leeds.

We also launched a new Public Health Strategy that sets out what our contribution is to the health of the population of Leeds over the next three years. It includes working closely with our partners to improve and promote health at every opportunity, taking a holistic perspective

of patients' health needs, and making resource allocation decisions that are evidence based in terms of their impact on population health.

As one of the city's biggest and most influential employers, the Trust has signed up to be part of a really exciting initiative called BID4Leeds which is about partnership working across the public and private sectors to drive forward, attract and co-ordinate investment into Leeds. By sharing our exciting vision and big ambition we can retain and attract the best possible talent into our city, which in turn will help us to deliver the best possible healthcare services for the local population.

Our links with the voluntary sector are extremely important to us. We have seen some fantastic examples of this over the last year, including our work with MESMAC on sexual health services and the British Red Cross to implement the hospital to home initiative. There are many more examples of these and we are very grateful to all the organisations who support us in this work.

Understanding the needs of our patients is fundamental to our success, and we'd like to offer thanks to our colleagues at Healthwatch who provide us with regular information direct from patients on how we can improve our services. We look forward to continuing to work with them in the future.

Our local commissioning colleagues at the Clinical Commissioning Groups in Leeds have been extremely supportive of our hospitals over the last year and it is clear that together we are completely focussed on achieving the best for the local population.

Research, education and innovation

In early 2015 we agreed a new Research and Innovation strategy, outlining our ambitions for the next five years. Among our priorities are to make a real difference to the quality of care we provide by increasing opportunities for patients to take part in and for staff to be involved in high quality research studies. We are already one of the largest providers of research opportunities in the UK with more than 12,000 patients involved in clinical trials every year.

In partnership with the University of Leeds we aim to achieve top 10 status across NHS Trusts nationally for our research funding and be a global leader in clinical research and innovation.

You can read more about our achievements in this area on page 69 of the report.

We also continue to be one of the largest providers of medical education in the country, delivering quality undergraduate and postgraduate programmes to more than 2,000 trainee doctors and medical students every year, in partnership with the University of Leeds. Over 700 student nurses and midwives and over 1000 medical students complete placements with us every year too. We feel extremely proud to be involved in training the next generation of clinical staff here in Leeds.

High quality care for all

The quality of care we provide to our patients is utmost in our thoughts and so we were very keen to receive the results of the Care Quality Commission inspection report in July 2014, following their visit in March 2014. A team of 80 people comprising of doctors, nurses, midwives, hospital managers, trained members of the public, a variety of specialists, CQC inspectors and analysts spent four days talking to our staff about their work with patients and checking our systems and processes.

There were many positives to be taken from the report including that three of our hospitals were rated as 'good' and in every clinical service area inspected, our staff were found to be caring and most services were also assessed to be effective. There was also recognition of the work we have done around staff engagement and the greater focus on quality and safety. Our overall rating was 'requires improvement' which means we still have plenty of work to do and must continue to make improvements. We are already making great progress in many of the areas identified by the inspection team.

In April 2014 we saw the launch of the Leeds Institute for Quality Healthcare which the Trust is playing a key role in, along with partner Trusts, commissioners, Leeds City Council and the University of Leeds. It was the culmination

of two year's work by clinical leaders across the city and is a very positive step, providing a place to learn and improve together across primary and secondary care.

In July 2014 we launched our very own quality improvement programme at two day-long events with over 100 staff and experts in attendance. Thirty of our wards signed up to the programme which shows the drive to make safety and quality for our patients a real priority. We are already making big improvements to the numbers of patients who fall whilst in our care.

We are also part of NHS England's 'Sign up to Safety' campaign, which signals our intent to always put patient safety first, reduce avoidable harm, and continually learn, be transparent, and supportive of people when things go wrong.

During the year our performance continued to improve and at the end of March 2015 we were pleased to receive the news that we had successfully met the Emergency Care standard for 2014/15 and were in the top quarter of Trusts across the country. It means that over 95% of people visiting our emergency departments in Leeds will be seen and treated within 4 hours. This is a fantastic achievement, especially given the many challenges we faced over a very difficult winter period across the whole NHS. It was no exception in Leeds and yet we worked hard to maintain high standards for our patients. It is a credit to our multi-disciplinary teams who we would like to sincerely thank. We aim to build on this in the coming months and do even better in 2015/16.

In other areas we have continued to work hard on improving performance standards overall and particularly to improve waiting times for patients including for planned care and cancer operations. As with the Emergency Care standard, delivering performance for Referral to Treatment Times and Cancer Waiting Times was especially challenging over winter but we made good progress in prioritising capacity for the longest waiting patients.

During 2014/15 we started work to ensure that individual clinical pathways are as efficient as possible and we will continue this in 2015/16.

We are pleased that the C.Difficile trajectory agreed with commissioners was achieved and demonstrates a significant reduction in harm for the patients under our care. We have also made good progress in reducing the numbers of MRSA cases, although the zero tolerance threshold has not yet been achieved.

You can read more about our performance and other initiatives we have launched in later sections of the report.

Financial performance

All of this has been achieved in an extremely challenging financial environment as was acknowledged in NHS England's Five Year Forward View. During the year we implemented new financial systems and delivered improvements to efficiency in the Trust. The year ahead will be another challenging year but we will work together on continuous improvement, which goes hand in hand with delivering high quality safe care for patients.

Open and transparent

We have no doubt that you will have been as shocked and appalled as we were at details of the activities of Savile at our hospitals, outlined in the independent report published in June 2014, and reported widely in the media.

We commissioned the report so we could fully understand what happened, and learn from it and we'd like to thank everyone who spoke to the investigation team about their experiences. Hospitals are very different places now and you can be assured that we have much greater safeguards, security and procedures in place now to protect our patients, visitors and staff. We have also worked hard to develop an open culture where everyone feels comfortable and confident to speak out and raise concerns. The learning from this and other investigations about Savile has provided valuable learning for the NHS as a whole.

We have promoted our new Whistleblowing Policy throughout the year and have also trained and introduced 28 designated whistleblowing leads across the Trust whose

role is to receive concerns and ensure they are managed effectively and supportively. This work is being led by our Non-Executive Director Lead for Whistleblowing, Mark Chamberlain and I have been pleased by the commitment from everyone involved to put in place a system that enables people to speak out.

We were pleased that the final reports into the review of Children's Heart Surgery services in Autumn 2014 showed again that the unit is safe and running well and would like to thank the staff on the unit for continuing to provide excellent care to their patients despite the significant uncertainty and pressure of the review which we know was very difficult. We continue to work with specialist commissioners NHS England to support the development of national standards around the delivery of this service and look forward to continuing the excellent services provided by the team.

Our members

We are delighted that over the last year we have continued to grow and consolidate our Membership which now stands at almost 23,000 people who have chosen to be involved with our hospitals.

We re-launched our Members' magazine - Connect - in Winter 2014/15 and have also held Medicine for Members engagement events across Leeds which are very well attended. We're aware that many of our Members would like to be more actively involved in the work of the Trust and will be working with them over the coming year to achieve this. You can find out more about how to get involved in the work of the Trust on our website at **www.leedsth.nhs.uk**.

Charitable support

Charities play an extremely important role in the Trust and there are many we work with to help us ensure we provide the best possible care and experience for our patients.

The Leeds Teaching Hospitals Charitable Foundation appointed a new Chair, Mr Edward Ziff, who took up post in the summer of 2014. Edward is a well-known figure in the business community in Leeds and his experience has already proved to be really valuable to the charity. We have been working closely with him and the Foundation on how they are supporting the strategic aims and objectives of the Trust. During this year alone around £6 million has been spent on charitable funding across the Trust which will be making a huge difference to our patients and for which we are extremely grateful. You can read more about their work later in the report.

We are very excited to be involved in the plans for a new Maggie's Centre which is to be built alongside the Bexley Wing at St James's. Maggie's is a leading national charity which provides free practical, emotional and social support to people with cancer. It means we will be able to offer even more support to those living with cancer in Leeds and throughout Yorkshire in addition to those already provided by the fantastic Robert Ogden Macmillan Centre.

Thank you to all the charities we work with for your continued help and support.

Royal recognition

We welcomed many important visitors to our hospitals last year too. Sophie, Countess of Wessex, Patron of the Leeds Children's Hospital, came on her third visit to the Trust and is developing a close relationship with staff and patients.

We also welcomed HRH Princess Royal to Seacroft Hospital for the launch of the Leeds Motor Neurone Disease Wheelchair Service, run in conjunction with the Motor Neurone Disease Association. This project is a great example of how we are working in partnership with charities, suppliers and commissioners to plan services around patients.

In September we had another Royal visit from HRH The Duke of Gloucester who officially opened the Leeds Major Trauma Centre at the LGI after a tour following a patient journey from the helideck to A&E, scanning, theatres, ITU and the major trauma ward itself. This was a great opportunity to showcase the fantastic work staff do and demonstrate the improved outcomes for patients that have made our service one of the top three trauma units in the country.

International partnerships

We continued to deepen our international partnership with colleagues at the King Hussein Cancer Center - the Middle East's leading cancer hospital - and were delighted to host a Royal visit from HRH Princess Ghida Talal of Jordan.

Such links boost our international reputation and have already opened up new sources of income with this partnership already bearing fruit with LTHT training senior clinical fellows from the King Hussein Cancer Center. We finalised a project to deliver Medical Physics training for staff from Malta too, on placement in the Leeds Cancer Centre which has now been renewed for a second group of Maltese staff. In addition, specialists from the Trust organised a three-day conference for over 100 consultant colleagues from Egypt to showcase their expert knowledge in treating liver disease. Our successes are a tribute to the fantastic teams we have working in these areas and our world-class technology.

All-in-all, this year was a significant one. We faced challenges, took opportunities, made service improvements, won awards and achieved excellent results in key clinical areas.

Of course we couldn't have done any of this without the contribution of so many people who we would like to thank on behalf of the Trust Board. This includes our staff and volunteers who work tirelessly to bring you the very best care, and our partners across Leeds who are committed with us to making Leeds a city where health care is a priority for all.

We will continue to build on our successes this year, focusing on the vision, values and goals that have been formed by our own staff, with the aim of delivering the very best care to the people of Leeds and further afield.

Dr Linda Pollard *CBE JP DL*
Chair

Julian Hartley
Chief Executive

About us

Leeds Teaching Hospitals NHS Trust was formed in April 1998, following the merger of two smaller NHS trusts in the city. Today, it is one of the largest and busiest NHS hospital trusts in the United Kingdom.

Every year, the Trust provides healthcare and specialist services for people from the city of Leeds, the Yorkshire and Humber region and beyond. It plays an important role in the training and education of medical, nursing and dental students and is a centre for world class research and pioneering new treatments.

Our care and clinical expertise is spread over seven hospitals and medical facilities:

- Leeds General Infirmary
- St James's University Hospital
- Seacroft Hospital
- Wharfedale Hospital
- Chapel Allerton Hospital
- Leeds Children's Hospital
- Leeds Dental Institute

Our services

We are committed to providing patients with the very best care across all our services.

These include:

- high quality and effective hospital services for our community in Leeds, such as A&E, outpatients, inpatients, maternity and older people services;
- highly specialised services for the population of Leeds, Yorkshire and the Humber, nationally and beyond.

This means that people in Leeds have access to some of the very best care in the country and benefit from a seamless provision of all services.

We are one of the largest providers of specialist hospital services in the country, covering over 100 specialties, many of which are delivered across the region. Around 50% of our overall income of around £1billion comes from specialised commissioners, NHS England.

It means we attract specialists at the top of their discipline and enables us to offer our patients the very latest in drug trials, therapies and treatments.

Evidence suggests that for many complex conditions patients will get a better outcome if they are seen by a specialist in a place with the best equipment and expert staff available.

The majority of specialist services we provide can be categorised into five key groups:

- Specialist children's services
- Cancer, blood and genetics
- Neurosciences and major trauma
- Cardiac services
- Specialised transplantation and other specialised surgery

The Leeds Cancer Centre at St James's University Hospital provides some of the most advanced treatment and care for patients with cancer anywhere in the world.

The centre is one of the largest in the UK, offering comprehensive, specialist cancer services for patients in Leeds, Yorkshire and across the North of England.

Our practitioners have access to state of the art diagnostic services in both radiology and pathology and leading edge surgery to achieve the best possible clinical outcomes for patients. The Centre is the first in the UK to offer some of the most innovative treatments in both radiotherapy and chemotherapy.

This work is underpinned by a world-class programme of research and innovation for which Leeds Cancer Centre and Leeds Teaching Hospitals NHS Trust have an enviable reputation. The Centre is supported by the University of Leeds and public and private sector partners to pioneer new approaches to cancer therapy and care.

About us

Leeds Children's Hospital provides one of the widest ranges of specialist children's hospital services in the United Kingdom, offering the highest quality treatment and care to children and young people living in Leeds, across Yorkshire and beyond.

We are one of the UK's largest children's hospitals with access to state of the art treatments and facilities, providing major services for children and young people in specialties such as cancer and heart surgery.

We are one of only a small number of centres nationally offering liver transplants; Selective Dorsal Rhizotomy, a specialist surgical procedure for some children with cerebral palsy; gender identity services and services for children with primary cilliary dyskinesia – a rare respiratory disorder.

All our practitioners are dedicated to delivering the best possible clinical outcomes for every child, every time. Many of our clinicians are experts in their field, conducting research and pioneering new approaches to the treatment of illnesses affecting children and young people.

Just as importantly, we understand that children, young people and families need support and reassurance when they come to hospital. We aim to make sure Leeds Children's Hospital is a welcoming, caring place for all who need our services.

The Leeds Major Trauma Centre was created at the Leeds General Infirmary in 2013 as part of a network set up across England to improve care for patients with life-threatening multiple injuries.

It is one of only 12 combined paediatric and adult trauma centres in the country and takes adult patients from across West Yorkshire as well as from the Harrogate and York district, and children from across the wider region.

The facility has already made a big difference to both the quality of care and outcomes, and is one of the top three centres for volume of patients and survival rates in the UK.

In heart surgery, Leeds has the largest single centre Percutaneous Coronary Intervention (Primary PCI) service across the UK and was one of the national pilot sites for this service. PCI services are provided to more than 1,000 patients each year admitted acutely with a heart attack.

We have also developed the largest heart valve implantation service in the UK, and the largest cardiac MRI service outside of London. We host the West Yorkshire arrhythmia service, with state-of-the-art facilities for the investigation and treatment of heart rhythm disorders. Our clinical teams also provide a regional service for inherited cardiac conditions and a multi-disciplinary heart failure service.

Our liver and kidney transplantation teams continue to provide complex, specialist and tertiary renal services for the population of the Yorkshire and Humber region. We are the largest solid organ transplant centre in the UK, the third largest liver transplant centre and the largest liver cancer surgery unit. Our teams also provide comprehensive urological cancer services.

Our vision and values

Leeds Teaching Hospitals NHS Trust is committed to delivering the highest quality and safest treatment and care to every patient, every time.

Our vision is for the Trust to become the best in the United Kingdom for specialist and integrated care - not only for patients in Leeds, but also for those from the wider Yorkshire and Humber region and beyond.

To achieve our vision, we are developing a new strategy for the Trust over the next five years called. In December 2013, we began by asking our staff to define the values that will be the foundations of our culture, what we believe and how we will work for the benefit of patients for years to come. These are listed opposite.

The Leeds Way - Our values

We are patient-centred

We consistently deliver high quality, safe care

We work around the patient and their carers and focus on meeting their individual needs

We act with compassion, sensitivity and kindness towards patients, carers and relatives

We are fair

We treat patients how we would wish to be treated

We strive to maintain the dignity and respect of each patient, being particularly attentive to the needs of vulnerable groups

We are collaborative

We are all one team with a common purpose

We include all relevant patients and staff in our discussions and decisions

We work in partnership with patients, their families and other providers so they feel in control of their health and care needs

We are accountable

We act with integrity and are always true to our word

We are honest with patients, colleagues and our communities at all times

We disclose results and accept responsibility for our actions

We are empowered

We empower colleagues and patients to make decisions

We expect colleagues to help build and maintain staff satisfaction and morale

We celebrate staff who innovate and go the extra mile for their patients and colleagues

Highlights of the year

We have made a huge effort over the past year to publicise all the fantastic achievements of the Trust and our staff, who work tirelessly to provide the best in patient-centred care. Using all the tools at our disposal, including social media, we have showcased clinical 'firsts', invaluable research and many special occasions to members of the public, showing that LTHT is at the forefront of specialist and integrated healthcare within the UK.

In April, the Trust was selected to take part in a nationwide evaluation scheme to assess the value and impact that Multiple Sclerosis specialist services deliver to the NHS.

LTHT was selected to take part in phase II of the MS Trust's *Generating Evidence in Multiple Sclerosis Services* (GEMSS) project, which involved eleven teams across the UK representing a cross-section of MS services, rural and urban, large and small, community and hospital based.

The project involved a full year of data collection (2014-15) and analysis with ongoing support from the MS Trust. In addition, they will conduct surveys of people with MS using their service as well as other health professionals in their area. At the end of Phase II, they will produce local reports and the MS Trust will publish a combined evaluation report on MS specialist services in the UK.

Early in April we saw the launch of the new Leeds Institute for Quality Healthcare. It was the culmination of two year's work by clinical leaders across the City who agreed it as a key priority.

Investment came from local commissioners but LTHT operated as a full partner in taking the work forward, with more than 20 members of staff attending the launch.

The Trust had a number of people participating in the first three priority areas, which were:

- fractured femur in frail elderly people;
- cardiovascular disease;
- chronic pulmonary disease.

These teams started work in earnest in July, with further work-streams developing later over the rest of year for in preparation for launch in 2015.

In May, LTHT was praised by former Chief Executive of NHS Blood and Transplant, Lynda Hamlyn, who called the Trust an "exemplar" for its work to promote organ donation and undertake transplants.

Lynda visited Leeds General Infirmary to find out more about the good practice in place at LTHT and thank staff for their commitment for the organ transplant programme.

During a visit to Ward L6 she told Chief Medical Officer, Dr Yvette Oade, that the Trust "has a lot to shout about and be proud of" before urging LTHT to continue to raise awareness of all that has been achieved and to set an example for other hospitals in the region to follow.

eWhiteboards were rolled out across the Trust in May helping us to progress towards our vision of a comprehensive electronic patient record system.

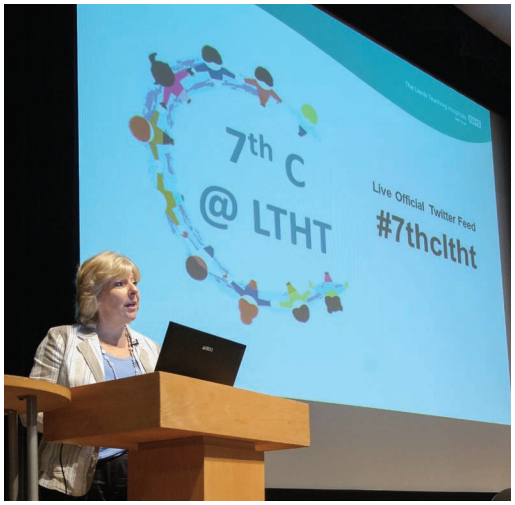
The eWhiteboard is a 55 inch, wall-mounted TV screen that displays important information about all patients on a ward, drawn from different sources to give a full perspective. All information, on all patients on the ward, is immediately transmitted in real-time to the big screen for easy viewing by staff.

Successful pilots were run on wards in Gledhow Wing, which showed that the eWhiteboards made our teams more efficient, enhanced patient safety and allowed more time for patient-focused care.

Responding to the need for a greater online presence, in June the Trust launched its official corporate Twitter feed (@LTHTrust).

The account, operated by the communications team gives the Trust the ability to share good news stories with the world, respond in real time to queries and interact with our patients, partners and stakeholders.

The month also saw our annual Nursing and Midwifery conference take place at the Royal Armouries in Leeds. The key focus of the conference was introducing collaboration to the 6 Cs.



The fantastic event was an opportunity to celebrate all the great things that our nursing teams do day-in day-out, share learning and best practice and look towards the future of the Trust.

There were some truly inspirational speakers such as Matt King OBE, and Dr Kate Granger MBE, as well as numerous other informative and motivational presentations on the importance and power of collaboration and compassion in healthcare.

Winners of the *Hilda Knowles*, *Janet Whittaker* and *Charitable Foundation* awards were also announced, showcasing the great work individuals and teams across the Trust are carrying out.

Highlights of the year

The Trust enjoyed two royal visits in July, highlighting the work of two of our services: The Leeds Children's Hospital and the Motor Neurone Disease Clinic at Seacroft.

Royal patron of the Children's Hospital, Sophie, Countess of Wessex, visited to officially open the new Children's Heart Ward on Clarendon Wing, L51, which had been relocated from Jubilee Wing to its new home.

The Countess, staff, patients and visitors marked the occasion with the cutting of a huge heart-shaped cake, specially made by staff nurse Louise Murphy.

In the same week HRH Princess Anne visited Seacroft Hospital to find out more about the partnership between the Motor Neurone Disease (MND) Association and the Leeds Wheelchair Centre. She met staff at the hospital and in particular Christine Orr, the Leeds MND Wheelchair Therapist, whose post was developed to provide specialist wheel care support to people living with MND.

Later in the year, HRH The Duke of Gloucester officially opened the Leeds Major Trauma Centre at the LGI. The centre is now one of the top three centres in the UK.

July was a key month in our calendar as LTHT launched The Leeds Way; the five values that define the Trust.

The values were introduced and shared at an event taking place in Leeds Town Hall with around 400 members of staff from every level and in every CSU and corporate directorate.

By working together and expressing views using crowdsourcing technology, the Trust defined 'the way we do things in our hospitals' through our five values:

- Patient-centred
- Fair
- Collaborative
- Empowered
- Accountable

The event was a really positive meeting and provided the opportunity for staff from across the Trust to share thoughts and ideas about how to embed the values into the day-to-day.

The Trust was pleased to announce in July that plans were in place for the development of a state-of-the-art Maggie's Centre at St James's.

Maggie's Centre, the first of its kind in Yorkshire, is set to provide a new-state-of-the-art facility to support cancer patients and their families. The new building will be funded by Maggie's, a leading national cancer support charity.

The £5 million facility will be located next to Bexley Wing, and designed by renowned architect Thomas Heatherwick, who designed the Cauldron for the 2012 London Olympic Games.

The Leeds Children's Hospital was selected as one of only five centres in the UK to provide Selective Dorsal Rhizotomy (SDR) in July, helping youngsters with cerebral palsy to walk.

Consultant neurosurgeon Mr John Goodden and his team worked tirelessly to secure the approval of NHS England to carry out the highly specialised operation to help improve the walking ability of certain children with cerebral palsy.

It means that children with spastic diplegic cerebral palsy can now have this operation on their doorstep instead of travelling to the US at huge personal cost.

The Trust played a key role in the organisation of the Tour de France weekend in July, being on alert to provide medical expertise and facilities for the Yorkshire stage had anything gone awry.

Extensive planning went into ensuring that teams across the Trust were ready and could respond to any eventuality.

The weekend passed without major incident and staff were praised for their amazing efforts in keeping the hospitals running smoothly despite the disruption.

In early August, the newly refurbished Adult Critical Care unit at St James's was officially opened, providing better care and more capacity for patients requiring intensive care.

The unit first opened 20 years ago, but in recent years it had become clear that the existing capacity was insufficient to meet the demand for critical care at St James's and also that the environment itself was not best suited to the needs of the 1300 patients treated there each year.

Due to the nature of the clinical work delivered in the unit, and the inability to close it completely, the work had to be done in phases with individual sections being isolated and upgraded one at a time.

The result is a much improved critical care unit, with two additional beds, more side rooms, greater visibility and accessibility of our bed spaces and improved privacy and dignity for our patients and relatives.

Highlights of the year

One of the highlights of August was the launch of our quality improvement programme at two day-long events.

The first looked at work to reduce the harm from the deteriorating patient and the second to reduce harm from falls.

Over 100 staff and experts were at the launch events and many wards and teams signed up to join the programme, which demonstrated the drive to make safety and quality of care for our patients a real priority.

Also in September, LTHT featured in a BBC Three documentary, *The Human Tissue Squad*, which highlighted our good practice and collaboration with partners.

The two-part documentary focused on colleagues at NHS Blood and Transplant, and their work to transport organs and tissue to where it's needed.

Children's heart surgeon Ms Carin van Doorn was filmed in our Children's Hospital to highlight how human tissue is used in life-saving procedures.

September saw the Trust short-listed for six HSJ awards.

The HSJ awards are the most prestigious healthcare awards in the UK with hundreds of applications every year so this was a massive achievement.

We were nominated in the following categories:

- Compassionate Patient Care
- Secondary Care Service Redesign
- Staff Engagement
- Rising Stars: Chris Jones (Service Manager, Leeds Major Trauma Centre)
- Workforce
- Improved partnerships between health and local government (along with Leeds Community Healthcare Trust and Leeds City Council).

We were delighted to have been recognised in this way and aim to do even better next year.

The Charitable Foundation and the Leeds Major Trauma Centre launched Day One charity on 8 September.

The charity was set up to support patients using our Major Trauma Unit, providing them and their families with an information resource at a time of great stress and to compliment the excellent clinical care we provide.

The event was attended by a number of former patients who had been treated by the unit; many of whom have also volunteered to get involved with the charity.

The Trust also saw the launch of the incredibly successful *Your Medicines, Your Health* campaign, which encouraged people to bring their own medicines to hospital.

The campaign went 'live' on 15 September with a powerful media and PR push taking place across Leeds to share the message far and wide to all those coming into hospital.

Since the start of the campaign, the Trust has seen a huge increase in the number of patients bringing their medicines in to hospital and experiencing the benefits of doing so. Delays at discharge are reducing and there has been a reduction in medicines waste within the Trust.

On Monday 22 September the Trust launched its new recruitment and 'on-boarding' website, improving the recruitment experience for prospective staff.

The new site is designed to reflect *The Leeds Way* values and ensure that we show our best assets to potential candidates who are looking for posts here at the Trust.

The same day also saw the implementation of Order Comms, the Trust's paperless system for ordering Pathology and Radiology tests.

The introduction of the system took place over a six week period starting with Bexley and Lincoln Wings on the St James's site, and then rolled out across LTHT. The system was the culmination of two year's work and has created many benefits in terms of improving patient safety and efficiency.

In October we welcomed Her Royal Highness, Princess Ghida Talal of Jordan to St James's and the LGI to find out more about cancer services provided by the Trust. The Princess was delighted to meet staff, patients and visitors while with us.

This visit came a year after signing a partnership agreement between the Leeds Teaching Hospitals NHS Trust and the King Hussein Cancer Foundation (King Hussein Cancer Center) in Amman, Jordan. The international link between the institutions was developed under the guidance of Healthcare UK, a joint venture between the Department of Health and UK Trade and Investment.

Highlights of the year

The Trust saw national UK media attention in November, following the first UK live liver transplant between identical twins.

Annemarie Atha donated part of her liver to her sister Geraldine Rowing in what was a heart-warming story and fantastic testament to the whole liver team here at LTHT.

The sisters did not realise that they were identical twins until Geraldine was placed on the Organ Transplant waiting list. Their clinician, Dr Davies, suggested that they looked similar and that he believed that they would be a match. After this revelation the transplant procedure finally went ahead without incident.

St James's also attracted attention in the press that month by performing its 3000th brachytherapy procedure. The team at the Leeds Cancer Centre carried out the specialist treatment for prostate cancer using this highly advanced targeted radiotherapy treatment which was pioneered in Leeds in the 1990s.

We are one of only a handful of UK centres to offer brachytherapy and have done the most procedures of any hospital in the country.

The 3000th patient, Edward Boynton, had previously heard about the treatment, and was delighted when told he could be referred here for the procedure. He was up and about within a couple of hours and able to return home that day.

In the same week our Urologists performed the first sentinel node biopsies for penile cancer here at LTHT.

The procedure had been a long time in development but well worth it for the difference it makes to our patients, with far less problems than traditional surgery and much better outcomes.

The Trust also celebrated performing its 4000th renal transplant in November with a special event to mark the occasion.

The Renal Transplant Team, support staff, former patients and their families came together in Bexley Wing to listen to presentations on how far the Trust has progressed in the field of renal transplants.

Patients talked about the difference a renal transplant has made to their lives and our clinicians delivered talks on developments around kidney transplantation at the Trust and how new techniques and procedures were revolutionising outcomes and saving lives.

In December the Trust celebrated success at the Yorkshire Evening Post Health Awards.

Lisa Beaumont, Play Specialist Team Leader and Jane Nicholson, Trainee Advanced Nurse Practitioner won *Unsung Hero* and *Nurse of the Year* awards, respectively. Senior sister, Gill Fallon, was also runner-up in the *Nurse of the Year* category.

In January the Leeds Dental Institute became the first dental hospital in the UK to move to Electronic Patient Records.

The Institute was allocated £1.7million from the Department of Health to make the move from paper to e-records, enabling the team to train over 600 students a year on the new system and helping to prevent data loss.

In February a new high-tech scanner costing £650,000 brought more world-leading technology to St James's

The hospital now benefits from an extremely advanced new SPECT-CT scanner which helps to improve the speed and accuracy of diagnosis for a range of conditions.

The equipment, installed in the Nuclear Medicine Department in the hospital's Bexley Wing, utilises two different types of scans. The images taken of a patient's body are then fused together to provide specialists at the hospital with more accurate information to aid diagnosis and decide on treatment plans.

Section 1

Operating and financial review

Operating and financial overview

In 2014-15, Leeds Teaching Hospitals NHS Trust saw and treated 1,021,261 outpatients, 29,155 elective inpatients, and 103,160 day case patients. We also treated 92,630 non-elective inpatients, had 221,069 patients attend our accident and emergency departments and 9,845 babies were born in our hospitals.

In addition, we delivered or subcontracted NHS services for a population of around 760,000 and provided specialist services for more than five million people.

1.1 Achieving quality, efficiency and financial sustainability

Like all NHS Trusts, Leeds Teaching Hospitals is under enormous pressure to meet the health care needs of a growing and diverse population, alongside great changes to the infrastructure of the NHS and a testing financial environment.

As part of our commitment to securing the best possible quality, outcomes and experience for our patients, we are working closely with the NHS Trust Development Authority (TDA). The TDA provides leadership, monitoring and support for non-Foundation NHS trusts to help them improve their services and ensure they are safe and sustainable.

We meet with TDA colleagues regularly and submit a number of documents to them, including our annual Operational Plan which sets out the Trust's ambitions for the year ahead. Particular areas of focus with our TDA colleagues include our journey towards financial sustainability, raising our CQC quality rating and achieving more of our NHS Constitution performance standards such as the four hour wait target in Accident and Emergency.

Although the standards in the NHS Constitution are difficult to achieve consistently, the Trust recognises that the NHS Constitution clearly sets out what we as staff, patients or members of the public can expect from the National Health Service and we are committed to meeting these standards.

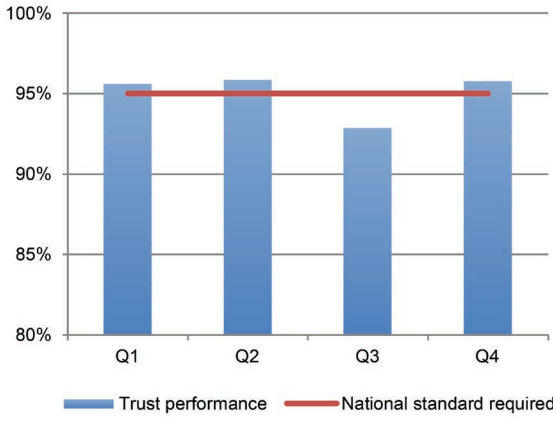
1.2 Our performance in 2014/15

The Trust's performance is assessed externally against a range of national targets and standards. Last year continued to be challenging, with hospital trusts like Leeds Teaching Hospitals striving to provide the highest standards of care for an increasing number of patients while achieving demanding efficiency savings and achieving financial balance.

Despite these challenges, we continued to provide safe, high quality care, with excellent clinical outcomes and a high level of patient satisfaction. Our performance in key areas is outlined below.

Emergency care

Percentage of patients treated within four hours in A&E

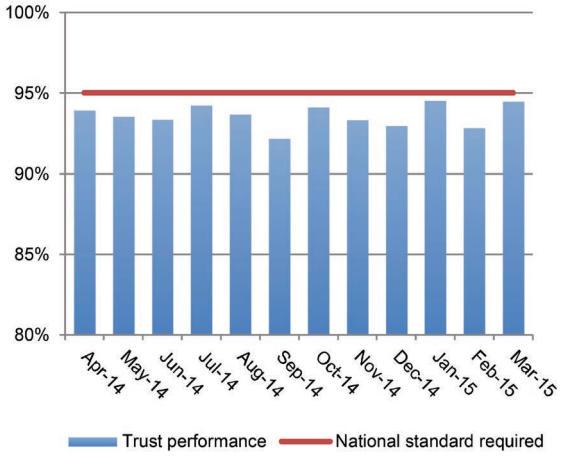


In 2014-15, our performance in Accident and Emergency (A&E) was maintained for the year, with our emergency departments seeing, treating and discharging or admitting 95% of patients within four hours, achieving the Department of Health target, despite the significant impact of winter pressures in Q3.

This was achieved through the continued hard work and dedication of our A&E and other hospital teams, and our ongoing approach to improving our systems and procedures. We will continue to refine these in 2015/16 to sustain and build on our progress.

Harm-free care

Percentage of patients experiencing harm free care

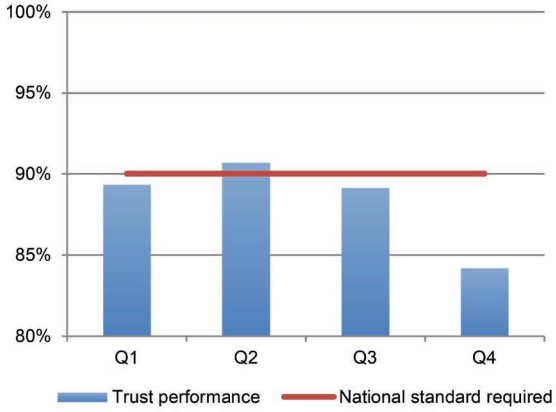


The percentage of patients receiving harm-free care has been largely sustained during 2014/15. Sustaining and improving on this position remains a priority for us during 2015/16.

18-week waiting times from referral to treatment (RTT)

Admitted

Percentage of patients starting admitted treatment within 18 weeks of referral

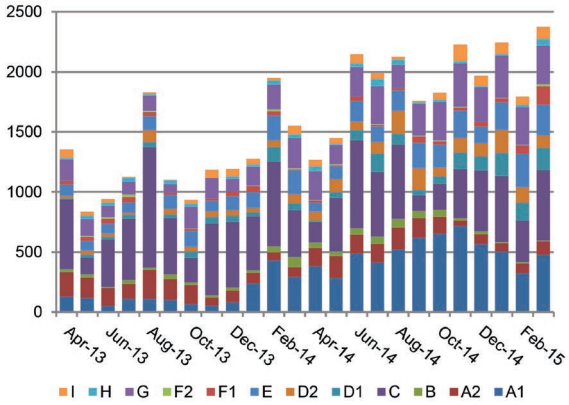


During the first half of 2014/15 good progress has been made in reducing the number of patients who waited longer than 18 weeks for elective treatment. In Q2 we achieved the 90% standard for admitted patients.

During Q3 2014/15 rising demand across elective specialties combined with a high volume of emergency activity, reduced our ability to continue this progress. A recovery plan is now in place alongside plans to increase activity in the coming year.

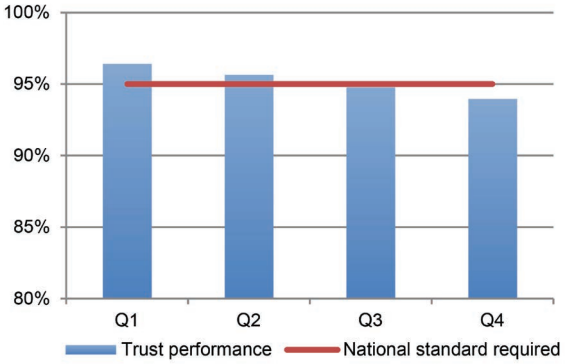
The impact of high and sustained levels of delayed transfers of care, which significantly reduced our elective capacity are demonstrated below:

Delayed Transfers of Care - lost bed days by delay code or reason



Non-admitted

Percentage of patients starting non-admitted treatment within 18 weeks of referral



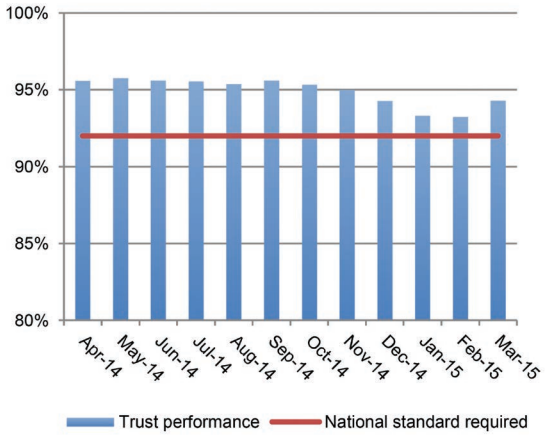
The standard of at least 95% of non-admitted patients to be treated within 18 weeks was achieved for the first two quarters of 2014/15.

During Q3 and Q4 of 2014/15 rising demand across a number of outpatient specialties has meant that the standard has not been achieved.

We have developed plans to ensure we meet both the Admitted and Non Admitted standards in 2015/16 and are working with referring GPs to understand and mitigate for increased demand. In addition, all Clinical Service Units have plans in place to ensure that outpatient pathways are as efficient as possible.

Incomplete referral pathways

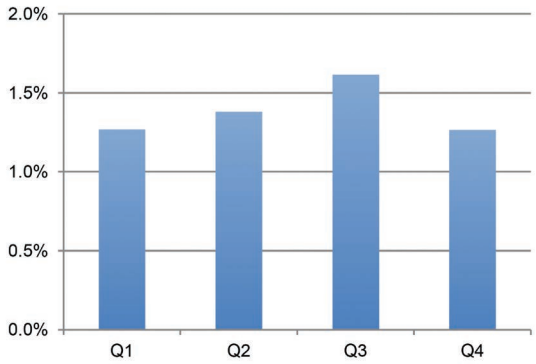
Percentage of patients on incomplete pathways waiting over 18 weeks



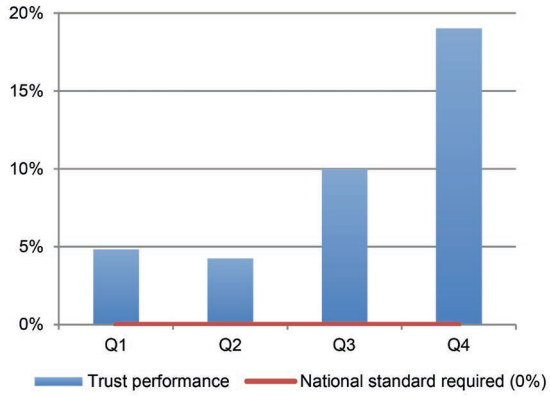
In 2014/15 we continued to achieve the standard for 92% of patients who remain on the waiting list to have waited less than 18 weeks (the incomplete standard).

Cancelled operations

Percentage of operations cancelled on the day



Percentage of patients not treated within 28 days of cancellation

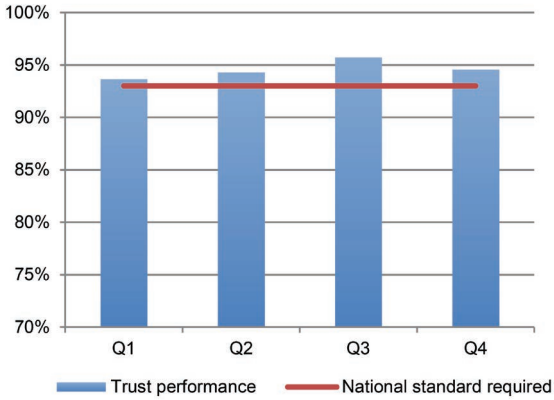


We recognise that last-minute cancelled operations are a distressing experience for patients and we have been working to reduce the number of these during 2014/15.

Whilst we made good progress in Q1 and Q2 this was significantly affected by the winter pressures, resulting in deterioration in our performance. We will again focus on achieving better results in 2015/16.

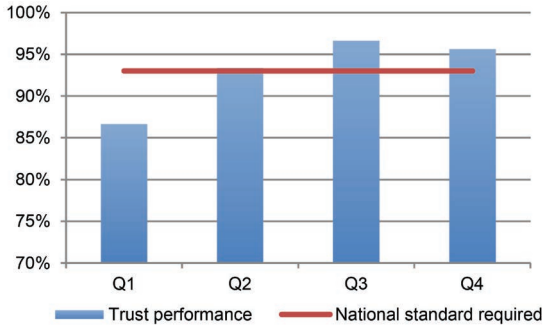
Cancer waiting times

Cancer access target: urgent GP referrals seen within 2 weeks



This standard of seeing urgent GP referrals for patients with suspected cancer within two weeks was consistently met in all quarters in 2014/15 despite the increases seen in demand.

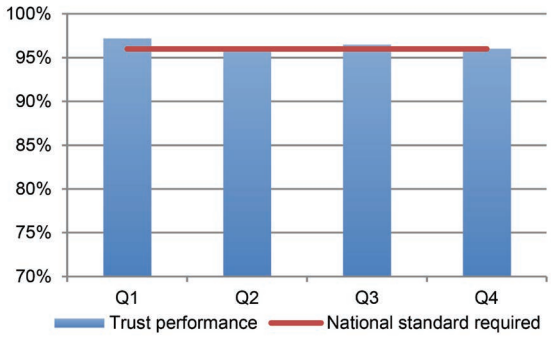
Cancer access target: breast symptomatic referrals seen within 2 weeks



The two week wait standard for patients referred with breast symptoms continued to be affected by large peaks in referrals and staffing issues, which led to the Trust not achieving the target in Q1 2014/15.

The strategy to improve our capacity and resources enabled us to meet the target sustainably for the remainder of 2014/15.

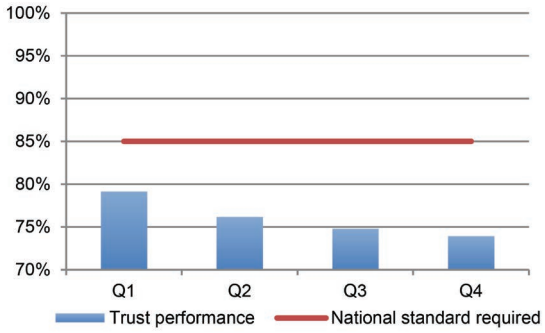
Cancer access target: first treatment within 31 days



During the first 3 quarters of 2014/15, we consistently achieved the target to treat patients within 31 days of a decision to treat. This was the case for first treatments and for subsequent surgery, drug or radiotherapy treatments.

However, during Q4 2014/15 the impact of winter pressures in January and February significantly impacted on our elective surgical capacity, including the cancer surgical specialties based at the St James's hospital site. This affected the 31 day first treatment and 31 day subsequent surgery targets in January, however teams were able to recover performance in February and March enabling the standard to be met for Quarter 4.

Cancer access target: treatment within 62 days of an urgent GP referral

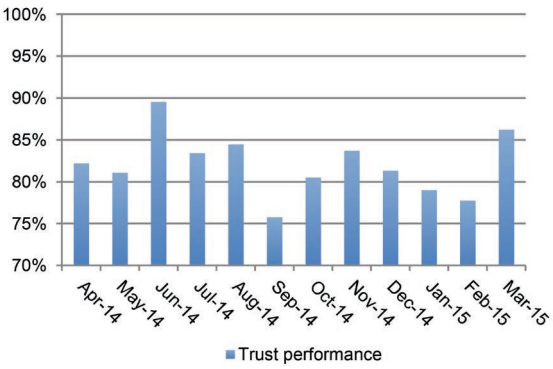


Meeting the standard for patients receiving their first definitive treatment for cancer within 62 days of an urgent referral for suspected cancer is a shared responsibility with other hospitals that refer their patients on to us for a significant part of our workload, which can make managing the standard more challenging.

During 2014/15, we continued to experience some resource issues in certain specialties as well as the impact of unprecedented winter pressures on our elective capacity.

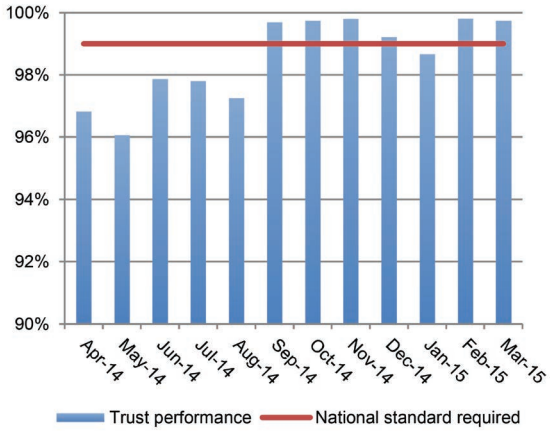
During Quarter 4 of 2014/15 we began to see our internal performance improve. Our work to resolve both our resourcing, and external referral issues will continue in 2015/16 to improve our performance further against this standard.

Cancer access target: treatment within 62 days of an urgent GP referral (internal referrals only; PPM data)



Diagnostic waiting times

Percentage of patients waiting less than 6 weeks for a diagnostic test at month end

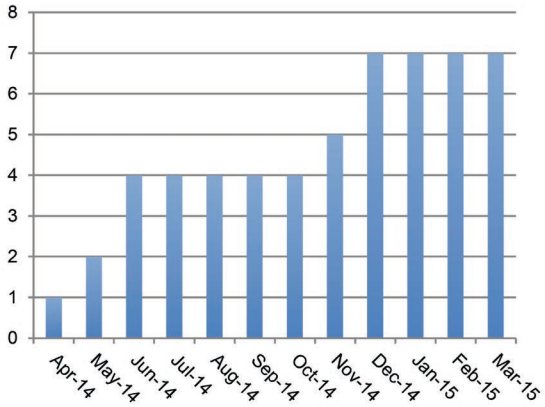


During 2014-15 significant progress has been made in addressing and sustaining our diagnostic waiting times performance (standard is for less than 1% of patients to have waited over 6 weeks at month end).

Our main issue was endoscopy staffing capacity which has now been addressed, putting us in a strong position ahead of our JAG accreditation for this service in June 2015.

Hospital acquired infections

Number of MRSA cases attributed to the Trust (cumulative)

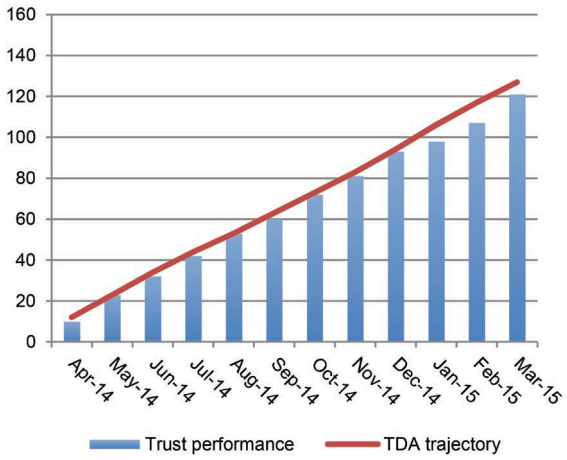


We are committed to reducing the levels of hospital acquired infections. Reducing the rate of Methicillin Resistant Staphylococcus Aureus (MRSA) infections is a key national target and indicates the degree to which hospitals prevent the risk of infection by ensuring the cleanliness of their facilities and good infection control compliance by staff.

During 2014/15 we had seven cases of MRSA bacteremia recorded against a zero tolerance standard. We need to continue to improve in this area and during 2015/16 we will focus again on keeping these infections to a minimum.

Clostridium Difficile (C difficile)

Number of CDI cases attributed to the Trust (cumulative)



Our commissioners had set us a target of no more than 127 cases of Clostridium Difficile (C difficile), another hospital acquired infection, which we achieved.

We are determined to continue to make progress, in line with our desire to reduce harm for our patients. For 2015/16, we have been set a target of 121 cases of C difficile.

Factors likely to affect performance in 2014/15

Providing patients with the highest quality service continues to be a priority for the Trust. In the next year, we have identified a number of factors that may impact on our performance and have plans in place to ensure we continue to maintain or improve our standards of treatment and care.

Emergency care
Delivering the four hour target for patients in A&E (the Emergency Care standard) during the year was a huge achievement for the Trust. To sustain our performance in 2015/16, we are planning further arrangements to ensure patients receive care in the right place at the right time and are discharged from the Trust in a timely way.

Referral to treatment
We want to restore our progress in reducing the numbers of patients who have waited more than 18 weeks for their procedure, and ensure that 90% of our patients receive their treatment in less than 18 weeks from the end of September 2015. To achieve this, we are working with other providers and our commissioners to make sure our pathways of care both inside our hospitals and across the local health care system are as efficient as possible and that any increased demand on our services above agreed levels is managed appropriately.

Cancer waiting times
Seeing patients with suspected cancer within the waiting times set by the NHS is of fundamental importance to us. Yet again, increases in the number of patients being referred for suspected cancer (two week wait referrals) means we have continued to face challenges in creating enough capacity within the Trust to meet demand, within the very tight two week timescales.

In 2015/16, we will continue to act on our plans to increase and sustain our capacity to deliver two week waiting times for urgent appointments, recruiting more staff in some cases, or using our resources more efficiently, as well as working with our commissioners to address areas of rising demand we cannot accommodate.

Achieving the target that a patient with suspected cancer should be treated within 62 days of an urgent GP referral remains a challenge. Many of our referrals are made by surrounding hospitals and we continue to work closely with them to make sure these patients arrive at our hospitals in line with trajectories agreed with them during 2014/15.

1.3 Improving quality

Anyone who is treated at Leeds Teaching Hospitals NHS Trust, whether as an outpatient, inpatient or in one of our emergency departments expects to receive only the best, the safest and most compassionate care.

Delivering the highest standards of service for our patients is the cornerstone of our work at the Trust. The drive to improve patient care informs our values, underpins our goals and is part of everyday working life for all our staff.

In 2014/15 we published our Quality Improvement Strategy that set our quality ambition up to 2017. We continued to work with the Yorkshire and Humber Improvement Academy to support the delivery of our strategy in conjunction with Salford Royal Hospitals Foundation Trust, nationally recognised experts in quality improvement. We also worked this year with our partners across the Leeds Health and Social Care Community and the Leeds Institute for Quality Healthcare. This unique partnership aims to redesign clinical pathways across health and social care to improve the experience of patients, focussing in this first year on patients with cardiovascular disease, chronic obstructive pulmonary disease (COPD) and Fractured Neck of Femur. We will continue to deliver improvements in 2015/16, building on these existing programmes and adding new ones, including the care of people with dementia, cancer and diabetes.

We joined the national Sign up to Safety Campaign in August 2014, making our pledges to contribute to the ambition to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. We developed our Safety Improvement Plan, setting out our quality goals for improvement, including falls and pressure ulcer prevention, improving the care of patients with sepsis and acute kidney injury, deteriorating patient and maternity care. We were delighted to be notified in March 2015 that our bid for funding to support the delivery of our Safety Improvement Plan was successful. This will be used to make further improvements in the quality and safety of our maternity services to help us reduce the numbers of incidents resulting in harm.

We have much to be proud of in our quality achievements through 2014/15. Some of the highlights are described below.

- We have continued to reduce the rate of infections in our hospitals, including MRSA and *Clostridium Difficile*.
- We have met the emergency care standard, ensuring that 95% of our patients were seen and treated within 4 hours. This is an excellent achievement, especially given the many challenges we faced over the winter period, along with a number of other hospitals. This was down to the hard work and determination of our staff to ensure that our patients received safe care in our emergency departments.
- We have worked with our clinicians, managers and local partners at Leeds West Clinical Commissioning Group and Healthwatch Leeds to identify the following priorities, among others, for 2015/16.

Patient safety

We aim to:

- Continue to reduce the incidence of falls and harm sustained to patients following a fall.
- Further reduce the number of hospital acquired pressure ulcers and the incidence of category 3 and category 4 pressure ulcers.

Clinical effectiveness

We aim to:

- Continue to improve the care of patients when their condition deteriorates on our wards.
- Improve the care of patients with serious infection (sepsis)
- Improve the care of patients with acute kidney injury

Patient experience

We will continue to improve the way we handle complaints and the timeliness of our responses. You can read more about our work in this area in Section 3 of this report: Patient Care and Experience, on page 81.

Further information on key improvements in our quality of care and patient safety, the Trust's performance against national targets in 2014/15, goals agreed with commissioners and our plans for 2015/16 can be found in Section 4: Quality Account, on page 95.

1.4 The NHS Constitution

NHS bodies like Leeds Teaching Hospitals NHS Trust are required by law to comply with the NHS Constitution, a document that establishes the principles and values of the NHS in England.

The Constitution sets out rights to which patients, the public and staff are entitled and pledges that the NHS is committed to achieve. It also describes the responsibilities that patients, staff and the public owe to one another to ensure the NHS operates fairly and effectively.

The Trust takes all reasonable steps to ensure the requirements of the NHS Constitution are met. Where patients are referred by their GP for consultant-led treatment the Trust aims to deliver this within 18 weeks, or where they have been referred to a cancer specialist within two weeks.

Where this is not possible, the Trust will offer alternative choices of provider when these are available and it is clinically appropriate to do so. In the coming year, the Trust has put plans in place to increase capacity to ensure that it can keep pace with growing demand for some services and offer more patients their treatment within 18 weeks.

1.5 Finance review

	Plan 2014/15	Actual 2014/15	Actual 2013/14
Income and Expenditure Reported Deficit/Surplus	-£50m	-£24m	£2m
Cash	£3m	£3m	£23m
Capital Spend	£32m	£42m	£29m
Cost Improvements	£54m	£54m	£39m
Continuity of Services Risk Rating - Score	1	2	3
Better Payments Practice Code	95%	90%	67%

The Trust commenced 2014/15 planning a revenue deficit of £50 million and having to find efficiency savings of £54 million. Both of these targets were achieved in a very challenging year for the NHS generally. As described elsewhere in this report they were delivered alongside improvements in patient care and safety.

The financial plans for 2014/15 were the first stage in a recovery plan which will see the Trust returned to sustainable breakeven in 2017/18. The plans have been agreed by our regulator, the Trust Development Authority. Inherent within that agreement is access to cash support to enable the Trust to meet all of its payment obligations in the years when it is reporting deficits.

Revenue Position

The Trust delivered a £24 million deficit against a planned deficit of £50 million as a result of the factors summarised below:

	£m
Planned Deficit	**50**
Non-recurrent Income Support	14
Depreciation Savings	9
Winter Pressures Funding	2
Income Improvement	1
Reported Deficit	**24**

Like a number of other trusts across the country we received a non-recurrent income payment from the Trust Development Authority to support the delivery of healthcare services.

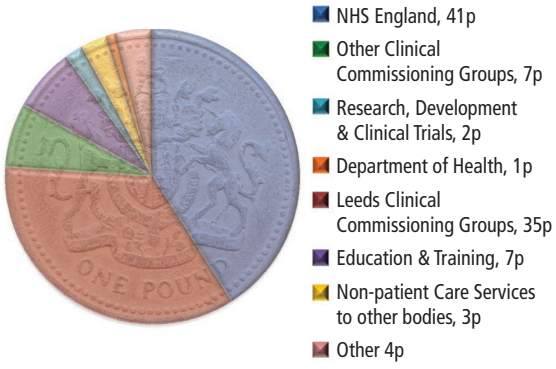
In the summer of 2014 the Trust engaged the services of DTZ Debenham Tie Leung Limited to conduct a full cyclical valuation of its land and buildings. This resulted in some buildings being impaired (fall in value), others having previous impairments reversed (increase in value) and extensions to the remaining economic lives of most having taken account of their age, condition and fitness for purpose. The net impact on the value of our estate was a reduction of £2 million and depreciation savings as identified above.

The difficulties faced by the NHS over the winter months were well publicised. The Trust received an additional £2 million as part of the national "winter pressures" allocation to help it through this traditionally challenging period.

Operating Income

The chart below gives an indication of where income came from in 2014/15.

Where each £1 came from



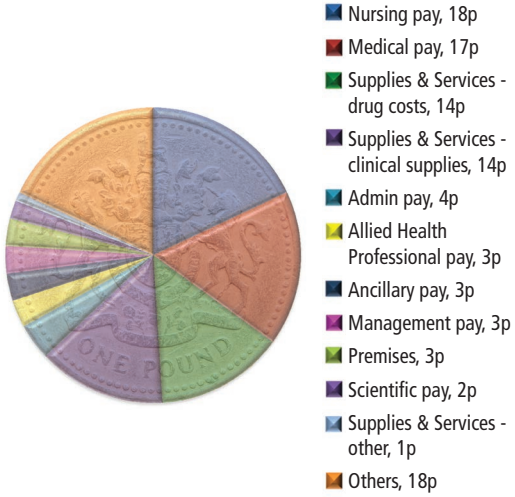
Income from our Clinical Commissioning Groups and NHS England (which commissions specialist services) increased in total by £35 million on the previous year and exceeded our plan by almost £40 million. This reflects an overall 2% increase in patient related activity with the Trust over performing against its two principal contracts (NHS England and the Leeds CCGs). Income for other patient care related services remained broadly consistent when compared to 2013/14.

Other operating income fell in total by £8 million. Of this figure, £5m is due to hosting arrangements for Research & Development on behalf of the National Institute for Health Research transferring from Leeds to Sheffield. The income reduction is however matched by a corresponding fall in expenditure. There was also a change in the way medical education funding is allocated nationally and this resulted in a reduction of £2 million in income received by the Trust.

Operating Expenditure and Cost Improvements

The chart below gives an indication of how the Trust spent its resources in 2014/15.

How each £1 was spent



The challenging target of £54 million of cost improvements was achieved in the year. £30 million came from schemes originally planned for 2014/15 and the balance from newer schemes identified in year. The schemes themselves varied enormously in their nature and value but included almost £3 million efficiencies in drug procurement and a further £1 million from our project aimed at asking patients to assist us improve their care by bringing their own medicines into hospital with them.

The costs associated with paying staff increased from £600 million in 2013/14 to £632 million in 2014/15. The national pay award increased costs by almost £9 million. The Trust invested a further £8 million in recruiting additional staff, many of which were nurses. The cost of agency staff increased by £17 million. In part this was due to the fact that many of our new nurses commenced mid-way through the year on completion of their training and in the early months agency staff filled those posts.

Non pay related costs saw a net increase of £30 million year on year. Total expenditure on drugs and other clinical supplies rose by £40 million reflecting general price rises and increased clinical activity. Use of the private sector to treat patients within waiting time targets showed a cost increase of £3 million. These increases were offset by £9m savings in depreciation and £3 million impairment reversals arising from the estate revaluation.

Working Capital

In 2014/15 a successful bid was made to the Independent Trust Financing Facility (ITFF) for cash support of £34 million. This was necessary to enable us to meet all of our day to day payment obligations in a year when we were planning a revenue deficit. The Trust Development Authority, our regulator, was fully behind our bid, which followed the process set down by them for trusts to access working capital. The support agreed by the ITFF came to the Trust in March as Public Dividend Capital (PDC) and the cash enabled us to repay temporary drawings of PDC cash of £29 million which had helped us to meet our obligations during the course of the year. This enabled us to improve our performance against the Better Payment Practice Code which requires organisations to pay suppliers within 30 days or other agreed terms. We improved from 67% compliance in 2013/14 to 90% in 2014/15.

The Trust's cash balance at the end of the year was £3 million, a £20 million reduction on the previous year. It was necessary to use our own brought forward funds to make payments during the year to mitigate the amount of support we required. Given that further cash support will be required in 2015/16 the planned cash balance at 31 March 2016 will again be £3m.

Going Concern

In view of the fact that the Trust has required cash support in 2014/15 and will do so again in 2015/16 it is appropriate to consider briefly why we should be considered a going concern for the purpose of preparing and reporting our accounts.

The reported and planned deficits are part of a longer term recovery plan which has been agreed by the Trust Development Authority. In 2014/15 we did receive the support we required to enable us to meet out payment commitments but we also achieved our £54 million of planned savings. In looking to 2015/16 and beyond there is every reason to believe that the cash support we require will be available to us through the Department of Health's recently implemented Working Capital Facility. The Trust Development Authority has written separately confirming that access to cash will be available throughout 2015/16. We have agreed contracts in place with all of our principal commissioners for 2015/16 and the Board approved a budget in March which is consistent with our longer term plan. The Trust has robust planning; efficiency delivery and external cash support arrangements in place. For these reasons it is entirely appropriate that the Trust presents its accounts on the basis that it is a going concern.

Capital Investment

Investment in our buildings, equipment and information technology amounted to £42 million, an increase of £13 million on the previous year. The table below shows how the money was spent.

Description	£m
Equipment	
Endoscopy Equipment	2.3
MRI Scanner	1.4
Anaesthetic Equipment	0.8
Paediatric Surgical Robot	0.8
Patient Monitors	0.7
CT Scanner	0.6
Bedside Ventilators	0.6
Mobile X-Ray Units	0.5
Ultrasound Scanners	0.5
Other	8.9
Sub Total	**17.1**
Building and Engineering Schemes	
Electrical Infrastructure	4.5
Alterations to Surgical Assessment Unit	1.9
Clarendon Wing Generator Replacement	1.4
Fire Precautions	0.8
Improvements to Critical Care	0.6
Alterations to Jubilee Wing Wards	0.5
Infection Control/Hygiene	0.3
Other	5.5
Sub Total	**15.5**
Informatics	
Electronic Patient Records	1.9
Hosted Data centre	1.2
E-Prescribing	1.0
Windows 7	1.0
Inpatient Mobile Point of Care	0.8
Maternity System	0.3
Other	3.5
Sub Total	**9.7**
Grand Total - Gross Capital Spend	**42.3**

A capital investment loan of £11 million was secured in addition to our revenue support from the Independent Trust Financing Facility. This increase to our planned expenditure was used to bring forward renewal of ageing medical equipment and thereby take prompt action to deal with recommendations made by the Care Quality Commission following their visit in early 2014.

Capital investment was once again enhanced by generous donations from a number of charitable organisations which work closely with us to help improve the general environment for our patients, support research and purchase medical equipment. During 2014/15 we received almost £3 million in capital donations which included:

Description	£m
Donated	
Paediatric Surgical Robot	0.8
Patient Monitors	0.2
Paediatric Intensive Care Ventilators	0.2
Other	1.6
Grand Total	**2.8**

Looking ahead

In 2014/15 the Trust made important progress moving towards achievement of its 4 year financial recovery plan and its strategic objective of financial sustainability. In order to continue with this progress and meet the financial challenges of 2015/16 the Trust will have to deliver £67 million in cost improvements, an increase of £13 million on the previous year. The planned revenue deficit is £40 million which, once again, will require cash support.

Delivery of such a programme presents significant difficulties. The scale of the savings requirement could be daunting and non-delivery presents a major risk not only to achievement of the planned deficit in 2015/16 but to the full financial recovery programme which ultimately is required if the Trust is to achieve Foundation status.

While these risks must be acknowledged, together with the possibility of external influences or constraints beyond our control, there is confidence in the Trust that the challenge can be met. Our achievement in delivering the 2014/15 savings requirement provides a platform and a framework on which to take our planning forward. There exists within the organisation the staffing resource and infrastructure to ensure specific savings plans are identified, monitored, reported and delivered alongside maintaining high quality safe care for our patients. The support provided to the Trust by the Finance Directorate has been strengthened and remodelled during the course of 2014/15 to ensure effective partnership working. The budget for 2015/16 was agreed by the Board before the commencement of the financial year and our relationship with our principal commissioning organisations is high. Contract agreements are in place to underpin confidence in our income plans.

1.6 Future direction

Our Five Year Strategy

Over the last 12 months the Trust has been developing its five year strategy. From the outset we encouraged our staff to be involved in this work and invited comments from partners across the health and social care community. The consultation exercise was very successful and produced some 40,000 contributions. The consultation demonstrated that people wanted us to work within a common set of values and behaviours. These were summarised in five attributes namely: "fairness, empowerment, collaboration, accountability and patient centred care". The Trust formally adopted these values and collectively called them "The Leeds Way".

As well as defining the organisation's values, the consultation also showed that people believed that the prime purpose of the Trust should be to provide the highest quality of care to all our patients. This was summarised in our vision to be "the best for specialist and integrated care".

In order to become the best for specialist and integrated care, the Trust identified five goals that it would need to achieve as part of its five year strategy. Each goal was linked to ten objectives from which we can monitor our progress.

Our Goals and Objectives

Goals	Objectives		
The best for patient safety, quality and experience	Drive quality improvements to become the safest healthcare organisation in the country	Involve patients in their treatment and use their feedback on the services they receive	Deliver all mandatory standards in line with the NHS Constitution and all regulatory requirements including improvement of care, capacity and demand management
Financially sustainable	Improve financial margins to support the delivery of high quality care	Seek out mutual business development growth opportunities to benefit the trust, its patients and the Leeds city region	
A centre of excellence for specialist services research education and innovation	Ensure the Trust is a leading provider of specialist services	Deliver Commissioners' activity and improved patient pathways by widespread deployment of improvement techniques, removing waste and increasing productivity	Be an outstanding research and education organisation
Hospitals that offer seamless, integrated care	Improve care and services through integration and collaboration across networks and partners		
The best place to work	Develop a highly engaged, highly performing workforce and positive patient culture delivering great care for patients		

For 2015/16 the Trust is required to produce a one year Operational Plan. This plan has been built using the Trust's five goals and sets out the key objectives for the year ahead.

Our Operational Plan for 2015/16

The best for patient safety, quality and experience

In 2015/16 we will focus on reducing our mortality rates. We will strive for harm free care as measured by the national safety thermometer and the occurrences of health care acquired infections. We will also involve patients in their care and listen to their feedback. A full list of the Trust's plans for quality care can be found in the Trust's new Quality Improvement Strategy. An important part of improving the quality of care we offer is to ensure that our patients do not wait longer than the maximum waiting times guaranteed in the NHS Constitution.

Financially sustainable

The Trust has needed financial support to balance its income and expenditure in 2014/15. We are required to eliminate this deficit which will mean that during the coming year the Trust will have to take difficult decisions about what we spend and how productive we are in the use of facilities such as operating theatres and critical care. We must also accurately record all the work that we do.

A centre of excellence for specialist services, research education and innovation

We will work with our commissioners to be accredited as a specialist centre for a variety of rarer conditions. We will also co-operate with neighbouring West Yorkshire hospitals to ensure that patients' services are provided as close to their homes as possible.

We will continue our commitment to research and education. In April 2015 the Trust launched its new five year strategy for research and innovation. The goal of the strategy is to deliver 'research for all', by significantly increasing opportunities for patients and staff to participate in high quality research studies.

Hospitals that offer seamless, integrated care

We will continue our work with the Leeds Health and Well Being Board, and colleagues in other health and social care organisations, to ensure that patients receive the most appropriate care in the most appropriate setting. It does not benefit the patient, or the Trust, if people are kept in hospital when there is no longer a medical reason to do so. In the coming year we will engage staff and patients in a review of how we provide care for people in Leeds so that it is integrated, co-ordinated and personalised around people's needs.

The best place to work

We appointed an additional 200 nurses in 2014 and we have made great progress in embedding the Leeds Way across our organisation. We are working to improve our recruitment process and we will be looking to progress a number of areas in 2015/16 including workforce planning, responding to the seven day working initiative, whistleblowing and volunteering. Our plans for all these initiatives were published in a People Strategy during the Spring of 2015.

Our future plans

The new Director of Strategy and Planning has been working with our Senior Leaders to develop our plans for the future. In the second half of 2014, our Clinical Service Units (CSU) teams held their own consultations and wrote their five year plans at specialty and CSU level. These were called Clinical Business Strategies and each CSU presented their strategy to the Trust Board in November 2014.

Work has since continued on the Trust wide strategies, taking up many of the themes from the CSU discussions such as those for the hospital estate and IT. Our Board is currently considering a number of options to dispose of some of our Victorian buildings at the LGI and invest in better facilities in operating theatres, crucial care, day units and some outpatient facilities. There is also a planned programme of investment to build resilience to our IT systems and improve its functionality.

In 2016 we will bring together the strategic planning work into a more formal, integrated five year plan for the Trust. This will show the further improvements that we believe we can make to the quality of care we provide, the estate from which we work and our financial and performance projections. This will be important in demonstrating to the TDA that

we can deliver the access times that patients are entitled to and that we can be a financially viable organisation, capable of governing ourselves as a Foundation Trust.

The access and financial challenge is significant but we are confident that all our staff are committed to a process of continuous improvement. We also know that we need to work with our colleagues in the community, and other agencies, to ensure that patients are given the right treatment in the best environment for their needs.

1.7 Managing risk

The Trust is committed to the safety of patients, staff, contractors and visitors. This is achieved through the management of risk and by encouraging safe working practices and procedures throughout the organisation.

In 2014/15 a review was undertaken on how risk is managed and escalated within the Trust. As part of this work a decision was made to transfer all our risk registers on to Datix, the Trust's risk management system which is also used for the reporting of incidents, complaints, claims and inquests. To bring additional scrutiny and challenge to the process, on a rolling basis, all of the Clinical Service Units are now required to present their risk registers to the Risk Management Committee, a sub-committee of the Trust Board, chaired by the Chief Executive. You can read more about this in Section 4: Quality Account on page 95.

In 2013/14 the Trust rolled out on-line incident reporting and in 2014/15 we have worked on embedding this process. We have been pleased to note an increase in reporting which is seen as a positive indicator of a strong reporting and learning culture. It has also brought about improvements in the timeliness of reporting and reviews of reports, enabling much quicker action to be taken.

In 2014/15 the Trust focused on improving its systems for the dissemination and embedding of learning. A task and finish group was established to review the existing processes within the Trust and to explore and test new ways of working to see if these were more effective than current ones. As a consequence of this work, new methods of sharing learning from incidents have been developed. These have included the use of social media and short videos to disseminate key learning. The feedback from staff has been very positive. We intend to build on these processes throughout 2015/16.

We have continued to build internal capacity within the Trust for robust risk management through the provision of training on a variety of topics including incident reporting and investigation; root cause analysis; lead investigator training; refresher training in the management of risk with a particular focus on risk assessment and analysis for senior managers; and utilising data effectively for identifying themes, trends and learning. We will build on this work in the coming year ensuring that risk management is embedded at all levels of the organisation.

During the year, the Trust joined the Sign up to Safety campaign - a national campaign aimed at reducing avoidable harm in the NHS by half over the next three years. We have published our commitment to embedding the principles of the campaign and developed a Safety Improvement Plan, based on our analysis of risk data, which underpins this commitment. We will be monitoring our performance against this plan on a regular basis over the next three years.

1.8 Regulatory ratings

The NHS Trust Development Authority (TDA) placed Leeds Teaching Hospitals NHS Trust in Escalation Level 2. We continue to work closely with them to ensure we are delivering the best quality outcomes and experience for our patients. We are committed to meeting their performance and financial standards, enabling us to progress to Foundation Trust status.

Further to the Care Quality Commission (CQC) inspection in March 2014 and the subsequent report received from them in July 2014, we have now delivered on all the actions set out in our improvement plan. This has been shared with the CQC and TDA and also discussed at the Joint Health Overview and Scrutiny Board.

1.9 Sustainability

Environmental Impact Performance Indicators 2013/14

Area		Non-financial Metric	Non-financial Metric		Financial data (£,000)	Financial data (£,000)
		2014/15	2013/14		2014/15	2013/14
Waste minimisation and management	Clinical HTI	2,599 Tonnes	2,335 Tonnes	Total Waste Cost	£1,664	£1,610
	Clinical - Alternative	2,585 Tonnes	2,330 Tonnes			
	Landfill disposal	1,003 Tonnes	1,181 Tonnes			
	Recycling / Recovery	1,715 Tonnes	1,294 Tonnes			
Finite resources	Water / sewerage	753,838 m^3	727,634 m^3	Water / Sewerage	£1,321	£1,272
	Electricity	16.12 GWh	17.19GWh	Energy	£10,728	£12,256
	Gas	297.9 GWh	297.6 GWh			
	Heat and Power	4.26 GWh	5.72 GWh			
	Oil	0.10 GWh	0.10 GWh			

Energy saving

Work is underway to renew energy contracts at both Leeds General Infirmary and St James's University Hospital in 2015 which aim to deliver significant energy savings and reduce the Trusts carbon emissions.

Carbon reduction

We continue to make progress to reduce our carbon footprint. Since the base year of 2007, we have saved over 6,263 tonnes per annum – a reduction of 9.2%. The national target is 10% by next year and 34% by 2020. This is measured against energy savings but it excludes reductions from the transport fleet and waste.

Waste segregation

We continue to run education campaigns across the Trust to improve the management and disposal of all waste. As part of these campaigns the Trust now has a dedicated Specialist Waste Trainer. This new role involves carrying out monthly waste audits in all wards and departments across the Trust and offering support, guidance and training on the safe and cost effective methods of waste segregation.

An example of improved segregation followed an initial waste audit where one department identified the requirement to move from two waste streams to six. This meant their carbon footprint has reduced substantially and the environment is safer for patients, visitors and staff as well as saving the Trust money on waste disposal costs. Over the past few months we have identified where £10K of annual savings in waste disposal costs can be made in one department alone. This was achieved by increasing staff knowledge on correct segregation.

Healthcare sharps

In 2014/15 the Trust produced 14 tonnes of sharps waste - all of which, including the receptacles, are currently incinerated. An investigation is currently underway exploring the possibility of trialing a reusable sharps container system. This system if implemented

will dramatically reduce the need to purchase single use sharps containers. Receptacles are decontaminated to the relevant HTM (Health Technical Memorandum) standards before being put back into service. The environmental benefit of such a system means that none of the receptacles will have to be incinerated. This will reduce the Trust's carbon foot print and also the benefit of reduction in plastic use will also be seen.

Golden sharps award

The Golden sharps award was introduced in December 2014 as a way of raising the profile of waste in a light-hearted way and to reward areas that had made significant improvements in their practice. The award is handed out on a monthly basis to the ward/department that has achieved the highest score in their waste handling audit. As part of the on-going improvement process some areas have introduced ward based 'Waste Champions' to ensure that the good practice identified during audit is maintained and continually improved.

Recycling

During 2013, we awarded a new municipal waste contract, which began in June 2014. The new contract ensures that non clinical waste is sent to a sorting facility where it is separated with all probable items being sent for recycling. The remainder is sent for energy recovery, significantly reducing the Trust's waste sent to landfill. The Trust's current recycling rate is around 85% and the electrical energy produced from the remaining 15% is 16mwh which would be enough electrical energy to power nearly 500 local homes for a year.

Our clinical waste disposer HES is due to commence a waste to energy trial in April 2015. They plan to incinerate offensive waste to produce heat energy and electrical power. Once the Environment Agency approves this trial the projection is it will produce 1mwh which is sufficient heat energy and electrical power to run the waste plant in Normanton, where all the Trust's offensive waste is processed. The benefit to the Trust would be that over 600 tonnes of offensive waste would no longer be sent to landfill.

Future Plans

Renegotiation of the two largest energy centre contracts in 2015 will be a major step in reducing our carbon footprint, reducing the energy we consume in our daily operations and saving money on our overheads which can then be better used for patient care.

Plans are in place to reduce our energy consumption further with the following measures:

- expansion of controlled LED lighting in circulation areas;
- improved control of heating and cooling systems in non-clinical buildings;
- use of renewable technologies in forthcoming refurbishments;
- an energy saving campaign to further encourage staff to contribute to the savings.

Section 2

Director's Report

Directors' report

2.1 Members of the Trust Board in 2014/15

The Trust is governed by a Board comprising of both executive directors, appointed to specific roles in the organisation, and non-executive directors, who can offer external expertise and perspective.

During 2014/15, the Board met bi-monthly on the last Thursday of every month (excluding August), in public at St James's University Hospital and between the public meetings, informal workshops were held to address such issues as; training and development, strategy and planning. Over two whole days in November they met each of the Clinical Service Units to discuss clinical business strategies. A staff council member is also invited to attend the meetings. The media attend and report on proceedings in the local press. Any member of the public is welcome to attend the formal meetings. These are advertised in the local media and on the Trust's website (see address below).

Board meeting agendas, papers, minutes and future dates are posted on the Trust's website - **www.leedsth.nhs.uk**.

Membership of the Trust Board

During 2014/15, the Trust Board saw a number of changes in both executive and non-executive membership.

At all times during the year, however, the Trust Board has been compliant with the statutory composition of executive officers which is covered in one aspect of the monthly declaration to the NHS Trust Development Authority (TDA). Simon Neville, Director of Strategy and Planning commenced his role on 1 May 2014. Dr Bill Kirkup, non-executive director commenced in role from 19 May 2014 and was recruited to lead on quality and chair the Board's Quality Committee. Dean Royles, Executive Director for Human Resources and Organisational Development commenced in post on 8 September 2014. Jackie Green, Director of HR, left the Trust on 28 August 2014 and Mark Smith, Chief Operating Officer, left the Trust on 15 September 2014.

Mark Ellerby joined the Trust at the start of December 2014 as a non-executive director and was recruited to the long term vacancy. Carl Chambers commenced his role as a non-executive director on 1 February 2015, to succeed Mark Abrahams as Chair of the Finance and Investment Committee, who had served two terms of office, totaling six years.

The composition of the Trust Board changed during the year with the appointment of the Director for Human Resources and Organisational Development as an executive director. In summary, we have five voting directors, and with the addition to the longer term non-executive director vacancy been filled by Mark Ellerby, we have seven non-executive directors, in addition to the Chair. The Remuneration Committee at its meeting on 26 March 2015 made the Director of Strategy & Planning an executive director position from 1 April 2015. This will increase the executive director balance on the Board to six voting executives.

Historically the Trust has had a number of senior executives in attendance at Board meetings, however supporting principles of good governance, attendance at Board meetings has been reviewed. In addition restructuring of the line management/leadership of Informatics is now provided from the Executive Director of Finance, and for Estates and Facilities this is provided through the Director of Strategy and Planning. Therefore the only directors in attendance at the Trust Board during 2014/15 were the Director of Human Resources until end of August 2014, the Director of Strategy and Planning, and the Trust Board Secretary.

Appointment of Non-executive Directors

The non-executive directors have been appointed by the NHS TDA. There is a defined term of office for each appointment. Re-appointments can be made, but non-executive directors will not serve more than six years, to comply with Monitor's Code of Governance.

Termination of the term of office of the Chair would be undertaken by Sir Peter Carr, Chair of the NHS TDA.

All Board directors comply with the 'fit and proper person test' that was introduced from 27 November 2014.

Measuring the performance of the Board members

The Chair of the Board was appraised by Sir Peter Carr in January 2014 and again in March 2015. The outcome was positive, with clear objectives for the coming year.

The Chair of the Trust has in turn appraised each of the non-executive directors during the year and set objectives for the coming year. Should the Chair have any concerns about their performance, this would be discussed with the NHS TDA and their term of office would be terminated.

The Chief Executive has appraised executive colleagues during the year which was reported to the Remuneration Committee in May 2014. His own appraisal by the Chair was also reported at this meeting without his presence and all executive directors had clear objectives set for the year.

The various committees reported their work plans to the Trust Board at the beginning of the financial year, and against these have given an annual report to the Board on their progress and an evaluation of their performance at the end of the year.

Register of interests

The register of interests for Trust Board members was reported to the public Board meeting in March 2015. This is available by emailing the Trust Board Secretary, Jo Bray, at jo.bray@nhs.net.

Non-executive Directors of the Board during 2013-14

Dr Linda Pollard CBE JP DL

Chair

From 1 February 2013

Prior to her appointment as Chair of Leeds Teaching Hospitals NHS Trust, Linda was Chair of NHS Leeds from 2009, and Chair of NHS Airedale, Bradford and Leeds Primary Care Trust Cluster from October 2011.

She has previously held posts as Chair of the West Yorkshire Strategic Health Authority, Bradford District Care Trust, Bradford Teaching Hospitals NHS Trust and Regional Chair of the Learning and Skills Council.

Linda was a founding Chair of *An Inspirational Journey*, a national organisation that supports women to reach the top of their professions and seeks to increase their participation at Board level.

Linda was until July 2013 Pro Chancellor/ Chairman of the University of Leeds where she was awarded an Honorary Doctorate.

In the private sector, as well as founding two successful businesses in women's fashion and international marketing, she has worked in numerous director and managing director positions for high profile brands such as BMW, Puma (UK) and The Guardian Media Group (Real Radio).

Linda is a non-sitting magistrate and also a Deputy Lieutenant of West Yorkshire. She is also a trustee of the Leeds Teaching Hospitals NHS Trust Charitable Foundation. In 2004 she was awarded an OBE in recognition of her outstanding contribution to the community, and in June 2013 she became a CBE.

Mark Abrahams

Vice-Chairman and Chair of the Finance and Investment Committee

From 1 Feb 2009 until 31 January 2015

Second term of office from 1 February 2012 – 31 January 2015

Mark lives in York and is the Chairman of Hull-based Fenner PLC, a company which is an acknowledged world-leader in reinforced polymer technology.

He is also Chairman of Inditherm PLC in South Yorkshire, a heating technology specialist supplier to range of industries.

Mark Chamberlain

Non-executive Director and Chair of the Workforce Committee

From 4 January 2010

Mark works as an independent consultant in the health, education and technology sectors He was previously employed by BT, where he worked since 1986, holding a variety of roles in HR, marketing, operations, strategy, business transformation and business development. He was a non-executive director of the Learning and Skills Council Regional Board until 2010.

The Workforce Committee was formally stood down by the Board at the January 2015 meeting.

Caroline Johnstone

Non-executive Director and Chair of Quality Committee

From 1 January 2013 (Deputy Chair/Senior Independent Director from 1 February 2015)

Originally trained as a chartered accountant, Caroline has had a career of 30 years working in professional services, based in Leeds, Edinburgh and London. As a partner with PricewaterhouseCoopers (PwC), she worked at senior board level, supporting some of the largest organisations in the UK and internationally implementing significant change including turnaround, mergers, cost reduction, culture and people change. She also sat on the board of PwC's assurance division with responsibility for people.

Among her other current roles, Caroline is Chair of BARCA - Leeds, a community-based charity in the city, and a non-executive member of the Audit Committee of the Crown Prosecution Service of England and Wales. She is also member of the governing body of the University of Leeds.

Professor Paul Stewart

Non-executive Director and Chair of the Education, Research and Training Committee

From 1 October 2013

Paul Stewart is the Faculty Dean of Medicine and Health at the University of Leeds and an Honorary Consultant Endocrinologist at the Leeds Teaching Hospitals NHS Trust, having moved from the University of Birmingham in August 2013. He received his medical degree from Edinburgh Medical School in 1982 and was awarded an MD from Edinburgh University with Honours and a Gold Medal in 1988. Professor Stewart supervises an active Endocrinology research group funded by renewed programme grant support from The Wellcome Trust, Medical Research Council, ARC grants and most recently an European Research Council Advanced Research Grant.

Due to the close working relationship between Leeds University and the city's hospitals, the Dean of Medicine has a key role on the Trust Board.

Alison Page

Non-executive Director

From 1 January 2014

Allison is a partner at DLA Piper LLP, one of the world's largest specialist business law firms.

She is based in their Leeds office where she specialises in advising on public-private partnerships and has a background in working closely with public sector contractors and banks on major infrastructure transactions in sectors as diverse as highway maintenance, energy and waste management.

Dr Bill Kirkup CBE

Non-executive Director and chair of the Quality Committee

From 19 May 2014

Dr Kirkup has held a variety of posts in public health, including at national level and has also worked extensively overseas in a number of roles. He retired from his post as Associate Chief Medical Officer and Director General of Clinical Programmes at the Department of Health in 2010.

He has led a number of health sector reviews including two high profile NHS inquiries: the Morecambe Bay Investigation and the Department of Health investigation into the activities of Jimmy Savile at Broadmoor Hospital.

Dr Kirkup is a Fellow of the Royal College of Physicians, a Fellow of the Royal College of Obstetricians and Gynaecologists, and a Fellow of the Faculty of Public Health (1994). He was made a CBE in the New Year's Honours List in 2008 and has an Iraq Reconstruction Medal.

Mark Ellerby

Non-executive Director

From 1 December 2014

Mark Ellerby, was formerly Divisional Managing Director of Bupa Care Services, globally responsible for providing residential care home services, retirement villages, assisted living facilities, medical alarm systems and nurse-led home healthcare to over 50,000 customers.

Before that Mark held a wide range of senior roles within Bupa, both in general management and in finance and strategy, and prior to that worked for ten years at Deloitte in London. Mark is a Fellow of the Institute of Chartered Accountants of England and Wales. He is also currently a Non-executive Director of the NHS Business Services Authority.

Carl Chambers

Non-executive director and Chair of the Finance and Investment Committee

From 9 December 2014 for induction and commenced in role from 1 February 2015

Carl Chambers, is a chartered accountant and barrister by profession. He has considerable experience in the financial sector and as a director in industry covering a range of sectors including gas, water and electricity supply, specialist engineering services, facilities management, security training and telecommunications.

He is currently Non-executive Chairman of utility support service business Haste Ltd, and Non-executive Chairman of CNG Ltd, a gas supply business. He has previously held a number of senior roles including Non-executive Chairman of Task International Ltd, Chief Financial Officer of Spice plc and Chief Executive of Team Telecom.

Executive Directors of the Board

Julian Hartley

Chief Executive

From 14 October 2013

Julian previously worked as Managing Director of NHS Improving Quality - a national organisation set up to drive change and improvement across the NHS.

Julian's career in the NHS began as a general management trainee working in the North East of England. Following his training, he worked in a number of NHS management posts at hospital, health authority and regional level. His first Board Director appointment was at North Tees and Hartlepool NHS Trust, where he was responsible for planning, operations and strategy.

Julian led Tameside and Glossop Primary Care Trust (PCT) as Chief Executive for three years, where he took it to three star status, developed new Primary Care Centres and managed the PCT's involvement in the Shipman Inquiry.

From 2005 Julian was Chief Executive of Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust, seeing the Trust transform and go on to achieve major financial turnaround, secure Foundation Trust status and become one of the first Trusts in the country to meet 18-week targets. In addition, Julian chaired the North West Leadership Academy.

Julian was appointed Chief Executive of University Hospital of South Manchester NHS Foundation Trust in June 2009 and led a major turnaround in MRSA reduction, A&E and 18-week performance. He also introduced a major programme of cultural change to improve patient experience and outcomes.

Professor Suzanne Hinchliffe

Chief Nurse

From 20 May 2013

Deputy Chief Executive

From 5 January 2015

Suzanne joined us from the University Hospitals of Leicester NHS Trust, where she was Chief Nurse from 2009.

Joining the NHS in 1979, Suzanne trained as a Registered Nurse and Registered Midwife building a portfolio of nursing and operational experience across the UK alongside further qualifications at masters level in business, finance and law.

Suzanne has extensive experience in acute NHS services and has also been a member of a number of national advisory committees, involved in regulatory inspection, and has led board governance reviews across acute, primary care and ambulance service organisations. Working at executive level over the past 15 years, Suzanne has had experience in Chief Operating Officer and Chief Nurse positions with two periods as interim Chief Executive.

The Chief Nurse temporarily covered the role of the Chief Operating Officer until formally commencing hew new duties as deputy Chief Executive/ Chief Nurse, responsible for Operational Services from 5 January 2015.

Tony Whitfield

Director of Finance

From 20 January 2014

Tony joined Leeds Teaching Hospitals NHS Trust as Director of Finance in January 2014, having worked in the NHS since 1983. He was previously Finance Director at Salford Royal for 11 years and part of the team that allowed Salford to grow in its reputation for high quality patient centred services delivered with strong financial sustainability.

Tony has been a Finance Director in the NHS for more than 20 years. He is a fellow of the Chartered Institute of Management Accountants, and holds an MA in financial management.

He is passionate about the development NHS finance staff and utilising their skills to improve the services delivered to patients. He is a former Healthcare Financial Management Association (HFMA) president and currently Chairman of the HFMA Strategic Costing Committee.

Dr Mark Smith

Chief Operating Officer

From 20 May 2013 until 15 September 2014

Mark joined us from City Hospitals Sunderland NHS Foundation Trust, where he was Chief Operating Officer since 2010.

Mark originally trained as a doctor in Leeds, becoming a GP in Newcastle in 1994. During this time he worked with the Department of Health on developing national cancer pathways and developing protocols to support GP referrals and locally led fundholding. In 2001 he undertook a sabbatical in Health Informatics working with the National Programme for IT to develop choose and book and cancer integrated care pathways using decision support.

Mark took the role of Deputy Medical Director at the North East Strategic Health Authority in 2006 with a focus on developing medical leadership and networks, commissioning and primary care. Whilst in the role he was a member of the National Practice Based Commissioning Board and the Commissioning and System Management Board at the Department of Health.

Dr Yvette Oade

Chief Medical Officer

From 1 June 2013

Yvette joined Leeds Teaching Hospitals in June 2013 as Chief Medical Officer. Her portfolio includes responsibility for Quality Improvement and Patient Safety in the trust.

She was previously the Chief Medical Officer of Hull and East Yorkshire Hospitals NHS Trust and Deputy Chief Executive, a role she undertook for two years, focussing on quality improvement and patient safety, achieving significant improvements in hospital mortality and healthcare acquired infections.

She was closely involved in the development of the Yorkshire and Humber Academic Health Science Network.

Originally trained as a doctor in Leeds, Yvette became a Consultant Paediatrician in Calderdale and Huddersfield Foundation NHS Trust. She has a special interest in paediatric diabetes and developed a high quality service being a leader locally in insulin pump therapy.

On moving into clinical management, Yvette held a number of senior managerial roles in the Calderdale and Huddersfield NHS Foundation Trust. These culminated in her being appointed Executive Medical Director at Calderdale and Huddersfield NHS Foundation Trust in 2007, leading to the trust being named as HSJ Acute Provider of the Year in 2010. Yvette has extensive experience in leading through clinical engagement, major service change, reconfiguring hospital services and working across organisational boundaries to deliver improvements to care.

Dean Royles

Director of Human Resources and Organisational Development

From 8 September 2014

Dean Royles was previously Chief Executive of NHS Employers appointed in December 2010. Previous roles include Director of Workforce and Education at NHS North West and Deputy Director of Workforce for the NHS at the Department of Health.

Dean was the first HR director at East Midlands Ambulance Service following its creation in 1999. He has also worked at an acute hospital and in a community and mental health trust having started his HR career in industrial relations in a local authority.

Dean has an MSc in Human Resources. He is a member of Sheffield Business School's Advisory Board and also a visiting fellow at Newcastle Business School, chair of the board of the Chartered Institute of Personnel and Development and a chartered fellow for the same organisation. He was awarded an Honorary Doctorate from the University of Bradford for his contribution to health services management.

In 2011 Dean became the first male business champion against domestic violence and is a national ambassador for the Apprenticeship Ambassadors Network. He is a regular conference speaker, published in a number of journals, on the editorial board of Human Resource Management Journal (HRMJ) and provides expert opinion in the national media. He was voted UK's Most Influential HR Practitioner in 2012, 2013 and 2014.

Simon Neville

Director of Strategy and Planning

From 1 May 2014

Simon joined us from Salford Royal NHS Foundation Trust in May 2014, where he was Director of Strategy and Development. He was also the Lead Executive for Clinical Support Services and Tertiary medicine and for Facilities and Estates services.

Whilst at Salford, Simon developed and led the strategic direction of the organisation, and headed up partnership working with Foundation Trusts across Greater Manchester. He also led their Redevelopment Programme in a £200m investment in improved facilities on their site. Prior to this he had been the Programme Director for the SHIFT Programme (Salford's Health Investment for Tomorrow) which has seen a whole system remodelling of services underpinned by a series of capital investments in new facilities across the city.

He has worked in the NHS since 1983, in a variety of general management and planning roles in London and the North West. He has specialised in major service change and capital investment since working on the development of the Chelsea and Westminster Hospital.

Before joining Salford Royal in 2002, Simon was Director of Corporate Development at the Acute Trust in Blackburn since 1993. From 1999 he was Project Director for Blackburn's £100m Private Finance Initiative project to centralise hospital services.

Non-voting Executive Directors in attendance at the Board

Jackie Green

Executive Director of Human Resources

From 16 March 2009 to 28 August 2014

Jackie's professional and academic background is grounded in Human Resource Management and Organisational Development. These specialisms have been at the core of a career in the education, housing and health sectors.

Jackie has extensive cross-sector experience at executive level, and prior to joining the NHS in 2004 was Assistant Chief Executive at The Housing Corporation. She came to Leeds in 2009 following five years as Director of Human Resources at Royal Liverpool and Broadgreen University Hospitals.

2.2 Trust Board attendance at public Board meetings

Name/Date	29 May 2014		31 July 2014		25 September 2014		27 November 2014		6 Feb - Workshop 29 Jan - Public		26 March 2015	
Members:	Pr	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu
Linda Pollard	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Mark Abrahams	✓	✓	✓	✓	✓	✓	✓	✓		✓		
Mark Chamberlain	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Caroline Johnstone	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bill Kirkup	✓	✓						✓			✓	✓
Yvette Oade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Allison Page	✓	✓	✓		✓				✓	✓		
Mark Smith	✓	✓										
Paul Stewart	✓	✓	✓	✓	✓	✓				✓		
Tony Whitfield	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dean Royles					✓	✓	✓	✓	✓	✓	✓	✓
Carl Chambers									✓		✓	✓
Mark Ellerby									✓	✓		
In Attendance:												
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jackie Green	✓	✓	✓	✓								
Linda White	✓		✓	✓			✓					
Simon Neville	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Attendance at Board Time-Outs

Name/Date	22 May 2014	CSU Review 14 November 2014	CSU Review 21 November 2014	22 Jan 2015	23 Feb 2015	05 Mar 2015
Linda Pollard	✓	✓	✓	✓	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	Annual leave	✓	✓	✓
Yvette Oade	✓	✓	✓	✓	✓	✓
Mark Abrahams	✓	✓	✓	✓		
Dean Royles		✓	✓	✓	✓	✓
Mark Smith	✓					
Paul Stewart	✓	✓		✓		
Carl Chambers				✓	✓	✓
Tony Whitfield	✓	✓	✓	✓	✓	✓
Mark Chamberlain	✓	✓	✓	✓	✓	✓
Allison Page		✓	✓	✓	pm only	✓
Caroline Johnstone	✓	✓	✓	✓	✓	✓
Bill Kirkup		✓	✓			
Mark Ellerby						
In Attendance:						
Jo Bray	✓	✓	✓	✓	✓	✓
Jackie Green	✓					
Simon Neville	✓	✓	✓	✓	✓	✓

Attendance at committee meetings

Audit Committee

Name/Date	8 May 2014	28 May 2014	9th July 2014	18 September 2014	15 December 2014	11 March 2015
Members:						
Caroline Johnstone	✓	✓	✓	✓	✓	✓
Mark Abrahams	✓	✓	✓	✓	✓	
Allison Page	✓	✓	✓	✓		✓
Tony Whitfield	✓	✓		✓	✓	
Carl Chambers					✓ Observing	✓
In Attendance:						
Jo Bray	✓		✓	✓	✓	✓
Craig Brigg	✓	✓	✓	✓	✓	✓
David Gregory	✓	✓	✓	✓	✓	✓
Julian Hartley	✓	✓				✓ Item 3.3
Phil Jones	✓	✓		✓		✓
Perminder Sethi	✓	✓	✓	✓	✓	✓
Melanie Simmonds			✓	✓	✓	✓
Bryan Gill					✓	✓

The Audit Committee has received a reasonable level of assurance about the progress in developing the Trust's governance arrangements, risk management processes and internal control systems.

Finance and Investment Committee

Name/Date	8 May 2014	4 Sep 2014	16 Oct 2014	20 Nov 2014	15 Dec 2014	22 Jan 2015	19 Feb 2015	19 Mar 2015
Members:								
Mark Abrahams	✓	✓	✓	✓	✓	✓		
Jo Bray	✓	✓	✓	✓	✓	✓		✓
Kim Gay	✓		✓	✓	✓			
Julian Hartley	✓	✓	✓	✓	✓	✓	✓	✓
Caroline Johnstone	✓	✓		✓	✓	✓	✓	✓
Tony Whitfield	✓	✓	✓	✓	✓	✓	✓	✓
Linda Pollard		✓	Annual leave		Sick leave	Sick leave	✓	✓
Simon Neville	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Ehrhardt		✓	✓	✓	✓		✓	✓
David Berridge			✓		✓		✓	✓
Mel Simmonds			✓	✓	✓	✓	✓	✓
Andy Thomas					✓ Presentation			
Carl Chambers					✓ Observing	✓ Observing	✓	✓

Quality Committee

Name/Date	3 Apr 2014	1 May 2014	5 Jun 2014	3 Jul 2014	7 Aug 2014	11 Sep 2014	13 Nov 2014	18 Dec 2014	15 Jan 2015	12 Feb 2015	12 Mar 2015
Members:											
Linda Pollard	✓	✓	✓	✓	✓		✓			✓	✓
Mark Chamberlain	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓			✓	✓	Annual Leave	✓		✓	Annual leave	
Yvette Oade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Craig Brigg	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Berridge		✓	✓	✓	✓	✓	✓	✓		✓	✓
Alison Dailly		✓	✓	✓							
Bryan Gill		✓	✓	✓	✓	✓		✓	✓		✓
Bill Kirkup					✓		✓	✓		✓	✓
Andy Thomas									✓	✓	✓
In Attendance:											
Jo Bray	✓	✓	✓		✓	✓	✓	✓		✓	✓
Julia Roper	✓		✓	✓	✓		✓	✓	✓	✓	✓

Remuneration Committee

Name/Date	9 May 2013	25 July 2013	14 Nov 2013	30 Jan 2014
Members:				
Linda Pollard	✓	✓	✓	✓
Mark Abrahams	✓	✓	✓	
Mark Chamberlain	✓		✓	✓
Caroline Johnstone	✓	✓	✓	✓
Paul Stewart	✓	✓		
Allison Page	✓			
Bill Kirkup	✓		✓	✓
Carl Chambers				✓
Mark Ellerby				
In Attendance:				
Julian Hartley	✓	✓	✓	✓
Jackie Green	✓	✓		
Jo Bray	✓	✓	✓	✓
Dean Royles			✓	✓

Research, Education and Training Committee

Name/Date	1 April 2014	28 May 2014	1 July 2014	2 September 2014	11 November 2014	13 January 2015	3 March 2015
Members:							
Paul Stewart	✓	✓	✓	✓	✓	✓	
Jacqueline Andrews	✓	✓	✓	✓	✓	✓	✓
Jill Asbury	✓ For SH			✓ For SH			
Yvette Oade	✓	✓	✓		✓	✓	✓
Stephen Smye	✓	✓	✓	✓	✓	✓	✓
Greg Reynolds	✓	✓	✓	✓			
Adam Glaser	✓				✓		✓
Andrew Lewington	✓	✓	✓	✓	✓	✓	✓
David Jackson	✓			✓	✓	✓	
Ann Marie Keenan	✓					✓	
Claire Gaunt		✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	Nursing Business Mtg	✓			✓	✓	Annual leave
Ian Simmons		✓	✓	✓	✓	✓	
Stuart Haines		✓	✓				
Jon Cooper			✓	✓	✓	✓	✓
Clare Linley			✓ For SH				
Balbir Bhogal					✓		
Karen Vella					✓	✓	
Dean Royles						✓	✓

Risk Management Committee

Name/Date	10 Jul 2014	7 Aug 2014	4 Sep 2014	2 Oct 2014	6 Nov 2014	4 Dec 2014	08 Jan 2015	5 Feb 2015	11 Mar 2015
Members:									
Julian Hartley	✓	✓	✓	✓	✓	✓		✓	✓
Darryn Kerr	✓		✓						
Simon Neville	✓	✓		✓	✓		✓	✓	✓
Yvette Oade	✓	✓		✓		✓		✓	
Suzanne Hinchliffe	✓	✓	✓	Meeting with CCGs	✓	✓	✓	✓	✓
Tony Whitfield		✓	✓	✓	✓		✓		
Dean Royles				✓		✓	✓	✓	✓
Andy Thomas						✓		✓	✓
In Attendance:									
Jo Bray	✓	✓	✓	✓	✓	✓	✓		✓
Craig Brigg	✓	✓	✓	✓	✓	✓			✓
Bryan Gill	✓	✓	✓		✓	✓	✓	✓	✓
David Gregory	✓	✓	✓	✓		✓		✓	✓
Caroline Johnstone	✓		✓		✓	✓	✓		✓
Nigel Lumb	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Moore	✓	✓	✓	✓	✓	✓		✓	✓
David Berridge		✓		✓	✓	✓	✓	✓	✓
Linda Pollard	✓ By invitation		✓ By invitation					✓ By invitation	

Workforce Committee

Name/Date	9 April 2014	19 June 2014	11 September 2014
Members:			
Mark Chamberlain	✓	✓	✓
Craig Brigg	✓	✓	✓
Jackie Green	✓	✓	
Yvette Oade	✓		✓
Suzanne Hinchliffe	✓	✓	Annual Leave
Dean Royles			✓
Linda Pollard	✓	✓	
In Attendance:			
Phil Ayres	✓	✓	
Suzanne Barker	✓		✓
Jonathan Booker	✓	✓	✓
Laura Brown	✓		
Chris Carvey	✓	✓	✓
Neil Ferguson	✓		✓
Tracy Gill	✓		
Graham Johnson	✓		
Wyn Jones	✓	✓	✓
Carol Robinson	✓	✓	✓
Karen Vella	✓	✓	
Caroline Johnstone	✓ Observing		
Jo Bray		✓	✓

2.3 Governance

Annual Governance Statement 2014-15

1. Scope of responsibility

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

2. The purpose of the system of internal control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Teaching Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leeds Teaching Hospitals NHS Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 The Board of Directors provides leadership on the overall governance agenda. The Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control; such Committees include the Audit, Quality, Finance & Investment, Workforce and Research, Education and Training. The Risk Management Committee is an executive committee reporting to the Board of Directors, established in March 2014. The Risk Management Committee focusses on all high or significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. The Risk Management Committee is chaired by myself as Chief Executive and comprises of all Executive Directors. Senior managers and specialist advisors routinely attend each meeting. The Trust has kept under review and updated risk management policies during the course of the year. While the Risk Management Committee reports directly to the Board through me, it also works closely with front line Clinical Service Units (CSU's) and all Committees of the Board in order to anticipate, triangulate and prioritise risk - working together to continuously enhance risk treatment.

3.2 Training is provided to relevant staff on risk assessment, incident reporting and incident investigation. In addition, the Board has set out the minimum requirements for staff training required to control key risks. A training needs analysis informs the Trust's mandatory training requirements and has been kept under review; this sets out the training requirements for all members of staff and includes the frequency of training in each case.

3.3 Incidents, complaints, claims and patient feedback are routinely analysed to identify lessons for learning and improve internal control. Lessons for learning are disseminated to staff using a variety of methods including 'Quality Matters' briefings, Learning Points Bulletin and personal feedback where required.

3.4 I have ensured that all significant risks of which I have become aware are reported to Board of Directors and Risk Management Committee at each formal meeting. All new significant risks are escalated to me as Chief Executive and subject to validation by the Executive Team and Risk Management Committee. The residual risk score determines the escalation of risk.

3.5 The Board of Directors regularly scans the horizon for emergent opportunities or threats, and considers the nature and timing of the response required in order to ensure risk is kept under prudent control at all times.

4. The risk and control framework

4.1 The risk management process is set out in 6 key steps as follows:

(i) Determine priorities

The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

(ii) Risk Identification

Risk is identified in many ways. We identify risk proactively by assessing corporate objectives, work related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation by the Trust.

(iii) Risk Assessment

Risk assessment involves the analysis of individual risks, including analysis of potential risk aggregation where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

(iv) Risk Response (Risk Treatment)

For each risk, controls are ascertained (or where necessary developed), documented and understood. Controls are implemented to *avoid risk; seek risk* (take opportunity); *modify risk; transfer risk* or *accept risk*. Gaps in control are subject to action plans which are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk, and developed and communicated a risk appetite statement to guide the management of risk throughout the Trust.

(v) Risk Reporting

Significant risks are reported at each formal meeting of the Board of Directors and Risk Management Committee. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management Policy. The risk report to the Board of Directors also details what action is being taken, and by whom, to mitigate the risk and monitor delivery. The Audit Committee and Board of Directors have reviewed assurance on the effective operation of controls to manage potential significant risk. The Board of Directors has in place an up-to-date Board Assurance Framework.

(vi) Risk Review

a. Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. In addition risk profiles for all CSU's remain subject to detailed scrutiny as part of a rolling programme by the Risk Management Committee. The purpose of the Trust's risk review is to track how the risk profile is changing over time; evaluate the progress of actions to treat material risk; ensure controls are aligned to the risk; risk is managed in accordance with the Board's appetite; resources are reprioritised where necessary; and risk is escalated appropriately.

b. Incident reporting and investigation is recognised as a vital component of risk and safety management. It is key to the success of a learning organisation. An electronic incident reporting system is

operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and routine mandatory training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

Risk Profile

5. Significant Risks Facing the Trust

5.1 As at 31st March 2015, Leeds Teaching Hospitals NHS Trust has identified a range of significant risks, which are currently being mitigated, whose impact could have a direct bearing on compliance, CQC registration or the achievement of corporate objectives in the following areas should the mitigation plans be ineffective. The significant risk profile captures risk in the following areas:

- National Standards (A&E, 18-week RTT, 62-day Cancer, 2-week Breast Symptomatic, 6-week Diagnostic Wait targets, waiting times for endoscopy and rate of Cancelled Operations not re-booked within 28 days)
- Finance The Trust is an organisation in financial recovery; the new leadership team is working with the TDA with the aim to return financial sustainability over the next 2-3 years. The key risks have been ensuring we are paid appropriately for the activity we deliver, alongside the rigorous scrutiny of costs to ensure CIP plans are delivered without compromise to clinical safety.
- Fundamental Standards of Safety & Quality (Nurse Staffing Levels, Medical Staffing, Mandatory Training, *C. difficile* and MRSA targets, Failure to Rescue a Deteriorating Patient, and Endoscopy accreditation/decontamination)
- Performance & Regulation (Inadequate data quality/governance, electrical plant replacement at LGI, Catheter Lab imaging equipment replacement at LGI, and a combination of demand and capacity factors giving rise to unsustainable levels of medical outlying and delayed discharges)
- Strategy (Genomics Centre bid, and viability of reproductive medicine services)

Detailed risk registers have been developed. These set out arrangements for risk treatment, risk appetite thresholds and further mitigating actions planned. We have established arrangements to allow a review of significant risk exposures by the full Board at each formal meeting, and we also subject each significant risk to detailed controls assurance (documented in the Board Assurance Framework), the results of which are examined by the Audit Committee and have been used to underpin this Statement.

6. Care Quality Commission Registration

6.1 Compliance with the provisions of the Health & Social Care Act 2008 (Registration Regulations) 2010 is co-ordinated by the Director of Quality. The Director of Quality oversees compliance by:

- reporting and keeping under review matters highlighted within the Care Quality Commission's Intelligent Monitoring Report and inspections;
- liaising with the Care Quality Commission and local Clinical Support Units to address specific concerns;
- engaging with the Care Quality Commission on the inspection process, co-ordinating the Trust's response to inspections and recommendations/ actions arising from this;
- analysing trends from incident reporting, complaints, and patient and staff surveys to detect potential non-compliance or concerns in Clinical Service Units;
- reviewing assurances on the effective operation of controls;

- receiving details of assurances provided by Internal Audit, and being notified of any Clinical Audit conclusions which provide only limited assurance on the operation of controls; and
- challenging assurances or gaps in assurance by attending meetings of Risk Management Committee, Quality Committee, Workforce Committee and Audit Committee.

6.2 The Trust is registered with the Care Quality Commission, has no compliance actions in force and is fully compliant with the *Essential Standards for Quality and Safety*. There were no unannounced inspections by the Care Quality Commission during 2014/15; the most recent inspection took place in March 2014 with the report published in July 2014. The Trust received good ratings within the Effective and Caring domains, and requires improvement in the Safe, Responsive and Well-Led domains. Overall the Trust was rated as 'Requires Improvement' by the CQC. The Board welcomed the report and accepted the findings. The Trust has met with local Clinical Commissioning Groups and the NHS Trust Development Authority to review progress. Progress has been made and continues in accordance with the plan.

7. Pensions

7.1 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

8. Carbon Reduction

8.1 The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act 2008 and the Adaptation Reporting requirements are complied with.

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

9.1 As Accounting Officer, I am responsible for ensuring that the Trust has arrangements in place for securing value for money in the use of its resources. To do this I have maintained systems to:

- Set, review and implement strategic and operational objectives;
- Engage actively with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon;
- Monitor and improve organisational performance; and
- Establish plans to deliver cost improvements.

9.2 The Trust is required to submit to the NHS Trust Development Authority an Annual Plan incorporating a supporting financial plan approved by the Board of Directors. This informs the detailed operational plans and budgets which are also approved by the Board. The Trust actively engages Commissioners, the NHS Trust Development Authority and others as necessary to develop and agree detailed financial and operational plans. Prior to approval the Board takes the views obtained from stakeholders into account.

9.3 The Board agrees annually a set of corporate objectives which are communicated to colleagues. This

provides the basis for performance reviews at CSU level. Operational performance is kept under constant review by the Executive Team and Board of Directors. In order to keep under review the delivery of the corporate objectives, the Board reviews at each formal meeting a Quality & Performance Report covering patient safety, quality, access and experience metrics, and a Finance Performance Report. Since my appointment as Chief Executive, I have continued to oversee the development of the Trust's Quality Account in readiness for publication.

9.4 Assurances on the operation of controls are commissioned and reviewed by the Audit Committee and, where appropriate, other Committees of the Board of Directors as part of their annual cycle of business. The implementation of recommendations made by Internal Audit is overseen by the Audit Committee.

10. Annual Quality Report

10.1 The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

10.2 The Trust has continued to embed strong clinical leadership for the development of the Quality Account during 2014/15 and this has been provided by the Chief Medical Officer in close collaboration with the Chief Nurse / Deputy Chief Executive and the wider Executive Team. Assurances relating to the outcomes highlighted within the Annual Quality Account were provided to the Quality Committee (QC), a formal committee of the Trust Board, which is chaired by a Non-Executive Director. The Quality Committee is responsible for overseeing the production of the Quality Account and for overseeing monitoring indicators and data quality. The Trust has engaged with partner organisations, including Leeds Healthwatch and commissioners at NHS West Leeds CCG to agree priority quality goals for the year ahead, relating to the key quality domains: safety, effectiveness, experience. A limited scope assurance report is provided by external audit on the content of the quality account and selected key performance indicators.

11. Review of effectiveness

11.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of Internal Audit and Clinical Audit, in addition to formal letters of representation from Executive Directors and Chairs of the Board's Committees. My review is also informed by comments made by the External Auditor in their management letter and other reports. I have been advised on the implications of the result of my review of internal control by the Board and the Board's committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

12. The Board of Directors

12.1 The Board has set out the governance arrangements including the committee structure within the Standing Orders. In summary, the Board's committee structure comprised of the following: (i) Finance & Investment Committee; (ii) Audit Committee, (iii) Quality Committee; (iv) Workforce Committee; (v) Remuneration Committee; (vi) Research, Education and Training Committee; supported by (vii) an executive Risk Management Committee. Chairs of the Board's Committees report to the Board at the first available Board meeting after each Committee meeting. Urgent matters are escalated by the Committee Chair to the Board as deemed appropriate.

12.2 The Board commissioned an independent review into Board governance and committee effectiveness during the year.

The review found no material concerns, but outlined a range of opportunities to advance governance arrangements. With external support, the Board devised a set of proposals to further develop the committee structure alongside a new and innovative approach to Board governance and assurance using the 'three lines of defence' model. These new arrangements came into effect in May 2015.

12.3 The Board assign high importance to risk management and internal control. The effectiveness of the Board's risk management and internal control framework is subject to independent review by Internal Audit on an annual basis. Substantial progress has been made during the year culminating in a 'significant assurance' opinion by the Head of Internal Audit, a notable improvement on the previous year. As a result of their work in 2014/15, the internal auditors have provided assurance that the Trust has adequate and effective arrangements in place to support the achievement of management's objectives over risk management, internal control, governance and value for money.

13. Internal Audit

13.1 With respect to the internal audits concluded during 2014/15, there were 3 (out of 41) assignments for which Internal Audit reported the level of assurance as limited for the year ended 31st March 2015. These audits provide limited assurance as a result of weaknesses in the design and/or operation of controls. Management action plans are developed and implemented, or in the process of being implemented, to address identified weaknesses. Progress is reviewed by the Audit Committee.

14. External Audit

14.1 External audit provides independent assurance on the accounts, annual report, Annual Governance Statement and on the Annual Quality Report.

15. Significant In-Year Matters

(i) There were 94 reported events during the year that crossed the seriousness threshold and were declared a Serious Incident. Pressure ulcers and falls involving serious harm account for the majority of cases. Each case has been thoroughly investigated and reported to local commissioners. Detailed action plans are developed and implemented in response to specific cases.

(ii) There were five incidents which qualified for reporting as a Never Event. Cases involved retained foreign body post procedure (n=4), and wrong site procedure (n=1). Each case has been thoroughly investigated and reported to local commissioners. Detailed action plans are developed and implemented in response to specific cases.

(iii) There were five formal *Prevention of Future Death Reports* (formerly known as Rule 43) issued by the Coroner. At the time of report, the Trust has addressed the concerns raised by the Coroner in four cases, and is on schedule to conclude the required action for the matter in hand.

(iv) There were 68 events that crossed the threshold for reporting to the Health & Safety Executive under the provisions of the Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) Regulations. The Trust has been raising the profile of safety management during the year, and has reviewed and making some changes to the Safety Management System.

(v) The Trust did not meet the national requirement to treat a minimum of 90% of patients within 18-weeks of referral for those patients on the admitted pathway. We closed the year with 88.3% of admitted patients being treated within 18 weeks. The Trust faced unprecedented emergency pressures and unplanned increases in demand during the year, including in particular challenges to discharge patients due to pressures on

out of hospital healthcare infrastructure. A Board-level recovery programme has been in place throughout the year and continues with a plan for compliance by quarter 3 2015/16.

(vi) The Trust did not meet the national requirement to treat a minimum of 85% of patients referred for suspected cancer within 62 days of referral from a GP or Dentist. We closed the year with 76.1% of patients with suspected cancer being treated within 62-days of referral. Capacity in Thoracic and Urology Surgery, combined with late referrals, adversely affected our ability to meet this standard in full. The Trust continues to work closely with neighbouring providers, GPs, commissioners and other stakeholders to improve the timeliness of referrals to the Trust and also working to improve internal systems and processes and build capacity to improve performance. The Trust is exploring options to increase theatre capacity and utilisation within Urology and Thoracic surgery to improve resilience and performance during the year ahead.

(vii) After making good progress during the beginning of 2014/15, unprecedented emergency pressures and unplanned increases in demand, combined with challenges to discharge patients due to pressures on out of hospital healthcare infrastructure, resulted in the Trust not meeting the national requirement for all last minute cancelled operations to be rebooked within 28 days. Improvement work is aligned to delivering action across a range of clinical pathways and also the plans associated with improving 18-week, cancer and urgent care performance.

(viii) The Trust did not meet the national requirement to undertake 99% diagnostic tests within six weeks of referral by a GP. We closed the year with 98.49% of diagnostic tests undertaken within six weeks of referral. Achievement has been challenged by staffing levels and particular problems in respect of the endoscopy programme. The Trust is making progress against this requirement but remains challenging going into quarter 1 2015/16.

(ix) The Trust did not meet the national requirement to see a minimum of 93% of patients within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected. The Trust closed the year with 92.71% of patients referred urgently for breast symptoms seen within two weeks. Achievement was compromised by capacity problems within the Breast Surgery team, which were addressed mid-year, and compliance achieved from that point forward.

(x) The Trust has continued to make good progress to reduce hospital acquired infection, reducing the incidence of Clostridium *difficile* and Methicillin-resistant Staphylococcus Aureus (MRSA) infection during the year. However, the Trust did not meet the requirement for zero cases of MRSA. We closed the year with 7 cases of MRSA infection. A detailed infection prevention plan is in place to continue reduce the risk for patients and staff.

(xi) The Trust has faced a number of financial challenges in 2014/15, and had a planned deficit. The Trust has received support from Commissioners and the Independent Trust Financing Facility (ITFF) to fund the deficit during the year. A further deficit is forecast for 2015/16 for which we anticipate continued support.

(xii) The Trust commissioned an independent review of arrangements for decontamination across the Trust. This highlighted areas for improvement and action is underway to strengthen compliance with relevant standards.

16. Concluding Remarks

16.1 As Accounting Officer with responsibility for maintaining a sound system of internal control at Leeds Teaching Hospitals NHS Trust, I have reviewed the system of internal control. Good progress has been made to address financial challenges and deliver the financial plan, however the Trust remains in Level 2 escalation with the NHS Trust Development Authority and is forecasting a deficit during 2015/16. I have focused on assessing the breadth and depth of problems leading to control weakness in order to understand the effectiveness of the system of internal control and I have taken steps to address the issues of which I am aware. My review confirms that Leeds Teaching Hospitals NHS Trust has a system of internal control in operation, and progress has been made, but further improvement is underway across a range of priorities to better support the achievement of the Trust's policies, aims and objectives going forward. Those control issues highlighted in this statement have been or are currently being addressed. I confirm that there are no other significant breaches of internal control that have been brought to my attention in respect of the financial year ended 31st March 2015 and up to the date of approval of the annual report and accounts.

Signed

Julian Hartley, Chief Executive
Date: 28 May 2015

Notes

I. Matters highlighted in section 15 have been identified in accordance with 2014/15 *Annual Governance Statement Guidance (Annex B)* issued by the NHS Trust Development Authority, and also using the qualifying criteria below, developed by the Trust.

II. A qualifying significant breach of internal control has been evaluated using the following criteria: *a significant breach of internal control is a breach where the Directors are satisfied that the issue was directly relevant to: (i) a failure to achieve a corporate objective; (ii) put the achievement of corporate objectives at significant risk of failure; or (iii) put any Licence to operate at significant risk (i.e. CQC Registration).*

III. At the review meeting held on 13/05/2015 the NHS Trust Development Authority have informed the Trust of new definitions relating to escalation. Level 2 escalation now replaces Stage 4 escalation.

2.4 Remuneration report

Remuneration

As set out more fully in section 2.1 of this annual report, the composition of the Trust Board changed during the year with the appointment of Executive Directors of Strategy & Planning and of Human Resources, three Non Executive Directors, the retirement of a Non Executive having served his full term and the departure of the Chief Operating Officer with the resulting transfer of many of his duties and responsibilities to the role of Chief Nurse/ Deputy Chief Executive.

Pay Multiples

In accordance with HM Treasury requirements following the Hutton Review of Fair Pay, reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director of the Trust in the financial year 2014/15 was £235-240k (2013/14, £230-235k). This was 8.72 times (2013/14, 8.48) the median remuneration of the workforce, which was £26,975 (2013/14, £27,675). The highest paid director in both 2014/15 and 2013/14 was the Medical Director.

Total remuneration includes salary, enhancements and non-consolidated performance-related pay. It does not include any severance payments, employer pension contributions and the cash equivalent transfer value of pensions. Remuneration is calculated on the annualised full-time equivalent staff of the Trust at the reporting date (31 March 2015).

Payments made to agency staff have been excluded as these mainly relate to payments made to cover absences of existing employees whose whole time, full year equivalent remuneration has already been included in the calculation of the median. Agency costs also include elements for travel, national insurance and the agency's commission which are not separately identifiable and would serve to distort the overall figures.

Salary and pension entitlements of senior managers

A) Salaries and allowances 2014-15

Name and Title	2014-15 Salary (bands of £5,000) £000	Expense Payments (taxable) Rounded to nearest £100	National Clinical Excellence Award (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
M. Abrahams - Non Executive Director (Vice Chair) (to 31 January 2015)	5-10	8	0	0	**5-10**
M Chamberlain - Non Executive Director	5-10	3	0	0	**5-10**
C Chambers - Non Executive Director (from 09 December 2014)	0-5	0	0	0	**0-5**
M Ellerby - Non Executive Director (from 01 December 2014)	0-5	3	0	0	**0-5**
J.M. Hartley - Chief Executive (from 14 October 2013)	225-230	0	0	50-52.5	**280-285**
Prof S Hinchliffe - Chief Nurse (from 20 May 2013) Deputy Chief Executive and Chief Nurse (from 15 September 2014)	180-185	1	0	107.5-110	**290-295**
C.A. Johnstone - Non Executive Director (Vice Chair)	5-10	15	0	0	**5-10**
Dr W Kirkup - Non Executive Director (from 19 May 2014)	5-10	0	0	0	**5-10**
S H Neville - Director of Strategy & Planning (from 01 May 2014)	135-140	0	0	72.5-75	**210-215**
Dr Y.A. Oade - Medical Director (from 01 June 2013)	205-210	0	25-30	7.5-10	**245-250**
A.J. Page - Non Executive Director (from 01 January 2014)	5-10	0	0	0	**5-10**
Dr L. Pollard - Chair	40-45	18	0	0	**45-50**
D.A.Royles - Director of Human Resources (from 08 September 2014)	90-95	0	0	25-27.5	**120-125**
Dr M.A. Smith - Chief Operating Officer (from 20 May 2013 to 15 September 2014)	70-75	0	0	25-27.5	**95-100**
Prof P.M. Stewart - Non Executive Director (from 01 October 2013)	5-10	0	0	0	**5-10**
T A Whitfield - Director of Finance (from 20 January 2014)	175-180	0	0	162.5-165	**340-345**

B) Salaries and allowances 2013-14 of senior managers who also served in 2014-15

Name and Title	2013-14					
	Salary	Expense Payments (taxable)	National Clinical Excellence Award	Other	All Pension-related Benefits	TOTAL
	(bands of £5,000) £000	Rounded to nearest £100	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
M. Abrahams - Non Executive Director (Vice Chair) (to 31 January 2015)	5-10	11	0	0	0	**5-10**
M Chamberlain - Non Executive Director	5-10	2	0	0-5	0	**5-10**
C Chambers - Non Executive Director (from 09 December 2014)	n/a	n/a	n/a	n/a	n/a	**n/a**
M Ellerby - Non Executive Director (from 01 December 2014)	n/a	n/a	n/a	n/a	n/a	**n/a**
J.M. Hartley - Chief Executive (from 14 October 2013)	105-110	0	0	0	20-22.5	**125-130**
Prof S Hinchliffe - Chief Nurse (from 20 May 2013) Deputy Chief Executive and Chief Nurse (from 15 September 2014)	140-145	1	0	0	0	**140-145**
C.A. Johnstone - Non Executive Director (Vice Chair)	5-10	17	0	0	0	**5-10**
Dr W Kirkup - Non Executive Director (from 19 May 2014)	n/a	n/a	n/a	n/a	n/a	**n/a**
S H Neville - Director of Strategy & Planning (from 01 May 2014)	n/a	n/a	n/a	n/a	n/a	**n/a**
Dr Y.A. Oade - Medical Director (from 01 June 2013)	170-175	0	20-25	0	12.5-15	**210-215**
A.J. Page - Non Executive Director (from 01 January 2014)	0-5	0	0	0	0	**0-5**
Dr L. Pollard - Chair	40-45	21	0	0	0	**45-50**
D.A.Royles - Director of Human Resources (from 08 September 2014)	n/a	n/a	n/a	n/a	n/a	**n/a**
Dr M.A. Smith - Chief Operating Officer (from 20 May 2013 to 15 September 2014)	130-135	0	0	0	32.5-35	**165-170**
Prof P.M. Stewart - Non Executive Director (from 01 October 2013)	0-5	0	0	0	0	**0-5**
T A Whitfield - Director of Finance (from 20 January 2014)	35-40	0	0	0	0-2.5	**35-40**

Benefits in kind are rounded to the nearest £100 in the previous two tables.

Pension related benefits are shown in bands of £2,500. All other remuneration is shown in bands of £5,000

Salary includes all amounts paid and payable in respect of the period the individual held office, including any salary sacrifice elements.

All taxable expenses are in respect of taxable business mileage

All pension-related benefits are calculated using the HMRC method as set out in Section 229 of the Finance Act 2004. The NHS Pension Scheme is a "final salary" scheme. Thus where a senior manager's salary increases this results in a larger movement in the overall value of their pension entitlement. Similarly, where there is a limited increase in the value of the pension payable relative to inflation and the employees contributions, then the HMRC calculation can show a "negative pensions benefits" figure for the year which is then shown as a "nil" figure in the table. These factors mean that year on year there can be significant volatility in the reported pensions benefits for an individual.

The Chief Nurse, Professor Suzanne Hinchliffe, was appointed Deputy Chief Executive and took on responsibility for operational services following the departure of the Chief Operating Officer.

C) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 as at 31 March 2015 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2014 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real Increase in Cash Equivalent Transfer Value £000
J.M. Hartley - Chief Executive (from 14 October 2013)	2.5-5	12.5-15	50-55	160-165	797	921	50
Prof S Hinchliffe - Chief Nurse (from 20 May 2013) Deputy Chief Executive and Chief Nurse (from 15 September 2014)	7.5-10	27.5-30	70-75	210-215	1,176	1,433	111
S H Neville - Director of Strategy & Planning (from 01 May 2014)	5-7.5	17.5-20	50-55	160-165	871	1,062	75
Dr Y.A. Oade - Medical Director (from 01 June 2013)	0-2.5	2.5-5	75-80	235-240	1,539	1,646	32
D.A. Royles - Director of Human Resources (from 08 September 2014)	2.5-5	5-7.5	60-65	180-185	956	1,086	29
Dr M.A. Smith - Chief Operating Officer (to 15 September 2014))	0-2.5	5-7.5	30-35	90-95	456	580	25
T A Whitfield - Director of Finance (from 20 January 2014)	12.5-15	42.5-45	80-85	250-255	1,446	1,849	179

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

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Off-Payroll engagements

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months.

	Number
Number of existing engagements as of 31 March 2015	9
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	4
for between two and three years at the time of reporting	-
for between three and four years at the time of reporting	-
for four or more years at the time of reporting	-

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	5
Number of new engagements which include contractual clauses giving the Leeds Teaching Hospitals NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	0
Of which,	
assurance has been received	-
assurance has not been received	-
engagements terminated as a result of assurance not being received	-

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements.	17

2.5 Research and Innovation

The ambition of Leeds Teaching Hospitals is to be a global leader in clinical research and innovation which is translated into patient benefit at pace and scale. Research and innovation is also central to our ambition to develop our specialist services and ensure we secure our future as a leading clinical research centre in the UK. In 2014/15 we developed an ambitious new strategy for research and innovation.

The clinical research, including trials, which takes place at Leeds Teaching Hospitals covers all areas of medicine and healthcare, testing treatments for a wide range of diseases. We are keen that the majority of our patients should have the opportunity to be involved in such trials. Much of the funding for this activity comes from the National Institute for Health Research (NIHR) Clinical Research Network.

We are one of the best performing trusts in England for projects recognised by the NIHR. Last year, we involved more than 12400 patients in 468 high quality research studies and conducted the highest number of complex studies of any Trust in England. In this year's annual report we focus on a number of case studies drawn from our leading edge research programmes.

Some of our trials are in experimental medicine, which is early stage research to take discoveries made in the lab and turn them into effective new treatments or new methods for diagnosis. In experimental medicine, we focus on a smaller range of diseases, including musculoskeletal disease such as arthritis, cancer and cardiovascular disease.

Case study: Professor Peter Hillmen identified the potential of the drug eculizumab to treat paroxysmal nocturnal haemoglobinuria (PNH), a rare acquired blood disorder, in which the bone marrow cannot compensate for a massive loss of red blood cells. This world class research has allowed patients who have previously been unable return to work, to do so.

NIHR Clinical Research Facility (CRF) for Experimental Medicine

Set up in 2012, the NIHR Leeds CRF carries out clinical trials in experimental medicine, focusing on cancer, musculoskeletal disease and cardiovascular disease. The new Cardiovascular Clinical Research Facility (CV-CRF) in the Jubilee Wing at Leeds General Infirmary was officially opened by Mr Edward Ziff, Chair of the Leeds Teaching Hospitals Charitable Foundation on 10 December 2014 after the Foundation provided funding of £250,000 to make the facility a reality.

The new location provides access for patients to early phase and high quality research into diseases of the heart and blood vessels. It allows protected space for teams from the hospital and the University of Leeds to conduct this important research in a dedicated space for the first time. It will also generate new links with commercial partners and industry, allowing novel treatments to be evaluated. Most importantly patients may be able to receive these treatments at an earlier phase in their development.

Leeds Cancer Research UK Centre

The Leeds Cancer Research UK Centre aims to harness the scientific power of Leeds-based cancer researchers to deliver improvements in cancer care at local, national and international level. The Centre's strategy is to focus on cancer immunology and virology, radiation biology, and brain cancer, involving as many University academics and Leeds Teaching Hospitals clinicians as possible. The Centre also works hard to involve the local community, patients, carers, survivors and the wider public.

Realising our ambition for research requires development of our clinical staff and, in partnership with the University of Leeds, we have created a novel science which designates Trust clinicians as honorary clinical associate professors, provided they meet criteria for research or educational excellence.

Case study: Simple injection could help shrink a brain tumour

Leeds scientists are exploring whether a simple injection could help shrink a brain tumour. The research team hopes to harness the power of certain viruses that can kill cancerous cells without harming healthy ones. Professor Susan Short, who is leading the five-year project at the Leeds Centre for Translational Neuro-Oncology, says the research could benefit patients who are hardest to treat.

"Since these viruses are non-toxic, they could be appropriate in situations in which standard treatment is difficult – for example, in young children or older people," she said. This is fantastic news for patients as there aren't enough clinical studies for brain tumour patients.

NIHR Musculoskeletal Disease Biomedical Research Unit (BRU)

A partnership between Leeds Teaching Hospitals and the University of Leeds, the BRU translates fundamental biomedical research into clinical research that benefits patients with £6.25m funding from NIHR.

BRUs focus on a single disease area; at Leeds, this is musculoskeletal disease, particularly inflammatory arthritis, osteoarthritis and joint replacement. Research at the Leeds BRU has led to new approaches for assessing and treating patients with rheumatoid arthritis. BRU researchers were also the first to purify stem cells from bone marrow, using a technique that is now in wide use by industry. Engineering the next generation of artificial joints is a strong theme in the BRU.

Case study: Lupus

Leeds Teaching Hospitals is a partner in a new £5.1 m project aimed at eliminating the 'trial and error' approach to the treatment of lupus.

Systemic lupus erythematosus (also known as SLE or lupus) is a condition which affects around 16,000 people in the UK. In people with lupus, the immune system attacks healthy cells, organs and tissues, causing severe inflammation. Researchers are using cutting-edge technology, such as next generation RNA sequencing, to examine skin biopsies in order to try to understand why the skin rashes and hair loss in lupus respond well to treatment in some patients but not others.

NIHR Diagnostic Evidence Cooperative

Leeds also hosts one of four NIHR Diagnostic Evidence Cooperatives (DEC) set up nationally in 2013, which look at new technologies to diagnose diseases. The Leeds DEC is targeting cancer, musculoskeletal diseases and diseases of the bladder, kidney, liver and bowel.

Case study: Better diagnostic tests for managing patients with scleroderma

The DEC is collaborating with the NIHR Leeds Musculoskeletal Biomedical Research Unit, University of Leeds and industrial partners, Myriad RBM and Siemens Healthcare, to develop and evaluate new diagnostic tests to improve the management of patients with Scleroderma and Raynaud's Disease. Scleroderma is a heterogeneous connective tissue disease characterised by disease of the blood vessels, changes in the immune system and thickening and scarring of connective tissue. The impact of the young age of disease onset is reflected in the individual and economic burden. Raynaud's disease is a clinical feature of scleroderma.

NIHR Health Technology Cooperative (HTC)

The NIHR HTCs work with industry to develop new clinical devices or healthcare technologies which improve treatment and quality of life for patients. The Leeds NIHR HTC focuses on colorectal (bowel) disease looking for ways to use new technology to reduce the need for invasive surgery, improve diagnosis and provide better treatments.

In addition to funding sources such as the NIHR we also receive funding from the Wellcome Trust, Research Councils, Cancer Research UK, British Heart Foundation and Arthritis Research UK, as well as key local charities including Yorkshire Cancer Research, Leeds Teaching Hospitals Charitable Foundation and Candlelighters.

Our funding helps to support work in areas of research where we have particular expertise, including clinical technologies, cardiovascular disease, diabetes and dentistry. We offer excellent access to clinical research studies in our Children's Hospital and have exciting programmes of research in infectious diseases and neurology.

Case study: The colorectal HTC in Leeds have worked with Bedfont Scientific, Yeovil District Hospital and University of the West of England to set up a small study to test the feasibility of using breath test analysis as a method to detect patients who have undergone surgery of the large bowel in order to determine if the surgical repair of the bowel has been successful. This test aims to provide early warning of any leakage from the bowel and has the potential to provide better patient outcomes and reduced costs for the NHS. Patients diagnosed early require less intervention and have a better chance of successful recovery from their initial surgery.

Medical Research Council (MRC) Centre for Medical Bio-informatics

The MRC Centre for Medical Bio-informatics brings together clinical and social science researchers with data scientists in mathematics and computer science to open up new ways to understand health and human behaviour. Leeds Teaching Hospitals is joining with the University to create a new, purpose-built space for the centre housing 40 staff, with high tech computational infrastructure and a safe data room.

People

The National Institute for Health Research (NIHR) provides funding to help NHS staff from all disciplines get involved in research and build research as part of their career, through a variety of schemes, including their Academic Clinical Fellows scheme.

Case study: Dr Nick West is a good example of a clinician who is developing a research career through NIHR funding. Dr West was in the first cohort of NIHR Academic Clinical fellows when the scheme was introduced in 2006. The funding allowed him to spend 25 per cent of his time building research data to apply for external funding for a PhD, while still continuing his clinical training.

Doing a full time PhD took Dr West out of his clinical pathology training for three years and he then chose to continue on the academic route and was appointed as a NIHR Clinical lecturer. "Although it will take me over twice as long to qualify and the workload over the last nine yers has been heavy, the positive massively outweigh the difficulties," says Dr West.

2.6 Information Governance

The Trust recognises that information is an important asset, supporting both clinical and management needs. We ensure that information is respected, held securely and used professionally. We also make sure personal information is dealt with legally, securely, efficiently and effectively, in order to achieve the best possible care.

The Information Governance Strategy, Policy and action plans ensure information is managed effectively and is subject to regular review to continuously monitor and improve our Information Governance processes. These reviews are conducted in accordance with NHS Information Governance Toolkit guidelines.

Assessing the quality of data has been a significant part of the workload of the Trust's Information Governance in the past year. The Trust has implemented the Clinical Information and Outcomes Group which is a senior level forum, which examines and co-ordinates issues impacting on the recording, accuracy and quality of clinical and corporate information recorded within Trusts information Assets.

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2014/15.

The Trust is fully committed to ensuring that personal information is protected and used appropriately. It is constantly reviewing its existing processes to significantly reduce the likelihood of breaches.

2.7 Our People

Developing and embedding "The Leeds Way"

We want Leeds Teaching Hospitals to be "the best place to work and volunteer". We are striving to develop a sense of community where every individual (staff, students and volunteers) feels part of the organisation, takes pride in what they do and works as part of a successful team delivering the best possible care for patients.

In 2014, we launched our five year strategy setting out a clear vision to be the best provider in the country for integrated and specialist care through the delivery of five core values and goals. This followed a six-month programme of engagement with patients, the public, our partners and staff to develop this work. One of our goals is to be "the best place to work" where we develop a highly engaged, high performing workforce and positive patient-centred culture delivering great care for patients.

Our engagement activity has been driven by staff, developed through innovative engagement methods and embedded in a co-produced set of values and behaviours. This work is known as "The Leeds Way". It's the "way we do things round here" and our emerging engagement strategy focuses on two-way communications, health & well-being, improvements in the employee journey and recognition and celebration, all set in the context of organisational learning and strong leadership. Equality considerations and priorities are integral to all of our work streams within the strategy.

Our 2014/15 highlights

Introducing the "Leading in Leeds" Leadership Programme

2014 saw the launch of Leaders in Leeds, the training programmes that support the way in which we embed The Leeds Way into everything we do and across all parts of the organisation. The programmes have ranged from an Introduction to Management for our new leaders in Bands 4-7 roles to Masters level qualifications. The portfolio of development also includes programmes for new Consultants, Lead Clinicians and Leading for Patients.

Improving the numbers of staff who had an appraisal

We have made huge strides in embedding our appraisal processes across the organisation. This is important to ensure that we are increasing two way conversations and feedback between staff and managers and planning for future development needs to ensure our staff have the right skills to deliver the best possible care for patients. 96.1% of our staff received an appraisal in 2014/15 and this was supported by the significant improvement in our staff survey results which puts us in the top 20 Trusts in the country for completion of appraisal. But it's not just about the numbers, we continue to improve the quality of our appraisal process to ensure that this is a meaningful process for all.

Re-designing our recruitment approaches

At Leeds we believe we need to "get the basics right" to enable our potential, new and existing staff to have a positive experience at all stages of their employee journey. In 2014,

we launched a major project to re-design our recruitment processes. Running alongside this was the launch of our new recruitment website that allows visitors to learn more about what we do, how we do it (our values and behaviours) and what type of careers are available. This is very responsive and supportive to potential applicants and new staff. We have ambitious plans to develop this work during 2015/16 and improving the employee and volunteer journey remains a key priority for us.

Supporting the health and well-being of our staff

Supporting our staff with their health and well-being continues to be an important priority for us and we have a range of services available to provide support and promote health and wellbeing. This includes a range of policies and services including Occupational Health, Staff Counselling and access to Staff Physiotherapy. For working families we offer on-site nursery services, advice, guidance and support from our employee care team and a range of parent classes including Baby Yoga and Baby Massage. Our staff can access services to support their health and fitness including two on site gyms, exercise classes and fitness classes. During 2014/15, our staff have enjoyed our cycling schemes, touch rugby and our fresh air fit programme - an outdoor fitness programme with circuits.

At the start of 2015 we launched our Health and Well-being campaign calendar and started the year with our commitment to support the Dry January campaign. This will be developed throughout 2015/16 with a strong commitment to focus and support staff with their physical and mental health and well-being.

Education and Training

We focus on embedding the right education and training opportunities at the right time for our staff and students. During 2014/15, 97% of our new employees attended a revised comprehensive induction on their first day of employment. This ensures that they receive information about "the Leeds Way", have the opportunity to meet our Chief Executive and receive all their mandatory training ensuring they are equipped to enter the work place. New starters can also access e-learning on our clinical systems before they join the organisation.

Compliance with our mandatory training programmes continues to make significant progress with 87.5% of requirements completed by our staff, supporting the safety of our patients, visitors and staff.

We have offered a range of training and development opportunities throughout the year in response to service and staffing feedback. A particular focus has been a customer care programme for our front line staff which has included "Sage and Thyme" training focussing on helping staff deal appropriately with distressed and upset people. Many of our training programmes are delivered at a team level.

Our "Learning Bursts" continue to be well received by our staff and provide an alternative to a classroom environment. The "bursts" allow the content of the session to be shaped by the attendees in areas where they feel they need further development or where they would like some advice and support. Examples during 2015/16 have included objective setting, managing difficult conversations and "the manager as a coach".

Launching ***"if in doubt, speak out"*** - our new approach to support Whistleblowing

We have launched our campaign to support staff in raising concerns "if in doubt, speak out". This followed a review of our arrangements undertaken by the leading independent Whistleblowing charity, Public Concern at Work. This work involved contributions from staff, managers, staff side representatives and our Executive and Non-Executive Directors. It aims to provide a simple

three step process to support and encourage staff to raise concerns in a supportive manner. As part of this work we also trained a cohort of Designated Whistleblowing Leads across the Trust who have specific responsibility and expertise in managing concerns in accordance with best practice. Under the leadership of Mark Chamberlain, Non-Executive Director, we have routinely monitored concerns that have been raised under the policy and reviewed our arrangements to ensure they are robust. In December 2014 the Chief Executive and Policy Director of Public Concern at Work attended our Whistleblowing Review workshop and made the following observation:

"most Trusts have not undertaken review work at the same depth as LTHT (to our knowledge). The vital "tone from the top" and leadership on this issue has been impressive. Further the development of designated lead officers as a key tier of individuals within whistleblowing arrangements has received a welcome focus. The Trust has also subscribed to an independent Freephone number for staff to use. This work is a strong start but not yet complete. Work to assess progress and the impact of activity will be the essential next step"

Working closely with Public Concern at Work we are currently reviewing our policy and organisational arrangements against our Staff Survey feedback, usage of the process and the recommendations of the national Freedom to Speak Up Review.

Promoting equality and delivery diversity in employment

We continue to promote equality and diversity as an employer. Equality priorities are integral to the delivery of our staff engagement priorities in terms of ensuring awareness of the agenda, signing up to best practice arrangements, inclusive engagement activities and recognising achievements in diversity. We are pleased that 96% of our staff have completed their mandatory equalities training (demonstrating an improvement of 13% in twelve months), we have committed to the principles of Two Ticks, Mindful Employer Charter and most recently the West Yorkshire Trans Pledge and equality considerations are fully reflected in our employment policies. Our work to promote equality & diversity in employment is a core and aligned part of our wider trust ambitions as presented on page 91.

Introducing the Staff Family & Friends Test

Following the patient feedback initiative, the Friends and Family Test (FFT) was extended to our staff from April 2014. We opened the survey to our staff, students and volunteers and provided a range of opportunities to complete the on-line survey. The Staff FFT includes the following questions:

- how likely are you to recommend the Trust as a place to receive care or treatment?
- how likely are you to recommend the Trust as a place to work?

Feedback is presented below. We are delighted to report an improvement in both response rates and scores for both a place to receive care and to work throughout the course of 2014/15.

Staff Friends & Family Test feedback	Response from Q1 (May 2014)	Response from Q2 (Sept 2014)	Response from Q4 (March 2015)
Response Rate (numbers of staff, students and volunteers)	750	1507	1514
How likely are you to recommend LTHT to Family and Friends if they needed **care or treatment**?	3.91 (stars out of 5)	4.08 (stars out of 5)	4.17 (stars out of 5)
How likely are you to recommend LTHT to Family and Friends if they needed care or treatment?	72.7%	81%	84.5%
How likely are you to recommend LTHT to Family and Friends as a **place to work**?	3.44 (stars out of 5)	3.63 (stars out of 5)	3.71 (stars out of 5)
How likely are you to recommend LTHT to Family and Friends as a place to work?	56.9%	65%	68.2%

N.B – due to the National Staff Survey in Quarter 3, the organisation did not complete the separate Friends and Family Test for Staff during this period

Celebrating our Apprentices

We are really proud of our apprenticeship programme. Since its launch in 2010, 370 apprentices have completed our Level 2 Apprentice Clinical Support Worker Programme (314 of these are still working in our hospitals whilst others have gone onto further development). We also have a range of Level 3 programmes. We have very effective, highly motivated and knowledgeable apprentices who are aligned with the trust values and behaviours. In recognition of our apprentices and the staff that support them in the workplace, we were delighted to receive a number of awards for our programmes including the Silver Award from Apprenticeships4England for Macro Employer of the Year and the Large Employer of the Year at the Leeds Apprenticeship Awards. Well done to many of our apprentices who have also won individual awards.

A successful Flu Campaign in 14/15

Our Occupational Health Service ran a successful flu campaign in 2014/15 supported with a dedicated team of peer vaccinator colleagues across the Trust. A total of 11,400 staff received the flu jab ensuring that 76.4% of our staff involved in direct patient care were vaccinated.

Ensuring that LTHT becomes "a great place to volunteer"

We recognise the enthusiasm and commitment of the 300 volunteers who are currently providing services and support across our hospitals. Our volunteers undertake a range of roles for example assisting with mealtimes on wards, trolley services, signposting visitors, and chaplaincy and within our A & E departments. Our volunteers are recognisable by their own uniforms. We absolutely value their contribution to the work of our hospitals and delivering the best possible services and experience to our patients. To support this, volunteering is a key priority for 15/16 as part of our wider People Strategy. We have pro-active plans to develop our opportunities for the recruitment, selection, training and recognition of volunteers. This will also include a commitment to double the numbers of our volunteers, develop the diversity of our volunteers to reflect the communities and patients we serve and develop new and exciting volunteering roles. For the first time, we have also piloted a staff volunteering programme to enable our own staff to volunteer in patient facing roles in the Trust. We have a strong commitment to developing all aspects of our volunteering programmes to truly make our hospitals "the best places to volunteer".

What did our staff tell us in the staff survey?

The National Staff Survey was undertaken between September and December 2014 and is an annual indicator of how NHS staff feel about their working life and environment. The survey is undertaken on our behalf by an independent provider and some of our key results are highlighted below.

- In the Staff Survey 2014 we undertook a larger 5000 sample of staff to maximise the feedback opportunity and to enable us to obtain results at local level. Our response rate was 50%, putting us above average for acute Trusts in the country
- In the results of the 2012 staff survey, we had 18 key findings in the bottom 20% of Trusts in the country; in 2014 this had reduced to 4.
- We have seen an 11% increase in staff confirming that they have had an appraisal since 2013 which puts us in the best 20% of Trusts nationally. Our focus for 2015 is to maintain the increased rates and continue to focus on the quality of appraisals.
- We have seen a 15% increase in staff reporting good communication between senior managers and staff since 2012.

Recognising and Celebrating Our Staff, Teams and Services

The expertise and dedication of our staff, teams and services has won praise, recognition and accolades throughout the course of 2014/15. We celebrate many of these achievements through the weekly Chief Executive Start the Week bulletin. We say huge congratulations to all of you and below are just a small selection of achievements.

Dr Kate Granger continued to be recognised over the last twelve months for her extraordinary contribution towards more compassionate and patient-centred care through the #hellomynameis campaign. She was awarded The British Geriatric Society President's medal at the Geriatric Society conference in Manchester, became the youngest ever Fellow of the Royal College of Physicians, as well as the first non-consultant to be given the title, and was named one of the most influential women in healthcare for 2014 by the Health Service Journal.

The Leeds NHS Facilities Staff Support Services which includes Employee Care Services, Health & Fitness and the Staff Nursery teams, were awarded the Investors in People Gold standard.

Dr Alison Cracknell, Consultant in Elderly Medicine, Dr Tony Shannon, Chief Clinical Information Officer, and Professor David Brettle, Head of Medical Physics and Engineering were named by the Health Service Journal (HSJ) as among the 50 most innovative people in UK healthcare for 2014.

Matron Rachel Hollis, Lead Nurse for Children's Cancer, was awarded a fellowship of the Royal College of Nursing (FRCN) for her services to the College.

Inflammatory Bowel Disease Nurse Specialist, Lisa Warren, was nominated for a lifetime achievement award at the Crohn's and Colitis UK 35th anniversary awards.

Dr Kevin Reynard was appointed to the role of Vice President of the College of Emergency Medicine. Dr Reynard took over the role from another LTHT Consultant, Dr Taj Hassan. That two consecutive appointments have been made from within the LTHT Consultant body to this important role reflects our national expertise and leadership in the field of emergency medicine.

Paediatric Allergy Nurse Specialist, Brenda DeWitt, was awarded the Holgate AAIR Prize for Excellence in Allergy.

To add to his host of other accolades, Professor Simon Kay was nominated for a national Health Hero Award, run in conjunction with the Daily Mail, Boots and ITV's This Morning. Mark Cahill, the recipient of the UK first transplant, made the nomination and has spoken movingly of how Simon has consistently gone beyond the call of duty to support him through the pioneering surgery and subsequent recovery.

The Trust's Teenage and Young Adult Cancer Service were shortlisted for a Nursing Times Award 2014 in the Child and Adolescent Services category for Creating an 'app' for teenagers and young people with cancer. The app is now available nationwide.

Consultant Physician, Eileen Burns, was elected President Elect of the British Geriatric Society.

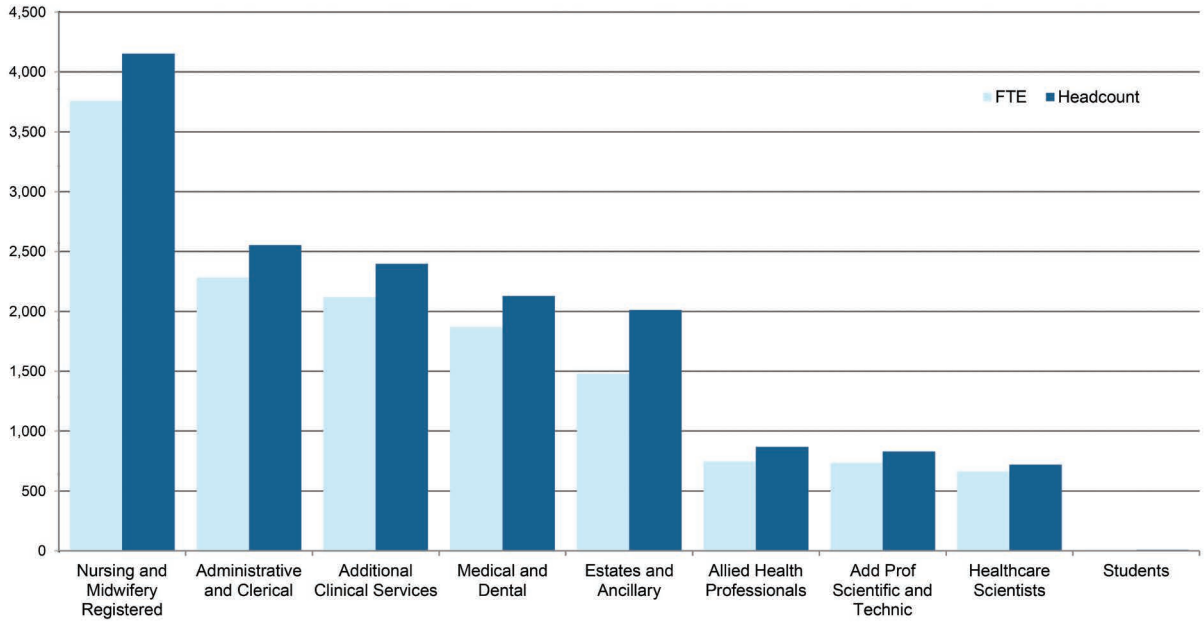
Consultant Dermatological Surgeon & Mohs Micrographic Surgeon, Walayat Hussain, was elected as a Fellow of the American College of Mohs Surgery (ACMS). He is one of only a handful of people to achieve this in Europe. It is an acknowledgement of the complexity and volume of Mohs surgery cases that he has performed since being in Leeds.

Midwife Amanda Burleigh won Midwife of the Year at the British Journal of Midwifery Practice Awards 2015.

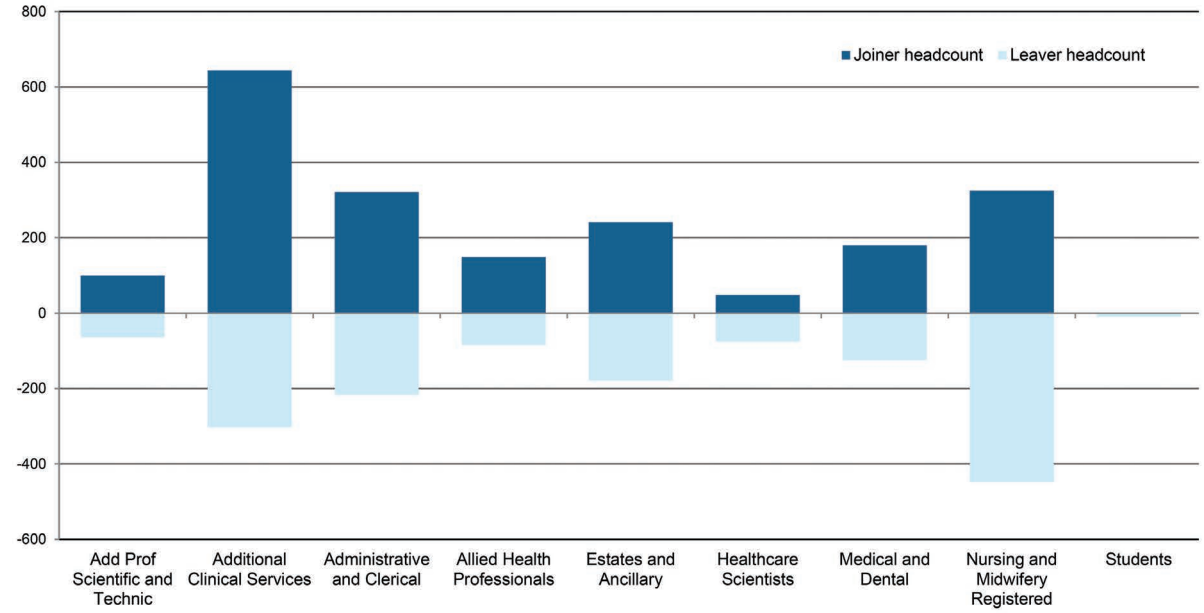
Gill Roe, Advanced Radiographer Practitioner, was awarded Radiographer of the Year for the Yorkshire and North Trent Region.

Understanding our people

Staff in Post



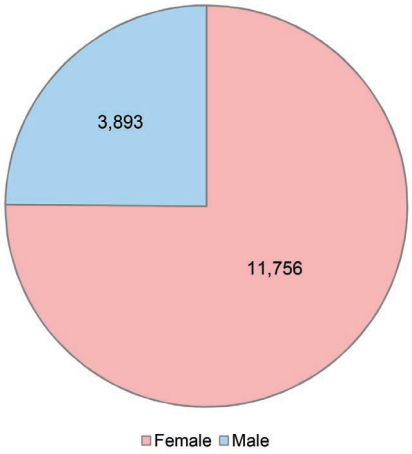
Joiners and Leavers



Ethnicity

Ethnicity	Headcount
White - British	12,120
Asian or Asian British - Indian	598
Not Stated	562
Asian or Asian British - Pakistani	392
Black or Black British - African	372
White - Any other White background	362
Any Other Ethnic Group	303
Asian or Asian British - Any other Asian background	214
White - Irish	170
Black or Black British - Caribbean	164
Mixed - White & Black Caribbean	75
Chinese	72
Mixed - White & Asian	60
Mixed - Any other mixed background	49
Asian or Asian British - Bangladeshi	41
Black or Black British - Any other Black background	39
Mixed - White & Black African	36
Black Nigerian	4
Filipino	3
White Scottish	2
Asian Unspecified	2
White Other European	2
White Mixed	2
White Greek	1
Black Unspecified	1
Other Specified	1
Mixed - Black & White	1
White Unspecified	1

Gender Distribution



Looking forward to 2015/16

Moving into 15/16 we have developed a "People Strategy" that includes supporting and complementary chapters that focus on our volunteers, staff engagement, talent & leadership, education & training and workforce planning to ensure we have the right staff, at the right time with the right skills. Embedding the work programmes and priorities of these chapters will be key to ensuring we become the "best place to work and volunteer"

Section 3

Patient Care and Experience

Patient care and experience

Contributions from patients, carers and the public are central to the Trust's aim to deliver quality care and access to services. During 2014/15, we listened to our patients and learnt from their feedback as a way of improving the care we deliver.

3.1 Involving patients and the public

As part of the Trust Public and Patient Involvement Strategy, in 2014/15 we developed a toolkit to support clinical areas in the Trust to listen and include patients' views when services are developed and improved. This toolkit is currently being piloted in four of our areas and we hope to make it accessible to more of our services in 2015/16.

This work is being supported by an independent panel of patients, carers and representatives from organisations outside the Trust. This panel is helping us by assessing how well we are doing in our pilots and by grading us on our achievements.

We continue to work on building our relationships with diverse communities and with our partners to improve the patient, carer and public experience of our services. Examples of our work with local communities include our PALS team visiting existing local forums to find out the specific issues that are affecting them and holding conversations with local faith groups about their special needs when bereaved.

In the past year we have also continued to provide support to a number of Advisory Groups including Learning Disabilities, Blind and Partially Sighted and Deaf and Hard of Hearing Groups. Outside of these groups we have participated in listening events, multi-organisation study days and conferences, for example a Black Minority Ethnic Dementia event, as well as arranging focus groups related to specific diseases and services. This work has resulted in a better understanding of patients' needs when accessing and using our services, for example environmental improvements in our A & E departments in response to concerns and suggestions from the Deaf and Hard of Hearing community.

Going into 2015/16 the Patient Experience team will seek to develop and enhance the relationships we have made and will look for further opportunities to meet with local groups and, hard to reach communities. This will ensure that we have the widest possible range of views and involvement when planning services or evaluating how effective the care we deliver is.

3.2 Improving patient experience

Friends and Family Test

The NHS Friends and Family Test (FFT) was introduced in 2013 to gauge patients' experience of their care and levels of satisfaction. The test asks patients how likely they would be to recommend our service to friends and family if they needed similar treatment. Patients can choose from six options, ranging from, 'extremely likely', to 'extremely unlikely'.

In September 2014 we completed the roll out of the FFT. Adults and children alike are now able to feedback their experience of our care in a number of different ways, whenever, and wherever they attend our services.

In 2014/15 we received 51,000 responses from patients and 89% of those recommended our services.

All Friends and Family feedback including free text comments is available to local teams within 36 hours of the patient completing the form, via the Trust's Ward Healthcheck Electronic Dashboard. This allows teams to search for and analyse their own feedback quickly, which is essential for making timely improvements to patient care.

Local teams have improved the experience of their patients in many ways such as:

- improving waiting room facilities for relatives who are supporting patients undergoing procedures;

- increasing the frequency of refreshments for patients awaiting assessment;
- improved information for patients who are progressing through our Emergency Departments; and
- improving the speed with which staff attend to patients buzzers.

Some of the feedback we receive through the FFT:

"Nursing care was attentive, friendly, and very efficient. I was kept informed about my procedure and I felt confident in the explanations and advice I received"

"The staff were always there when required and gave reassurance on worries and concerns I had. Nothing was too much trouble and I feel I got the best possible treatment from entering the ward to my discharge."

National Patient surveys

In addition to the Friends and Family Test (FFT), PALs comments and feedback via websites and social media, the Trust participates in a number of National Patient Surveys conducted and analysed by an independent contracted provider. The benefit of commissioning these surveys is that we can benchmark our performance against other similar Trusts and also compare our own current performance against previous year's results.

In 2014/5 we undertook the mandatory National Inpatient Survey and also a voluntary A & E Survey.

National Inpatient Survey 2014

This is conducted annually and asks patients specific questions about their admission to hospital, what to expect after procedures and discharge.

Compared to previous surveys we compared significantly better on five questions and only performed significantly worse than last year in one respect; that was a reported increase in the number of patients stating that during a planned admission their specialist was not given all the necessary information.

Areas in which the Trust was reported as having improved significantly were; provision of emotional support by staff; being treated with respect and dignity; cleanliness of toilets; provision of privacy during discussions of condition or treatment; and being asked to provide views on the quality of care.

Accident & Emergency Survey 2014

The Trust carried out a voluntary survey to check on progress and improvement since a mandatory survey undertaken in 2012. The survey looks at all aspects of the patient's experience in A&E including arrival, waiting, staff, care and treatment and environment.

Compared to 2012 the A & E department compared significantly better in five areas in 2014 and did not score significantly worse in any areas.

The areas in which A & E demonstrated significant improvement were: doctors/ nurses demonstrated time to discuss health problems; doctors / nurses listened fully; the ability to get help from staff where needed; the cleanliness of department; and not giving contradictory information.

In 2015/16 we will be repeating the national in-patient survey and conducting surveys in out-patients and in maternity services.

Patient stories

We continue to collect rich information about the experiences of our patients and their carers in a variety of ways, including the use of video. Patient stories in a range of formats are published each month in the Trust's 'Open and Honest' publication on the internet, and there is a library of videos available to the public via the Trust website - **www.leedsth.nhs.uk**.

Stories we have captured include the experiences of people with cancer, carer's stories and the needs of diverse communities

including Black, Asian and Minority ethnic groups and the Lesbian, Gay, Bisexual and Transgender community. Some of the patient stories are very positive about the care we provide, while others demonstrate how we need to improve.

All Trust Board and senior meetings begin with the showing of a patient story film. They are a powerful reminder of why providing the highest quality patient care must always be the Trust's greatest priority.

We have made a number of service improvements following individual patient stories, for example we have started a piece of work about how to work more collaboratively with the carers of patient's living with dementia and other cognitive impairments.

3.3 Improving information for patients and carers

Providing good quality information for patients and carers is an important part of delivering the high standards of care we expect at the Trust.

In 2014-15, we began a project to look at the many information leaflets we use. The aim is to ensure all leaflets are electronically stored in one place, so that we can keep track of the information we are giving to patients and understand which leaflets are used within each of our services. It will also help us keep our leaflets updated and relevant.

We have listened to what our patients have told us and are reducing the number of leaflets that repeat the same information. This reduction in the amount of information we give out will improve the experience of people who use our services and will help make sure we do not overload patients with too much information unnecessarily.

Our work next year will look at how our information is presented to patients and carers, to ensure it is user-friendly and of a high quality. We will also look at how we distribute patient information, ensuring it is as accessible as possible for all patients.

A patient information group has been set up to support this work and will be seeking members of the public to help us look at the content of our patient information and advise where it could be improved.

In 2014/15 the Model Outpatient Group (including the Dermatology Patient Panel), based at Chapel Allerton, designed an outpatient patient information leaflet. The group are now looking at patient letters on the site, enabling them to be more focused with specific content about the clinic the patient is about to attend and key pieces of information. This work is helping to improve the experience of our patients.

The outputs from this group will then fit into the wider efficient booking project (part of Outpatient Transformation 15/16) to review all letters across the Trust and patient information.

The inclusion of "Calling boards" is still very much on the agenda for 2015/16 too. This will enable information about wait times to be displayed in clinic. This technology needs to be deployed in the correct manner and a plan is being worked up in the coming year.

3.4 Resolving complaints

We value all feedback from patients, relatives and carers. This is an invaluable resource, helping us to improve the treatment and care we provide, and the environment for patients across the Trust.

We are committed to promoting an open culture of feedback and continual improvement. The complaints we receive give us valuable information about what it feels like to be cared for in our organisation.

Following a comprehensive review of our complaints handling led by the Chief Nurse, our work in 2013/14 focused on improving the quality of our complaint responses. In

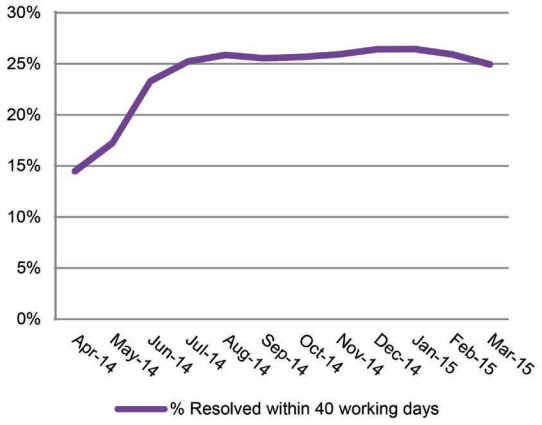
2014/15, we built on this by improving the quality assurance process we had in place and by offering staff the opportunity to access additional training. We also increased the support offered by the complaints team to our services.

Following investment in the complaints team we are now able to make telephone contact with all complainants as soon as we receive their complaint. This allows us to reassure the complainant that we are taking their concerns seriously and enables us to better understand the persons concerns and the outcome they require.

We are also working closely with Children's Services and their service users to develop improved information for children and young adults who are concerned about the care they are receiving and their experience of being in hospital.

Our improvement aspirations this year have focused on the timeliness of our response to people raising concerns and complaints. Following investment and significant restructuring of our complaints service we have seen improvements in our ability to investigate and respond to all formal complaints in less than 40 working days. However, during the coming year we will continue to focus on making further improvements so we handle complaints as quickly and efficiently as possible.

Percentage of complaints received in 2014/15 responded to within 40 working days



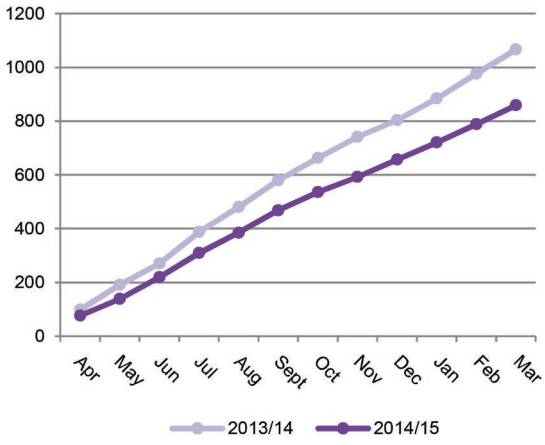
The National Inpatient Survey 2014 demonstrated a significant improvement in the number of patients who are asked to give their views on the quality of the care they receive. The survey also showed that we are providing more patients with the information they need on how to complain if they wish to do so.

Every Clinical Service Unit has an identified lead for complaints who is usually the Head of Nursing. All responses to complaints must go through a quality assurance process, which includes input from the Chief Nurse and Chief Medical Officer. They are signed by the Chief Executive.

You can read more about our complaints review, and our policy in the Quality Accounts on page 105.

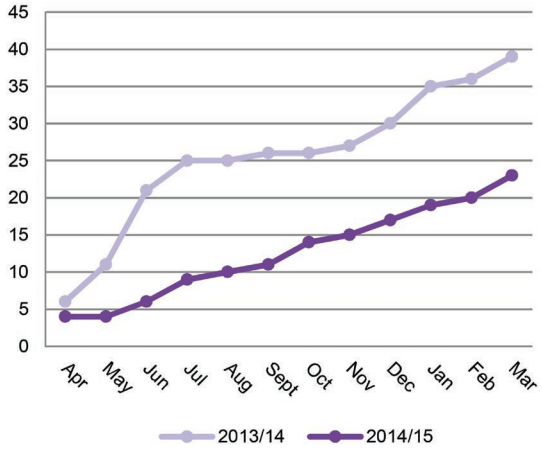
During 2014/15, we received 856 complaints, 19.7% less than the number received during 2013-14.

Cumulative complaints received in 2014-15 compared with 2013-14
(19.7% reduction on 2013/14)



All complaints are assessed when received by the Trust. In the first instance this is undertaken by the Complaints Manager or their deputy. In addition, complex complaints are discussed with the Senior Nurse for Patient Experience who can offer a clinical perspective. All our most serious complaints are reviewed weekly by the Chief Nurse and Chief Medical Officer. This year we have seen a significant reduction of 43% in the volume of this type of complaint.

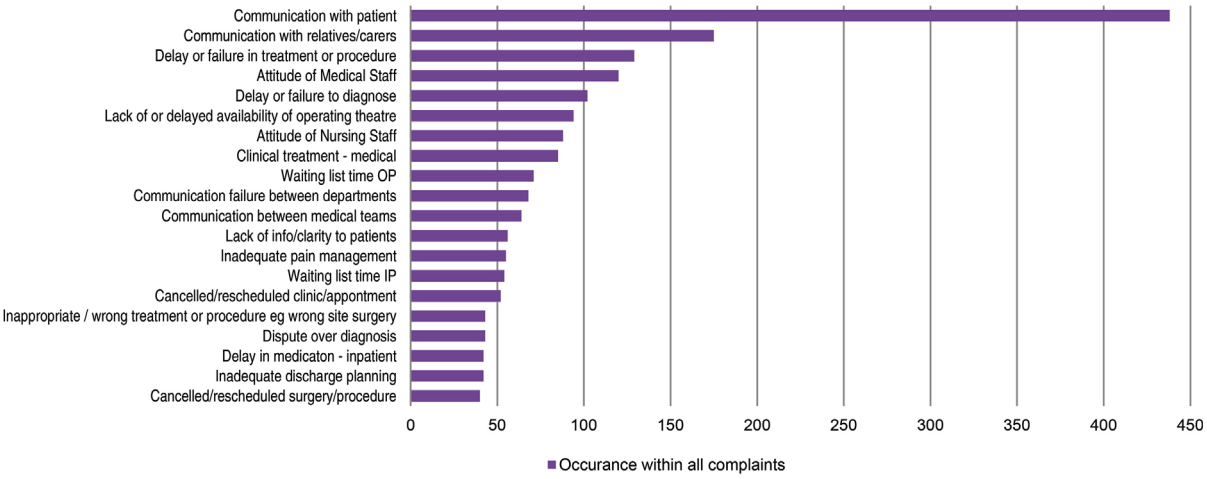
Cumulative Serious Complaints Received in 2014/15 (41% reduction from last year)



A single complaint may cover more than one issue. Starting in April 2014 we aligned our complaint subject categories more closely with the experiences of our patients. We also expanded the range of subject categories available to allow our staff to better understand where the care they provide can be improved.

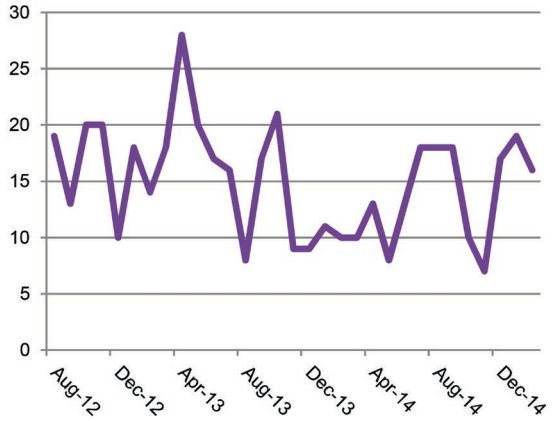
The main themes raised in complaints during 2014/15 are shown below

Top 20 Concerns Raised by Patients in all Formal Complaints received by the Trust in 2014/15



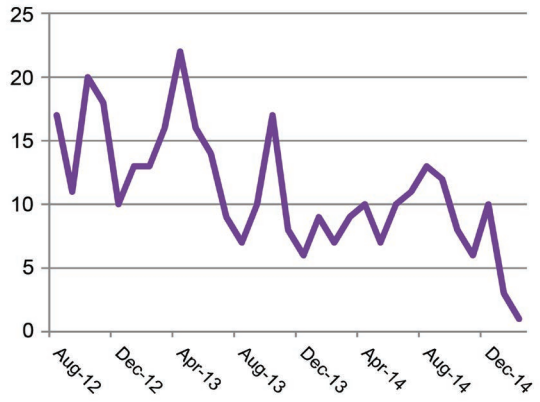
We have maintained our commitment to the quality of our written complaint responses. This year we have continued to see a reduction in the number of complaints which are reopened.

Total Re-Opened Complaints
August 2012 - February 2014



Complaints are reopened for many reasons and overall the reduction is modest however, the majority of complaints which are reopened due to the recipient being dissatisfied are reopened within three months. It is in this group where we have seen the greatest improvement.

Total Re-Opened Complaints within 3 Months of First Response August 2012 - February 2014



3.5 Working with partners

We continue to build on relationships with local stakeholders such as advocacy groups, community forums, and involvement groups, for example Leeds Involving People (LIP).

We have supported Healthwatch Leeds in making visits to our hospitals and a diverse range of clinical specialties. These visits are either part of a rotational programme of scheduled visits, or are undertaken as a result of concerns or feedback from members of the public. During visits the Healthwatch team independently survey patients, families and carers and reports its findings back to the Trust. As a result of feedback from Healthwatch an action plan is generated and the Trust must provide feedback assuring that any required actions have been completed in a timely manner.

The Healthwatch team has visited our Accident and Emergency Departments, (Adults and Children's) and our Children's Hospital. In addition, we have worked with Healthwatch to assist them in identifying patients to help them with specific pieces of work aimed at improving services outside the hospital. In 2014/15 we assisted them in hearing the views of people who use our sexual health services.

Leeds Involving People continues to work with the Trust to organise listening events. As well as an event for carers in 2014/15, we have contributed to events for the Deaf and Hard of Hearing Community, a Black Asian and Minority Ethnic event which focused on Dementia, and a local community group looking at hospital food. Feedback from the Carers and Deaf and Hard of Hearing events has been collated and has provided the basis for action plans which are shaping the way we plan and provide services. As a result of initial discussions regarding hospital food, we are planning to reconvene the Hospital Food Group and to seek participation on it from a wider and more diverse community to help improve the experience of our patients.

Carers

Carers make a huge contribution in supporting the people they care for and as a Trust we are committed to improving the carers' experience of our services. Following carer feedback we are looking at working more collaboratively with carers of patients with cognitive difficulties to develop shared care plans and provide individualised support.

We continue to work the Carers' Strategy Implementation Partnership (CSIP) and are contributing to the development of a Carers' Strategy for Leeds City 2015 – 2016, which takes account of the Care Act 2014.

In 2014/5, and working in partnership with the city's commissioners and Carers Leeds, we hosted an onsite Dementia Carer Support Worker. During her time in post she has offered practical support and advice to more than 200 carers. In recognition of the success and value of this role, we have secured funding for a further year, and will now host two Dementia Carer Support Workers, one based at LGI and one at SJUH.

Involving our members

Over the last year, the Trust continued to grow its membership, which now stands at 22,811 members compared with 22,308 a year ago. The mix of gender, ethnicity and age is monitored to ensure our membership continues to be representative of the wider Leeds population, in addition to Yorkshire and the Humber and the rest of England.

Constituency	Membership as at 31st March		
	2013	2014	2015
Leeds	16458	17877	18277
Yorkshire & Humber	3565	3981	4074
Rest of England	425	450	460
Total	20448	22308	22811

In addition to circulating our member's newsletter in Winter 2014/15 to almost 23,000 members, the Trust has held a number of Medicine for Members engagement events, which have been well attended. These sessions were held across various Trust sites and at different times of day to enable members to attend at a time suitable for them. Topics have included brain aneurysms and stroke, cancer and the development of future radiotherapy treatment, the Trust's Public Health Strategy, rheumatology and older people's medicine. The total number of registrations to attend one or more events to the end of March 2015 was 176.

Included with the newsletter circulation was a Public and Patient Involvement (PPI) questionnaire inviting members to provide feedback on their experience of Trust services and whether or not they wish to participate further in helping the Trust to develop its services and improve the patient experience. Previously this has only been available in paper format but, in response to requests from our members, this year we have made it available to complete online. This allows our members to provide feedback in a timely manner and as often as they would like. Feedback, which can be made anonymously, will be taken into account when changes to services are being considered or to inform improvements.

Whilst many of our members are happy to receive our newsletter, some 1,268 have indicated that they would like to be more actively involved with the work of the Trust. A small number of members have formed part of the assessment panels in the recruitment process for senior members of staff and the Trust is hoping to develop this aspect of membership activity further in the coming year.

Chaplaincy

In 2014-15 the chaplaincy service worked to ensure that all patients have the opportunity to receive professional spiritual care. Two pilot projects in gastro-intestinal oncology outpatients and pre-assessment chemotherapy saw all those attending screened for spiritual needs and offered chaplaincy support.

Patients with a wide range of beliefs accessed these services and the feedback has been very positive. It is intended that this approach will be developed in other services in the coming year. In 2014 the chaplaincy service provided 13,302 documented episodes of care and

attended 202 out-of-hours urgent calls. A full report of the service's activity is available on line or by request.

Volunteers working with the chaplaincy add enormous value to what is offered, both in time listening to patients and also providing specialist knowledge about a wide range of beliefs and practices. In 2014-15 the service continued to recruit new volunteers and set up training for Sikh, Muslim, Christian and Humanist applicants.

The chaplains in Leeds support research to develop and enhance care. This included a pilot workshop using simulated patients to develop communication skills for spiritual care as well as ongoing research to evaluate a model of active listening training for volunteers.

Staff support is an important part of chaplaincy's work, including the preparation of books of condolence following the death of a colleague. At the carol services in 2014 twelve members of Trust staff were remembered by name and during a period of silence wreaths were laid in memory of staff, patients and those associated with the Trust who had died during the year.

Raising funds

We are lucky to have a significant number of donors and individuals who contribute charitable funds towards our work. It is their support that enables us to develop the highest quality treatment and services, improve the hospital environment and promote the wellbeing of our patients. The Leeds Teaching Hospitals Charitable Foundation Board of Trustees is extremely grateful to them all.

The Charitable Foundation is responsible for the administration of the Leeds Teaching Hospitals NHS Trust charitable funds. It is independent of the NHS Trust Board and ensures all money gifted to the Trust is spent strictly in accordance with the donor's wishes.

THE LEEDS TEACHING HOSPITALS Charitable Foundation
REGISTERED CHARITY No 1075308

In 2014-15, the Charitable Foundation said goodbye to Cllr Bernard Atha Chairman and long term Trustee and welcomed Mr Edward Ziff as its new Chairman. The Board of the Charitable Foundation consists of six lay trustees and one NHS link Trustee all appointed via the NHS Trust Development Authority using powers delegated by the Secretary of State for Health.

During this financial year around £6 million has been spent on charitable funding across the Trust. This expenditure is supervised by various Special Advisory Groups each of which is chaired by a Trustee and also consists of Trust representatives. Patient, Staff and Support Services Environment & Equipment Groups identify projects that enhance the hospital environment for patients and provide additional equipment over and above that funded by the NHS.

In 2014, the Charitable Foundation funded the #Hellomynameis campaign at the Trust which was created by Dr Kate Granger MBE, supporting the delivery of compassionate and patient-centred care.

The Trustees are also committed to encouraging high quality, ethical research and development, and during 2014-15, the Foundation gave specific support to fund Honorary Clinical Associate Professors. This consisted of funding 'protected time' in the job plans of clinicians for work linked to a strategic, high quality programme of research in line with the Trust's Research & Innovation strategy and with a clear plan to produce high quality outcomes.

The Leeds Children's Hospital Appeal has gone from strength to strength and raises money to enhance and provide a child-friendly environment and fund additional state-of-the-art medical equipment. In 2014-15, the appeal successfully reached a target of raising over £2 million and has funded countless projects to enrich childrens' experience when they attend hospital. It makes it possible to buy numerous pieces of additional equipment for the Leeds Children's Hospital.

This is all made possible by our generous donors who we offer our heartfelt thanks to for giving so selflessly. We value your support immensely and our gratitude and that of the patients who benefit is immeasurable.

3.6 Emergency preparedness

Tour de France

The Tour de France (TdF), one of the largest sporting events in the world, came to Yorkshire on 5 and 6 July 2014. Over 250,000 spectators gathered in and around Leeds for the Grand Départ. Due to the unprecedented road closures and additional visitors to the city, extensive planning with our partner agencies and special measures were put in place in order to maintain safe patient care and access to services at our hospitals over the weekend.

There was a clear consensus among the public, staff and partner agencies that the event was a great achievement for Leeds and Yorkshire. The success and learning from the TdF were used to inform planning and preparations for a further large scale sporting event, the Tour de Yorkshire, which finished in Leeds on 3 May 2015.

NHS National Industrial Action

A number of health trade unions took part in three separate days of national industrial action (strikes) and periods of working to rule, over national pay conditions during October and November 2015. The Trust worked closely with trade union representatives to plan for and ensure the continuation of essential services. Whilst disruption to patient activity was kept to a minimum, regrettably, some non-urgent appointments had to be rescheduled during strike periods.

National Fire Brigades' Union

The National Fire Brigades' Union carried out 49 periods of industrial action. These ranged from 2 hour to 24 hour strikes. The main implication for our hospitals during these periods was a potential delayed response by the Fire and Rescue Service in the event of a fire. Contingency plans were put in place and staff were required to be extra vigilant in all aspects of fire safety.

Ebola

It is important to stress that while the spread of Ebola is posing a huge challenge in parts of West Africa - particularly in Sierra Leone, Liberia and Guinea - the risk of encountering patients with Ebola in the UK remains very low.

However, it is anticipated that a small number of Ebola cases will be seen in the UK. Therefore, the Trust has put in place robust plans and procedures to ensure our hospitals are as well prepared as possible to safely deal with patients with suspected Ebola in Leeds.

Resource Escalation Action Plan (REAP) Levels

The NHS experienced an unprecedented level of demand during winter 2014/15 and we were no exception. As part of the Trust's planning for Winter, an Operational Response Procedure was developed and applied. This procedure describes the roles and responsibilities of key staff in managing the fluctuations in demand for Trust resources. The procedure also describes the newly adopted trigger points and escalation arrangements within Leeds Hospitals and across health services in West Yorkshire. These are known as Resource Escalation Action Plan (REAP) Levels. This allows partner health organisations to clearly understand and manage the levels of demand and activity within each organisation.

Flu Season 2014/15

During the 2014/15 flu season the Trust's Occupational Health Team worked closely with 198 peer vaccinators from wards and departments across our hospitals. They successfully met the Department of Health target and vaccinated over 75% of frontline healthcare staff. This together with a dedicated internet flu resource helped to manage the impact of flu and protect staff, patients and the public from the flu virus.

Responding to unprecedented Events

To ensure the Trust can respond to the needs of the public during unprecedented media or high profile incidents or events, the Emergency Planning Team developed a Strategic Plan. This plan outlines how the Trust will coordinate its response and establish a helpline to provide immediate access to vital support and information.

Past events involving severe ice and snow have caused a significant rise in the number of patients with trauma and orthopaedic injuries attending our Emergency Departments. A plan to respond to multiple minor casualties has been developed which includes how to treat large numbers of minor injuries while maintaining services for non-orthopaedic patients.

Valuable learning from past incidents and events has been applied this year. This additional learning has enabled the Emergency Planning Team to improve plans and procedures which will strengthen further the hospital's emergency preparedness, resilience and response arrangements.

3.7 Equality and diversity

Leeds Teaching Hospitals NHS Trust is committed to challenging discrimination and promoting equality and diversity both as an employer and a major provider of health care services. We aim to ensure that equality and diversity is at the centre of our work and is embedded into our core business activities.

The Trust acknowledges all protected characteristics to be of equal importance, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

We have an Equality and Diversity Manager who is based in our Patient Experience team and works closely with the Head of Human Resources for Policy and Performance. We also have an Equality and Diversity Strategic Group led by our Chief Nurse, to help us to deliver our equality objectives.

Setting and publishing of equality objectives

The following 2012 to 2016 organisational equality objectives were agreed by the Trust Board in 2012.

Objective 1 To improve the collection, analysis and use of equality data and monitoring for protected groups.

Objective 2 To support the development of leadership at all levels within the NHS economy in Leeds in a way that values and promotes equality, diversity and inclusion.

Objective 3 To ensure on-going involvement and engagement of protected groups and 'local interests' including patients, carers, staff, third sector, CCGs and the local authority.

Objective 4 To improve access to NHS services for protected groups.

Throughout 2014-15 the following actions were achieved:

Equality Objective	Action Achieved 2014 to 2015
1	Development of the central patient administration system, which will result in the provision of additional equality data linked to access and quality of service in relation to sexual orientation.
	Explored negative experience reported through national patient survey results in relation to Asian and blind/partially sighted patients and reported findings to relevant Clinical Service Units for action where necessary.
	Participated in the Stonewall Health Champions Programme and Stonewall Healthcare Equality Index in response to limited information on sexual orientation.
2	Improved uptake on mandatory equality and diversity staff training (96% as at January 15 from 83% as at January 14).
	Further analysis of outcomes from equality data collected and analysed on staff.
	Development of staff engagement strategy with equality-related actions for each priority.
	Provided regional leadership on participation in the West Yorkshire Transgender Pledge.
	Development of equality and diversity checklist for Clinical Service Units to readily and meaningfully consider equality as part of day-to-day practice.
3	Development of Patient, Carer and Public Involvement Framework to encourage and support inclusive and meaningful involvement activity.
	Partnership working with local public sector organisations in collectively engaging with the lesbian, gay, bisexual, Trans and Deaf community.
	Review of progress against NHS Equality Delivery System benchmarking tool.
	Review of profile of Foundation Trust Membership.
	Continued support and development of Deaf and Hard of Hearing and Blind and Partially Sighted Patient Advisory Groups.
4	Development of plan of action in improving access to key health information from the point of GP referral to the delivery of hospital services.
	Set up an internal Trans Policy Group that has to date developed a draft Trans equality policy.

Publishing of Equality Information

Leeds Teaching Hospitals NHS Trust publishes information in January each year to show how equality is placed at the heart of everything it does. This includes information on the extent at which the Trust makes sure everyone can access its services and experience the best possible clinical outcomes every time and all employees are supported, representative of the local community and led to deliver on equality.

The following key actions were identified from the information published and have been built into the Trust's actions on equality and diversity for 2015/16.

Key Headline Actions for 2015 to 2016	
All people can access the Trust's services and when received experience the best possible clinical outcomes every time.	Improve access to key health information from the point of GP referral to the delivery of hospital services and implement the requirements of the NHS Accessible Information Standard
	Launch the Trans Policy and develop and launch an Interpreting and Translation Policy
	Align engagement activity with cultural events throughout the calendar year
	Based on the key findings of an equality analysis of patient activity, seek verification, develop action and deliver improved patient outcomes where needed
	Launch and roll out of the Patient, Carer and Public Involvement Framework to ensure inclusive and meaningful involvement activity
	Develop the profile of our Foundation Trust Membership and volunteers
	Roll out equality and diversity checklist across all Clinical Service Units to readily and meaningfully consider equality as part of day-to-day practice
	Action the findings of participation in the Stonewall Healthcare Equality Index
All employees are supported, representative of the local community and led to deliver on equality.	Improve quality of equality profiling information to enable more effective analysis with a focus on reducing gaps
	Increase reporting of equalities data to Clinical Service Units and corporate teams as part of performance data sets
	Continue to prioritise employee engagement and test out the appetite for staff reference groups
	Further analysis of outcomes from the equality data on employees to identify any remedial action
	Continue staff training and awareness, including staff in management/leadership roles, to understand the importance of equality and diversity
	Complete baseline assessment and establish improvement targets and actions against the Race Equality Standard

Section 4

Quality Account 2014-15

Quality Account 2014/2015

4.1 Chief Executive's Statement from the Board

Introducing the Trust

The Leeds Teaching Hospitals NHS Trust is one of the largest and busiest NHS acute health providers in Europe, a regional and national centre for specialist treatment, a world renowned biomedical research facility, a leading clinical trials research unit, and also the local hospital for the Leeds community. This means we have access to some of the country's leading clinical expertise and the most advanced medical technology in the world. Each year around 10,000 babies are born in our hospitals; we see around 100,000 day cases, 125,000 inpatients, 200,000 patients attending A&E and 1,050,000 in our outpatient departments, across 7 hospital locations:

- Leeds General Infirmary
- St James's University Hospital
- Seacroft Hospital
- Wharfedale Hospital
- Chapel Allerton Hospital
- Leeds Children's Hospital
- Leeds Dental Institute

We have a £1 billion budget, providing local and specialist services for our immediate population of 780,000 and regional specialist care for up to 5.4 million people.

Our patients are at the heart of everything we do. We employ over 15,000 people who are committed to delivering high quality care to all our patients all of the time. We also have an international reputation for excellence in specialist care, research and medical training. We contribute to life in the Leeds region, not only by being one of the largest employers, but by supporting the health and well-being of the community and playing a leading role in research, education and innovation.

Development of the Quality Account

This is our fifth quality account which has been developed with our staff and stakeholders and partner organisations, including clinicians and senior managers, commissioners at NHS Leeds West CCG, and Healthwatch Leeds. It has been approved by the Trust Board.

Chief Executive's Statement on Quality

On behalf of the Trust Board and staff working at Leeds Teaching Hospitals NHS Trust, I am pleased to introduce you to our Quality Account for the year 2014/15.

We aim to provide care that is of the highest quality, and is safe and effective, offering the best experience for our patients. In 2014/15 we developed the Leeds way to delivering excellent high quality care, recognising that we need to have the very best staff working together towards the same goals to achieve this. We published our vision, which is to be the best for specialist and integrated care; this is underpinned by our core values, which will always be patient-centred, fair, collaborative, accountable and empowered. Our first goal is to be the best for patient safety, quality and experience. We will do this by involving patients in their treatment and using their feedback on services to drive quality improvement and become the safest healthcare organisation in the country.

This report focuses on the year 2014/15 (April 2014 to March 2015), describing our progress over the past 12 months against the quality improvements we set out to achieve and outlining our priorities for the year ahead. It is an open and honest account of the quality of services for which the Trust Board is accountable, and it is a true and fair reflection of our performance in 2014/15.

We have continued to make good progress in a number of areas, including falls prevention, pressure ulcer reduction, and care of the deteriorating patient. We have continued to reduce the rate of infections in our hospitals,

including MRSA and Clostridium Difficile. We have also met the emergency care standard in 2014/15, ensuring that 95% of our patients were seen and treated within 4 hours. This is an excellent achievement, especially given the many challenges we faced over the winter period, along with a number of other hospitals. This was down to the hard work and determination of our staff to ensure that our patients received safe care in our emergency departments. We know that earlier intervention means better outcomes, and improves the experience and level of satisfaction of those patients visiting our hospitals.

In 2014/15 we published our Quality Improvement Strategy that described our quality ambition up to 2017, focusing on harm free care, patient experience, avoidable mortality and integrated care with partners. We continued to work with the Yorkshire and Humber Improvement Academy to support the delivery of our strategy in conjunction with Salford Royal Hospitals Foundation Trust, nationally recognised experts in quality improvement. We also worked with our partners across the Leeds Health and Social Care Community and the Leeds Institute for Quality Healthcare (LIQH). This unique partnership aims to redesign clinical pathways across health and social care to improve the experience of patients, focusing in year 1 on patients with cardiovascular disease, chronic obstructive pulmonary disease (COPD) and fractured neck of femur. We will continue to deliver improvements in 2015/16, building on these existing programmes and adding new ones, including the care of people with dementia, cancer and diabetes.

We joined the national Sign up to Safety Campaign in August 2014, making our pledges to contribute to the ambition to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. We developed our Safety Improvement Plan, setting our quality goals for improvement, including falls and pressure ulcer prevention, improving the care of patients with sepsis and acute kidney injury, deteriorating patients, and in maternity. We were delighted to be notified in March 2015 that our bid for funding to support the delivery of our Safety Improvement Plan was successful. This will be used to make further improvements in the quality and safety of our maternity services to help us reduce the numbers of incidents resulting in harm, and claims.

I hope you enjoy reading about the progress we are continuing to make in improving the quality of care here at Leeds Teaching Hospitals. Our staff are fully committed to the provision of safe and effective care for all our patients and we look forward to making further improvements in 2015/16. Our plans and priorities are explained further in this report and our progress will continue to be overseen and supported by the Trust Board.

Signed

Julian Hartley, Chief Executive

Signed for, and on behalf of the Trust Board

Date: 30 June 2015

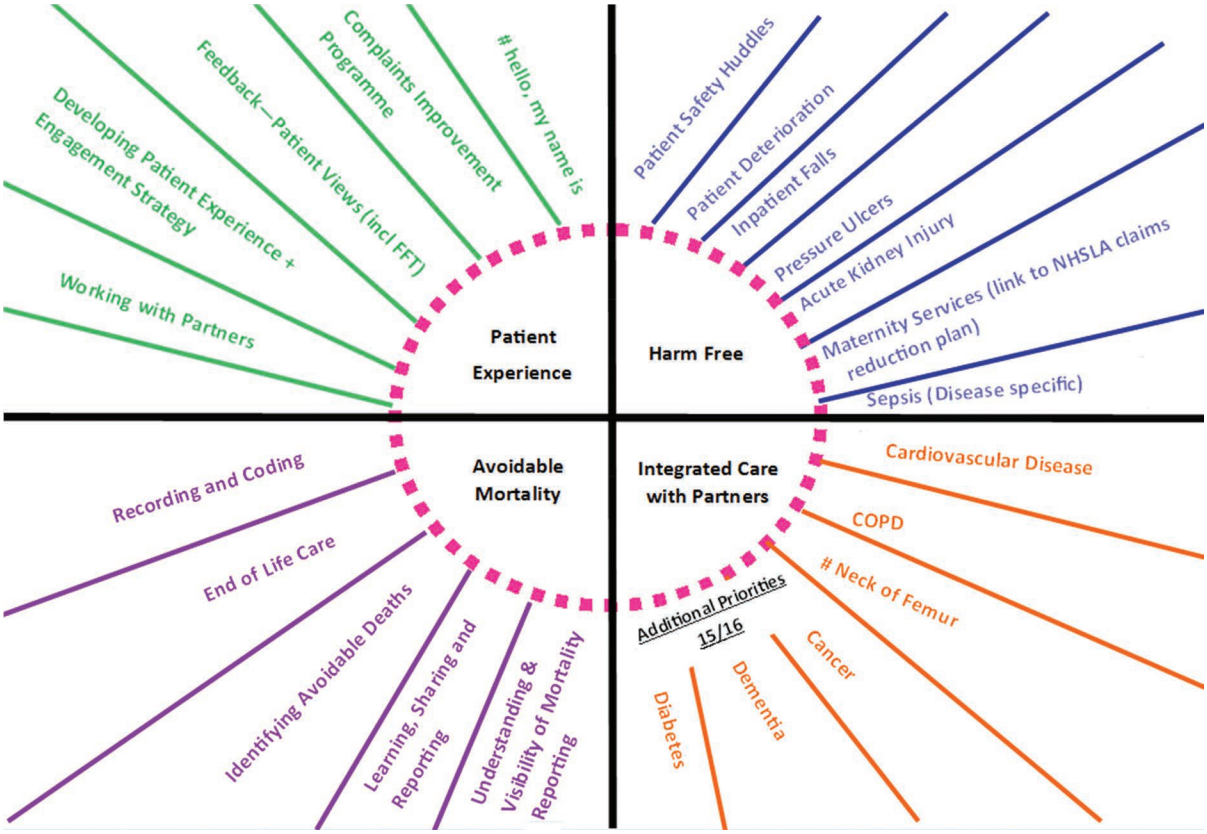
4.2 Improving our Quality of Service

Quality Improvement Programme

Following the Trust's Quality Ambition Workshop in October 2013, a Quality Improvement Strategy was developed and endorsed by the Trust Board in September 2014. This sets out a comprehensive programme of work over the next 2-3 years. The Strategy covers four domains:-

- **Harm Free Care** as set out in our Safety Improvement Plan (see section 4.8.3) and our priorities for 2015/16.
- **Integrated Care** - working with the Leeds Institute for Quality Healthcare developing fully integrated care by improving the management of patients with cardiovascular disease, chronic obstructive pulmonary disease, and fractured neck of femur (phase 1) (see section 4.8.1).
- **Mortality** - reducing avoidable mortality.
- **Patient Experience** - improving patient experience through responding to and learning from complaints, obtaining and learning from patient feedback, and supporting the *#hellomynameis* campaign.

LTHT Quality Improvement Programmes 2015/16



4.3 Our Priority Improvement Areas for 2015/16

We recognise that improving the quality of care for our patients is a continuous process and we aim to maintain our progress to improve in a wide range of areas. We have worked with our clinicians, managers and our local partners to agree the key topics to focus on in 2015/16. These are our priority quality goals and represent the areas where we believe we need to continue to make further improvements to ensure that the care we provide for patients is the safest and highest quality.

The following improvement priorities for the Trust have been identified for particular focus in 2015/16:

Patient Safety

- Reduction in the incidence of falls and harm sustained by patients following a fall
- Reduction in the number of hospital acquired pressure ulcers, and the incidence of category 3 and category 4 pressure ulcers
- Reduction in harm - maternity care

Clinical Effectiveness

- Improvement in the care of patients when their condition deteriorates on our wards
- Improvement in the care of patients with serious infection (sepsis)
- Improvement in the care of patients with acute kidney injury

Patient Experience

- Improvement in the way we handle complaints, and the quality and timeliness of our responses.

4.4 Priority Goals for Improvement

4.4.1 Patient Safety

Reduction in the incidence of falls and harm sustained by patients following a fall

We know that patients fall whilst they are in our care and a small number suffer harm as a consequence. This is the most common harm that is reported by NHS trusts. We identified this as a priority goal for improvement in 2014/15 and will continue to include this as a priority to help us make further improvements in 2015/16. We are determined to reduce the numbers of falls further in our hospitals, and also the number of falls where harm is caused to the patient.

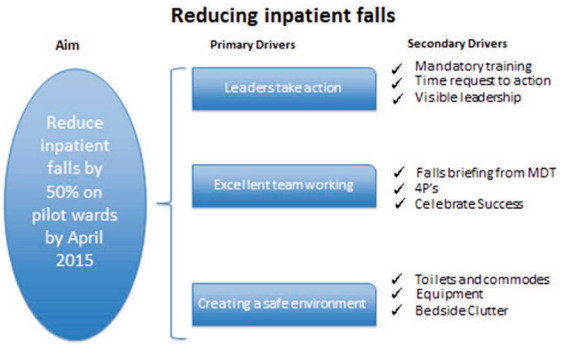
Progress in 2014/15

The Trust Falls Group has continued to lead the developments to reduce falls on our wards. This has involved introducing new care plans, risk assessments, staff training, falls prevention aids, and Root Cause Analysis investigations to help us understand the cause of falls, take action to prevent these, and to share learning.

Falls Improvement Programme

In July 2014, as part of our Quality Improvement Programme, we launched a collaborative programme for 15 wards from the Cardiology, Elderly Medicine, Orthopaedic, Renal and Stroke departments, supported by the Haelo group from Salford Royal Hospitals Foundation Trust (see www.haelo.org.uk for more information about Haelo). The aim of the collaborative was to reduce inpatient falls, as measured by the monthly patient safety thermometer data, by 50% by April 2015. The pilot wards have been testing specific interventions to reduce falls. All the interventions will be merged into a package of measures in June 2015 and embedded into the pilot wards by October 2015. These will then be implemented across all our wards from Autumn 2015.

Falls Driver diagram



Based on the work that has been done to date, the interventions that are most likely to be included in the change package are:

- Multidisciplinary falls safety briefings - for identifying and managing patients at high risk of falling including the use of cohorting high risk patients in the same bay on the ward.
- A structured approach to toileting - small scale tests are showing a large decrease in the number of falls on the wards where this has been tested.
- Good footwear - testing is taking place to see if ensuring patients have good footwear decreases the number of falls.
- Multidisciplinary review of a patient who falls - doing a 'mini review' of patients who have fallen to try to see if they can prevent that patient falling again.

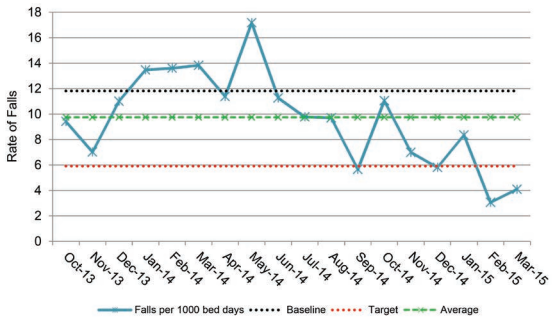
Throughout the year (2014/15) the wards have come together for Learning Days to share their learning and celebrate the success of the collaborative. Alongside the Falls Improvement Programme, in 2014-15 the Yorkshire & Humber Academic Health Science Network Improvement Academy has continued their support work on the Gledhow Wing Elderly Medicine wards and all the acute medical admission wards to reduce inpatient falls. This work is complementing the falls programme and focusing on safety briefings and toileting, to spread throughout these wards. In the first eleven months of 2014-15, compared to the same time period of the previous year, falls reduced by 37.5% (704 falls compared to 1127) on these nine wards. Five of the nine wards involved also reached 20 days in between falls which is a great achievement for wards with a very high number of patients who are at risk of falling.

Overall we have started to see a sustained change in the total number of falls (incidence) and the number of patients sustaining serious injury from falls across our hospitals. All members of the ward staff involved are very proud of the level of improvement seen.

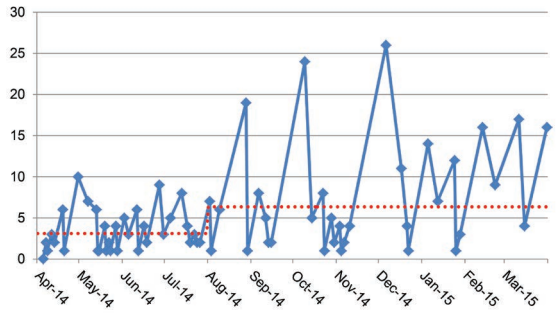
Ward J14 is one of 15 wards involved in the Falls Improvement Programme to reduce falls. The charts below are examples of how the improvement is measured. The graphs below illustrate the improvement in incidence of falls, and days between these falls, on Ward J14 since the start of the Quality Improvement Programme.

The average number of days between falls on the ward has increased from 3.1 days to 6.3 days since the start of the work, with the best run of days between falls increasing from 10 days to 26 days. This improvement is reflected in the incidence of falls, which has improved from 11.8 falls per 1,000 bed days to 6.9 falls per 1,000 bed days.

Ward J14 - Incidence of Falls per 1,000 days

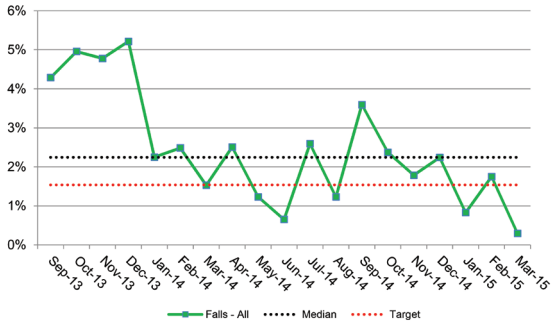


Ward J14 - Days between Falls

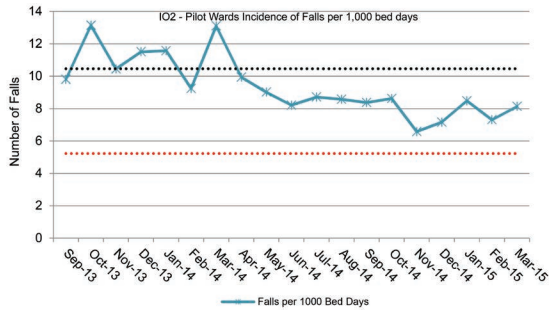


The graphs below demonstrate these reductions in prevalence relating to patients who have suffered a fall from September 2013. This is now below the national average, and we recognise we need to sustain this.

Percentage of Falls on Pilot Wards (Safety Thermometer)



Incidence of Falls per 1,000 bed days on Pilot Wards



Aim for 2015/16

The challenge for us in 2015/16 is to share the learning from this good work across the Trust to deliver the same improvements in all of our clinical areas. We know that the national average for all falls prevalence is 2% and 0.2% for falls with harm. We have made good progress with this and we know we need to do more.

We will continue to implement our programme of improvements relating to falls reduction in 2015/16. Our aim will be to continue to reduce the number of falls in our hospitals by 50% compared to our initial baseline in those wards selected for the pilot, and to sustain this improvement in future years. Additionally, CSUs have been asked to aim for a reduction of 20% in falls across all areas.

How will this be monitored?

The prevalence of falls (the number of falls at a given point in time) on all our wards will continue to be monitored through the monthly Safety Thermometer return. More detailed measurement and reporting is also used as a core element of the improvement programmes. Progress in relation to this quality goal will be reported through the Trust's Quality Improvement Sub-Group, which reports to the Quality Management Group and Quality Assurance Committee, a formal committee of the Board.

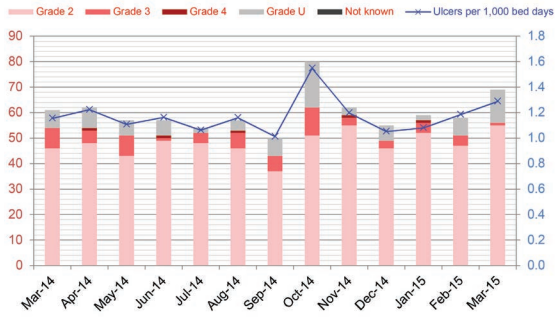
Reduction in the number of hospital acquired pressure ulcers and the incidence of category 3 and category 4 pressure ulcers

Pressure ulcers can occur in people who are unwell and immobile, and we know this is a cause of concern for our patients and their families. They are categorised from one to four according to the level of severity; they can result in patients suffering pain, discomfort and reduced mobility, and may increase their risk of acquiring complications such as infection and prolong their stay in hospital.

Progress in 2014/15

In 2014/15 we have been working with clinical teams to improve assessment and planning interventions to reduce the risk of pressure damage in patients identified as being at risk. We have done that through the introduction of PURPOSE T, a new tool that has been developed jointly with Leeds University and the Trust, and is now being rolled out across the country. This tool has improved the robustness of the initial assessment, facilitates earlier intervention, and has increased awareness and more accurate reporting. We anticipate it will start to positively reduce the number of patients developing pressure ulcers in our care. With the introduction of the new tool, we have seen a reduction in the number of more serious pressure ulcers being reported in our hospitals.

Incidence of developed pressure ulcers and rate per 1,000 bed days, by month



We have also been working closely with our colleagues across Leeds to reduce pressure damage in all settings, including the patient's home and care homes. We have a city wide action plan and have had a number of forums where teams have come together to discuss where the risks are and plan how to reduce them. We are planning a wider engagement event for staff, patients and families in the coming year.

Aim for 2015/16

In 2015/16 reduction of pressure damage will be one of our main Quality Improvement areas. We will work closely with clinical teams to ensure that the actions identified to reduce risk and incidence of pressure damage are tested and shared across the organisation. Our aim will be to achieve 95% harm free care relating to the number (prevalence) of new pressure ulcers developed in our hospitals by the end of 2015/16, measured by our safety thermometer return.

We are working with our senior nursing leads to agree a goal that we will work towards as a Trust, and are already aware that some of our CSUs have set themselves challenging ("stretch") targets based on last year's improvements.

How will this be monitored?

We will continue to monitor the prevalence of pressure ulcers through the monthly Safety Thermometer return. Progress in relation to this quality goal will be reported through the Trust's Safety and Outcomes Sub-Group, which reports to the Quality Management Group and Quality Assurance Committee, a formal committee of the Board. Progress reports will be provided to the Trust Board and commissioners at Leeds West CCG.

Reduction in harm - maternity care

We know that harm caused to a mother and baby in maternity services is a cause of significant concern. This is also the highest reporting area relating to legal claims, both locally and nationally. Our maternity team has developed an improvement plan which aims to reduce the risk of harm to mothers and babies. This is linked to our 'Sign up to Safety' Improvement Plan and the implementation of this will be supported by our successful bid for funding in 2015/16.

Aim for 2015/16

We will aim to reduce the incidence of harm at birth by 50% and loss of baby (death) by 50% by 31 March 2018; this will be achieved through staff training and support, improved screening, audit and public health interventions.

How will this be monitored?

Progress in relation to this quality goal will be reported through the Trust's Safety and Outcomes Sub-Group, which reports to the Quality Management Group and Quality Assurance Committee, a formal committee of the Board.

4.4.2 Clinical Effectiveness - Deteriorating Patient

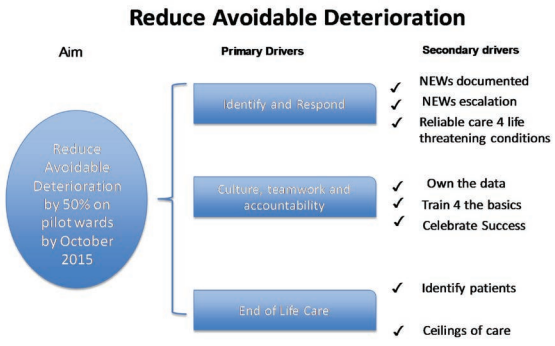
Improvement in the care of patients when their condition deteriorates on our wards

Last year we identified the need to improve the treatment and care of our patients when they deteriorate on our wards, to ensure they receive safe, timely and effective treatment and care. We know from our incident reports and investigations that we still need to improve in this area and will, therefore, continue to include this as a priority goal for improvement in 2015/16.

Progress in 2014/15

In August 2014, 15 wards from across the Trust (including medical, surgical and children's wards) began their improvement journey, forming a patient safety collaborative in partnership with Haelo. This has been supported by an internal Faculty, with membership including clinicians, leadership fellows, resuscitation officers, and outreach nurses. The aim of the approach is to improve early recognition of patient deterioration, achieved by focusing on three key areas: the identification and response to deterioration, culture and teamwork, and recognising and managing end of life.

Reducing Avoidable Deterioration Driver diagram



Where are we now?

The Faculty has been developing, growing and learning from experience, to build improvement capability from within and create an environment to support frontline teams. A lot of work has been required to get real time data on "2222 calls", and the nature of these. The teams continue to test interventions in their area, and share the learning across the collaborative wards to reduce avoidable deterioration (measured by a reduction in 2222 calls). Examples include: team debrief following a 2222 call, team safety huddle focused on patients at risk of deterioration each day, 1:1 training on wards for new starters, and prompts to consider escalation decisions on admission.

The ward teams are developing increased understanding of improvement, and these wards are supported and empowered to test changes, creating a culture of learning and improvement from the frontline. Current outcome data for the pilot wards are highlighted in the graphs below.

Figure 9: Number of calls to 2222 (pilot wards)

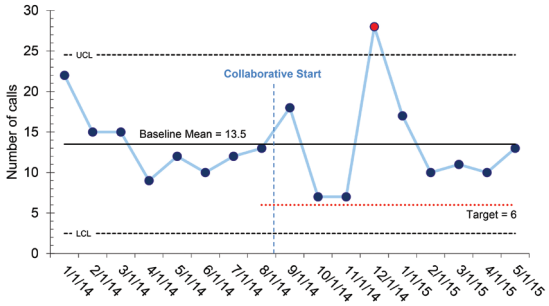
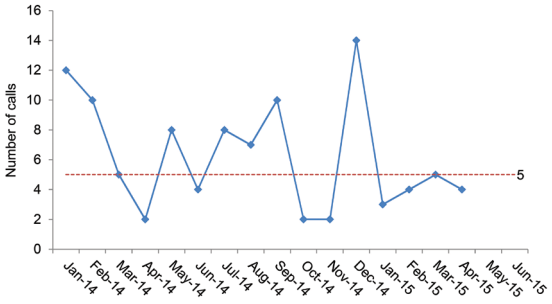


Figure 10: Number of 2222 calls for medical assistance (pilot wards)



These are showing promising results, with reductions below the mean in 2222 calls. Although not statistically significant yet, it appears the reduction in calls currently is driven by an improvement in calls being made for urgent medical assistance, with more effective prevention and recognition of early deterioration. It is a reflection of the work going on in the teams and shows the potential that can be achieved when successful interventions are scaled up across the collaborative from June 2015.

Aim for 2015/16

The deteriorating patient collaborative now has interventions ready to test at scale across all collaborative wards from June-October 2015. If successful these interventions will determine the "intervention bundle" for spread across all wards at LTHT. However, the testing at small scale will continue on the collaborative wards with more interventions ready for testing

over time, creating continuous learning and reflecting an ongoing improvement journey.

Our aim is to reduce avoidable deterioration on the inpatient wards that are included in our programme by 50% by October 2015, and to sustain this in future years.

How will this be monitored?

Progress in relation to this quality goal will be monitored and reported through our improvement programme, and reported through the Trust's Quality Improvement Sub-Group, which reports to the Quality Management Group and Quality Assurance Committee, a formal committee of the Board.

Improvement in the care of patients with sepsis

The care of patients with serious infection called 'sepsis' has been identified as a priority in the national quality scheme (CQUIN) for 2015/16. We know that this has an impact on harm and mortality, and we are committed to making improvements regarding this. The aim of the scheme is to develop and implement protocols for screening for sepsis within the emergency department, and in the medical admission and surgical admission wards where patients are directly admitted. The aim of this is to ensure that intravenous antibiotic treatment is initiated within 1 hour of presentation for those patients with suspected severe sepsis, red flag sepsis or septic shock.

Progress in 2014/15

Throughout 2014/2015 the Trust Sepsis Team has been busy raising sepsis awareness throughout the Trust. The Trust Sepsis guidance has been tailored to reflect the recently published evidence in 2014 from three international multicentre randomised control trials regarding care packages for patients with Sepsis. Central to this strategy is the BUFALO Sepsis tool. BUFALO is an acronym for the 6 key aspects of sepsis care, which involves taking blood cultures, and measuring urine output and a lactate level to help identify the cause and severity of sepsis whilst delivering oxygen, fluids and antibiotics to treat the underlying infection: this has been shown to improve outcomes for patients with sepsis.

Working alongside Yorkshire Ambulance Service, and with clinical toolkits provided by the UK Sepsis Trust, we have started to use the term Red Flag Sepsis to identify those patients most at risk of Severe Sepsis and Septic Shock through basic observations. This highlights those patients most at need of BUFALO screening and delivery of broad spectrum antibiotics, helping to improve antimicrobial prescribing practice, and prevent overuse of inappropriate antibiotics in those patients at the less severe end of the sepsis spectrum.

The Red Flag Sepsis Quality Improvement programme has been trialled in the Emergency Department and found to be effective: the next step is to spread this to other acute areas such as surgical and medical assessment areas. This work should ensure that patients with sepsis are screened and treated effectively and that operationally we are prepared for the national CQUIN in 2015/16. Work is being done with the Trust's coding teams to improve the accuracy of sepsis reporting across the Trust and recognise the volume of cases that the Trust manages each year. We will be adopting a structured approach including collaboration across the Multi-Disciplinary Team (MDT) linking in with other organisational work aligned with deteriorating patients and reducing overall mortality.

Aim for 2015/16

We will develop a plan to implement screening tools for sepsis within the emergency department, and in the medical admission and surgical admission wards, by the end of July 2015. Plans to collect the required clinical audit data to monitor the effectiveness and use of the screening protocols in the defined areas will be agreed by 31 October 2015.

How will this be monitored?

Progress reports will be provided to commissioners at Leeds West CCG at the end of Q2 (31 October 2015) and Q4 (30 April 2016). Progress in relation to this quality goal will be reported through the Trust's Safety and Outcomes Sub-Group, which reports to the Quality Management Group and Quality Assurance Committee, a formal committee of the Board.

Improvement in the care of patients with acute kidney injury

We know that the early detection of acute kidney injury (AKI) is important in reducing longer-term harm to patients and this has been identified as a priority in the national CQUIN scheme 2015/16. We have been working to make improvements in this area and implement the national guidance, led by our AKI group.

Aim for 2015/16

We will identify key clinical specialty areas in the Trust to focus on improvements in the early detection and treatment of acute kidney injury. We will develop and share plans to improve the detection and reporting of acute kidney injury diagnosis that includes medicines review, blood test monitoring, and acute kidney injury staging on discharge, by 31 July 2015. We will develop and share proposals on how we will audit the inclusion of these items within patient discharge summaries by 31 October 2015.

How will this be monitored?

Progress reports will be provided to commissioners at Leeds West CCG at the end of each quarter in 2015/16. Progress in relation to this quality goal will be reported through the Trust's Safety and Outcomes Sub-Group, which reports to the Quality Management Group and Quality Assurance Committee, a formal committee of the Board.

4.4.3 Patient Experience

Improvement in the way we handle complaints and the timeliness of our responses

In 2014/15 we continued to implement our complaints improvement plan, to improve how we handle and respond to complaints we receive, particularly regarding the timeliness of our responses and the language we use in some of our letters. Whilst we have made good progress we have not achieved our goal to improve our response time so that 80% of complaints are responded to within 40 days by the end of 2014/15.

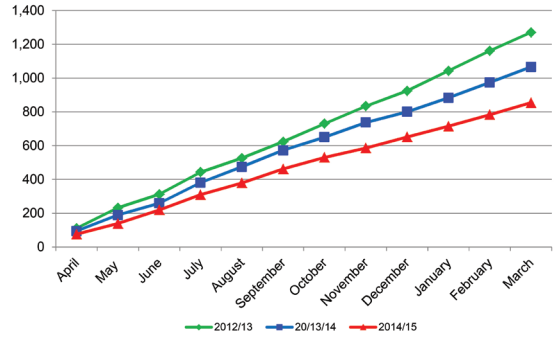
Progress in 2014/15

In 2014/15 we expanded and developed our Complaints Department introducing a new structure which has allowed us to make the following changes:

- All complainants are contacted by telephone as soon we receive their concerns so we ensure that we understand the person's experience, what they would like the outcome of their complaint to be, and explain what they can expect from the process from there onwards.
- A named member of the complaints team acts as the single point of contact for each complainant, to make it easier for them to know who they should talk to if they have any questions.
- Clinical teams are encouraged to meet with all complainants face to face to resolve concerns if they wish.
- Clinical records are made available more quickly for investigators, which improves the timeliness of responses.
- A simple electronic dashboard has been introduced which automatically provides our clinical teams with real time information about the complaints they receive and how well they are performing in addressing them quickly.

We have seen a reduction of 19.7% in the number of formal complaints received compared to last year.

Complaints received in 2014/15 compared to 2012/13 and 2013/14



Green 2012/13 Blue 2013/14 Red 2014/15

We said that in 2014/15 we would reduce the number of complaints that were re-opened within 6 months of the response being received by 50%. We reduced this by 42% this year. We also had 38% less re-opened complaints overall than last year, including those that may have been re-opened more than once. This means we are getting better at making sure we address the concerns people raise in a way that satisfies them, and reflects the success of the process we have put in place (quality check) for all complaint responses to be reviewed by a senior member of the team before they are reviewed and signed by the Chief Nurse or Chief Medical Officer.

We have also been using a new coding system for all the complaints we receive to give us better information about the type of concerns our patients, their carers and their relatives raise. This has helped us to better understand what areas we need to focus on most across the whole organisation, including communicating with patients' relatives and carers, and waiting times. Examples of improvements made to services as a result of complaints can be seen in section 4.11.4.

Aim for 2015/16

We will continue to make improvements to the experience of those who raise concerns. Our aim will be to improve our response time so that 60% of complaints are responded to within 40 working days by the end of Q3 2015/16, and 80% by the end of Q4 2015/16.

For complaints received in 2015/16, looking at all the complaints we receive in a year, we will aim to reduce the number of those that are re-opened within 6 months because we have not satisfactorily addressed concerns in our response from 24% to 15%.

How will this be monitored?

In 2015/16 we will continue to implement our complaints improvement plan. Monthly reports will be sent to CSUs and a 6 monthly report on progress to Trust Board will be provided. This will also be monitored at the monthly quality meeting with commissioners at Leeds West CCG. Progress in relation to this quality goal will be reported through the Trust's Patient Experience Sub-Group, which reports to the Quality Management Group and Quality Assurance Committee, a formal committee of the Board.

4.5. Progress against our Quality Goals 2014/15

Our three priority goals for 2014/15: Falls, Deteriorating Patient and Complaints, are part of our overall Quality Improvement Programme and span more than one year. Progress on each of these can be seen in section 4.4.

4.6 Statements of Assurance from the Trust Board

The Leeds Teaching Hospitals NHS Trust considers that the data within our Quality Account is accurate. Processes are in place within the organisation to monitor data quality and to train staff in collecting, inputting and validating data prior to reporting it internally or externally. An ongoing programme of improvement is in place led by the Information Quality Team and the Information Technology Training Team.

4.6.1 Review of Services

During 2014/15 the Leeds Teaching Hospitals NHS Trust provided NHS services across 90 specialist areas, known as "Treatment Functions", and/or sub-contracted NHS services to a core population of around 780,000, and provided specialist services for 5.3 million people.

The income generated by the NHS services reviewed in 2014/15 represents all of the total income generated from the provision of NHS services by the Leeds Teaching Hospitals NHS Trust for this period.

Leeds Teaching Hospitals NHS Trust has reviewed all of the data available to it on the quality of care in all of these NHS services. We have reviewed the quality of care across these services through the monthly Trust Board Quality and Performance Report (QPR) and internally through the performance review process. The Trust's quality governance meeting structure also routinely reviews quality and performance measures to gain assurance on quality improvements.

4.6.2 Participation in Clinical Audit

The Trust is committed to improving services and has a systematic clinical audit programme in place which takes account of both national and local priorities. The Trust programme is managed within Clinical Service Units, by the Clinical Director and Head of Nursing within each CSU, supported by the Clinical Audit Leads in each specialty.

The Department of Health recommended 42 specific national audits that all hospitals in England should contribute data to, if relevant to the services they provide. The Trust contributed data to 95% (38) of the recommended national clinical audits and 100% (2) of the confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust participated in are listed in Appendix D (pg 162), together with individual participation rates.

The Trust did not participate in the following Department of Health recommended national clinical audits for the reasons given in in the table below.

National Clinical Audit Title	Reason for Non Participation
National Cardiac Arrest Audit	The Trust has its own local cardiac arrest audit process and has put systems in place to participate in this audit in 2015/16. It was decided not to start participating mid 2014/15 as the value of the data would have been limited.
Ulnar Neuropathy at Elbow Audit	The Leeds neurophysiology service in 2014/15 was under significant service delivery pressures due to the staffing level of its Consultant Neurophysiologists and technicians. The Trust has invested in this service with new accommodation, new equipment and two new consultants. Neurophysiology technician posts are also planned. We will be able to participate in any future national neurophysiology audit.

The reports of 21 national clinical audits, and of 727 local clinical audits, were reviewed by the Trust in 2014/15. Examples of actions arising from this work that the Trust has implemented or intends to implement to further improve the quality of care are provided on the next page.

VTE Appropriate Thromboprophylaxis

The National Institute for Health and Care Excellence (NICE) provides guidance on appropriate VTE thromboprophylaxis for adult patients when in hospital. Audits of VTE thromboprophylaxis were included as part of the Trust's 2014/15 Annual Clinical Audit Programme: the aim was to assess if patients were being prescribed VTE prophylaxis, whether the dose was appropriate for their weight and renal function, and if patients' thromboprophylaxis was being reassessed. The results showed that the majority of patients were on appropriate prophylaxis. The audit highlighted that some doses needed to be amended for extremes of weight and when renal function changed, as well as the need to ensure patients are reassessed 24-48 hours after admission. To ensure patients receive the correct dose of the required medicine and are reassessed, electronic risk assessments and electronic prescribing are being introduced. The electronic systems will highlight that a patient needs to be reassessed, and incorporate prescribing protocols to ensure that dose changes occur rapidly if a patient's condition changes, and the appropriate dose of thromboprophylaxis is given to the patient for their weight and renal function.

Audit of Occupational Therapy for Osteoarthritis of the Thumb

The Occupational Therapy (OT) service provides care to patients with osteoarthritis at the base of the thumb across three areas; Hands & Plastics, Rheumatology, and the Direct Access GP Referral Service. NICE guidelines published in 2014 included recommendations applicable to the care of these patients, and this audit was carried out to ensure the recommended care was being provided. Results showed that the recommended care was being provided for the majority of patients. Occupational Therapists were good at gathering the relevant information from patients to influence treatment decisions, and also at assessing for and offering splints. The results also showed that improvements could be made in offering information to patients about their condition, discussing self-management techniques with patients, and offering regular reviews. To ensure patients are given relevant information, extra leaflets and resources have already been made available in relevant departments. A checklist has also been developed and is in use, as a prompt to ensure all elements of the recommended care are covered when patients are seen.

Delirium Audit

Delirium is a serious condition that can be prevented and treated if dealt with urgently. An audit was carried out in 2013 in Medicine for Older People with the aim of identifying if delirium was being diagnosed at the earliest opportunity, and whether the correct tests were being carried out to diagnose delirium. The previous audit noted room for improvement in recognising and diagnosing delirium, and a new clerking booklet was introduced in Medicine for Older People at the start of 2014 to prompt consideration of delirium. This re-audit was carried out to assess the effect of the new booklet. The mental testing of patients on admission had improved since the introduction of the booklet, as had completion of a history to determine patients' usual state, and hospital mental health review. Further improvements could still be made in all specialties, not just in Medicine for Older People. A Delirium guideline is presently being written to improve the recognition of delirious patients and standardise practice for their care, and the questions prompting consideration of delirium are being incorporated into a new Trust-wide clerking booklet that is currently being developed.

National Neonatal Audit Project

The results of the 2013 National Neonatal Audit Project (published in October 2014) showed the Trust was better than the national average on the following aspects of care: screening premature babies for an eye condition called retinopathy of prematurity, consulting with the parents of babies, and completeness of blood culture results. The audit results did not show the Trust as a negative outlier for any of the areas compared to national averages, although the Trust is specifically monitoring the areas of temperature control, and blood stream infections. Room temperatures can sometimes be low, and improving this will form part of a project being started in 2015/16. In order to reduce the number of blood stream infections, a central line team has been established, and a new care bundle introduced.

4.6.3 Participation in Clinical Research

We know that high quality clinical research and innovation improves outcomes for patients. Our vision, and the aim of our newly developed Research & Innovation (R&I) Strategy, is to be a global leader in clinical research and innovation which is translated into patient benefit at pace and scale. Our ambition is to deliver "research for all" by significantly increasing opportunities for Trust patients to take part in research studies.

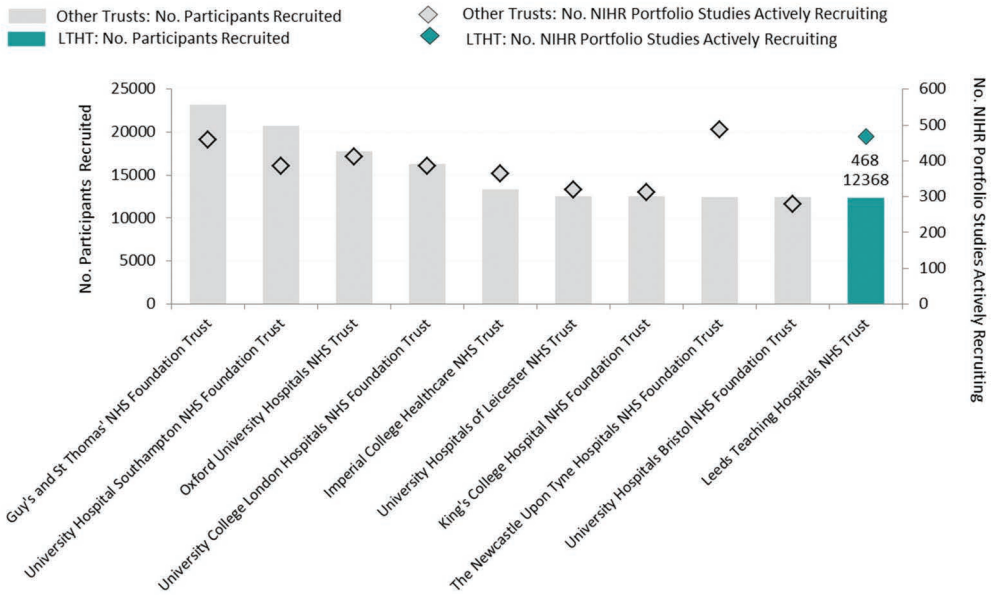
During 2014/15 we have continued to work hard to embed the management of research and innovation within normal Trust business with expert support for both managers and researchers from our central R&I Team. This year, for the first time, R&I became an integral part of the Trust's clinical service units' (CSU) business planning process. 2014/15 also saw the launch of a research information hub for CSUs which provides live research performance and activity information to operational departments.

NIHR Clinical Research Network

During 2014/15 the Trust remained in the "Top 10" performing trusts in England for projects recognised by the National Institute for Health Research (NIHR), playing a leading role in recruiting patients into high quality studies. This year we have involved 12,368 patients in 468 research studies as shown in the graph below.

The prestigious NIHR funding provides the infrastructure, support, and facilities needed for first class research which results in high quality care for patients and the public. The NIHR fund the following patient-centred research programmes in the Trust:

R&I Participation - Top 10 Trust Comparison, 2014/15



Biomedical Research Unit (BRU) in Musculoskeletal Disease

The NIHR BRU translates fundamental biomedical research into clinical research that benefits patients. Research at the Leeds BRU has led to new approaches for assessing and treating patients with rheumatoid arthritis. BRU researchers were the first to purify stem cells from bone marrow, using a technique that is now in wide use by industry. Engineering the next generation of artificial joints is a strong theme in the BRU.

Colorectal Therapies Healthcare Technology Co-operative (HTC)

The Leeds NIHR HTC is focused on developing solutions for patients who suffer from colorectal disease. During 2014, the HTC has developed a network of academic, NHS, industry, and patient partners looking for new ways to use new technology to reduce the need for invasive surgery, improve diagnoses and provide better treatments. An example of this is The Verdict Study which is funded by the University of Leeds and commercial partner Bedfont Scientific. The study involves capturing the exhaled air of a patient who has had a piece of bowel removed and testing it to see if their surgical wound has broken down and become infected.

Diagnostic Evidence Co-operative (DEC)

The DEC works with patients, industry and NHS commissioners to look at new technologies to diagnose diseases. The DEC in Leeds evaluates and provides evidence on diagnostic tests in musculoskeletal, renal and liver disease. The research will lead to improvements in healthcare services and the quality of life for patients by helping improve access to the most appropriate treatments more quickly and helping the NHS make the best use of its resources.

Clinical Research Facility (CRF) for Experimental Medicine

The NIHR Leeds CRF carries out clinical trials in experimental medicine, focusing on cancer, musculoskeletal disease and cardiovascular medicine. 2014 has seen the progression of plans for further investment and expansion of the CRF.

Collaborations for Leadership in Applied Health Research and Care (CLAHRC) - Yorkshire and Humber

Leeds is a partner in the new CLAHRC for Yorkshire and the Humber - a 5 year applied health research consortium. Leeds is actively involved in three of its nine themes, namely, avoidable admissions, evidence based transformation, and public health.

Medical Technologies

The Trust is the key clinical partner in the Welcome Trust/Engineering and Physical Sciences Research Council (EPSRC) Centre of Excellence in Medical Engineering, and the EPSRC Innovation and Knowledge Centre in Tissue Engineering and Regenerative Medicine. Both these programmes are developing novel diagnostics and therapies which address conditions of later life, including joint degeneration and cardiovascular disease.

Informatics

Information extracted from large clinical and health data sets will play a critical role in developing new treatments and monitoring the effectiveness of existing therapies. The Trust is a primary clinical partner in a major award (£7m) from the Medical Research Council to create an integrated medical information system, which will enable the Trust and University to play a leading role in this exciting area.

Cancer Research UK Leeds Centre (CRUK)

The CRUK Centres are one of the charity's highest strategic priorities. They drive local partnerships and high-calibre collaborations between universities and NHS Trusts under a united strategy to accelerate the translation of research into practice. Research at the Leeds Centre focuses on two interrelated themes; Viruses and Immunology, and Radiation Biology and Radiotherapy.

Commission for Quality and Innovation (CQUIN) - Indicator for Research

In 2014/15 the Trust agreed its first research target under the Commission for Quality and Innovation (CQUIN) scheme. This highlights that commissioners see research participation as essential to improving patient outcomes and are committed to supporting clinical research. The target agreed with commissioners was to increase the number of patients enrolled onto clinical trials within infection and microbiology by 10% or 100 patients. The target was met in 2014/15.

R&I in 2015/16

The new R&I Strategy will be formally launched in April 2015. This sets out our aim to create a centre of excellence for research and innovation in which the Trust develops and supports:

- Leading edge research and innovation
- Delivered by outstanding individuals
- Collaborating in world class facilities
- Focused on the needs of patients and the public
- Delivering economic benefit

Alongside the strategy we will publish a delivery plan detailing how our strategic aims will be realised.

4.6.4 Goals Agreed with Commissioners

The CQUIN (Commissioning for Quality and Innovation) scheme has continued in 2014/15 with the aim of encouraging Trusts to improve quality in priority areas. The Trust's CQUIN quality goals are agreed nationally, and also with commissioners at Leeds West CCG and the Specialist Commissioners. A proportion of the Trust's total contract income is allocated to the CQUIN scheme as an incentive to make improvements in quality; the value of the scheme remained at 2.5% of total contract income in 2014/15, which equated to approximately £17 million.

In 2014/15 the Trust was required to achieve 3 national goals, 7 local goals, and 6 goals set by the Specialist Commissioners. In addition to this the Trust was required to submit quality data relating to a range of specialist conditions set by the Specialist Commissioners. The Trust delivered all of its CQUIN targets for specialist commissioners in 2014/15 and the majority of its CQUIN targets for local commissioners.

Delivery of CQUINs 2013/14

	Indicator	Quarterly performance			
		Q1	Q2	Q3	Q4
National	Friends and Family Test				
	Dementia risk assessment and referral				
	Safety thermometer: falls, pressure ulcers, VTE, catheter-associated urinary tract infection				
Local	Reducing hospital acquired VTE				
	Improving the management of patients with asthma in the emergency department				
	Improvement in the timeliness of outpatient clinic letters				
	Improve health through addressing unhealthy lifestyle behaviours (Making Every Contact Count - smoking, alcohol, obesity)				
	Improving patient experience of discharge working with partner organisations				
	Reducing catheter-related blood stream infections (surveillance)				
	Best start - children with complex needs				
Specialist Commissioners	Preventing unplanned admissions to PICU				
	Hepatitis C - MDT reviews				
	Increasing the number of patients enrolling patients in clinical trials				
	Increase uptake in breast screening				
	Diabetic eye screening				
	Improving reporting in secondary care dental services				
	Provide data returns for quality dashboard				

Achieved	Partially achieved	Not achieved	Data not required

In addition to this a number of quality and efficiency improvements linked to the CQUIN scheme were agreed with commissioners, including implementing best practice in radiotherapy treatments, reducing the number of days patients stay in hospital in highly specialised areas, reduction in the cost of special treatment devices, and reducing the ratio of new and follow-up outpatients, to meet best practice.

The CQUIN scheme for 2015/16 includes new national quality goals for improvement relating to sepsis and acute kidney injury. Whilst the CQUIN scheme will not form a proportion of the contract value in 2015/16, we will continue to deliver the improvements identified, including the national priorities and schemes agreed with our local commissioners.

4.7 What Others Say About Leeds Teaching Hospitals NHS Trust

4.7.1 Care Quality Commission

The Leeds Teaching Hospitals NHS Trust was required to register with the Care Quality Commission (CQC) under Section 11 of The Health and Social Care Act 2008 from 1 April 2010. The Trust is compliant with the essential standards of quality and safety, and has no improvement conditions.

The Trust was required to be compliant with sixteen essential standards of quality and safety in 2014/15. These will be replaced by the new Fundamental Standards from 1 April 2015. To help Trusts monitor their performance against these standards the CQC developed an Intelligent Monitoring tool in October 2013 as part of the new inspection regime. This involves a range of indicators to help the CQC assess the level of risk to quality and safety in an organisation.

CQC Intelligent Monitoring Report

Following publication of the first CQC Intelligent Monitoring report, the Trust was placed in wave 2 of the new comprehensive inspection programme that was introduced in September 2013. This was because the risk assessment placed the Trust in Band 1 (higher level of risks identified) based on the specific indicators used for the period of time reviewed. The specific risks related to the incidence of *Clostridium difficile* infection, whistleblowing alerts, education concerns, incidence of Never Events, referral to treatment times, and outcomes from the staff survey. These risk areas have been subject to programmes of improvement and progress was reflected in the publication of the second Intelligent Monitoring report in March 2014, which placed the Trust in Band 4 (lower risk). The Trust was placed in Band 3 in the most recent report that was published in December 2014.

Inspection visits 2014/15

The CQC did not undertake any unannounced compliance inspection visits in 2014/15.

The CQC undertook a comprehensive inspection of the Trust in March 2014, at the end of the 2013/14 year; the report of the inspection was therefore not included in last year's Quality Account as the final report was not published until June 2014.

The inspection visit was preceded by a detailed programme within the Trust to prepare for the inspection, led by the Chief Nurse. This involved engaging with a wide range of staff groups at all levels of the organisation and the provision of information to the CQC inspection team to assist with their inspection. The inspection was extremely thorough, involving visits to a wide range of clinical areas across the Trust. The CQC returned to do an unannounced visit at the LGI and St James's Hospital locations on 30 March 2014 to complete their inspection, focusing on the care provided to patients out of hours during the weekend (Sunday).

The new inspection approach involved identifying the key questions to ask about the quality and safety of care, based on the things that matter to people. The CQC adopted 5 key questions to use for the inspection of all service areas:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

The new programme of inspection included the introduction of ratings at service level, hospital level, domain level (relating to the 5 key questions) and Trust level. These are on a 4-point scale:

CQC 4-point scale

The CQC identifies core services to be inspected and rated, involving the following 8 clinical areas and pathways, identified as priorities by the chief inspector of hospitals:

Outpatients	Critical Care
Paediatrics	A&E
Acute Medical Pathways	Acute Surgical Pathways
Maternity	End of Life Care

The Trust received the report of the findings from the inspection on 5 June 2014. The report was based on a combination of what the CQC found when they visited the Trust in March 2014, information from their Intelligent Monitoring system, and information provided to them from patients, the public and other organisations.

The judgements made by the CQC following their inspection relating to the five key questions for the Trust overall were:

CQC Five Key Questions

Overall rating for this Trust:	**Requires Improvement**
Are services at this Trust safe?	Requires improvement
Are services at this Trust effective?	Good
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Requires improvement
Are services at this Trust well-led?	Requires improvement

The Trust was given an overall rating of Requires Improvement. The summary quality report included an overview of the ratings for each of the locations at LGI, St James's Hospital, Wharfedale and Chapel Allerton Hospitals, together with a summary of the overall ratings. Detailed reports were also produced for each of the hospital locations and core services. A judgement was made for each core service, as follows:

CQC Ratings

Core Service	Rating
Medical Care	Requires improvement
A&E	Good
Maternity	Good
Children	Requires improvement
Surgery	Requires improvement
End of Life	Good
Critical Care	Requires improvement
Outpatients	Good

The summary quality report included narrative to support the judgements that were made for each of the key questions. It also included a list of recommendations about what the Trust must do to improve quality and safety of care, and a further list of recommendations about what it should do. These were considered against the specific regulations set out in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The reports from the CQC inspection were published on their website in July 2014 and can be found at the following link:
http://www.cqc.org.uk/provider/RR8

Quality Summit meeting 20 June 2014

The CQC inspection team arranged a Quality Summit meeting on 20 June 2014 attended by senior representatives from the Trust and partner organisations, including the Trust Development Authority (TDA), CCG, Healthwatch Leeds, Health and Social Care, and Local Authority.

At the meeting the CQC provided an overview of the inspection process and the methodology used, together with a summary of their findings and rationale for the judgements that they had made. The Trust's Chief Executive provided a response and feedback to the CQC regarding the Trust's experience of the inspection. The Trust considered that the report was fair and balanced overall, was an accurate reflection of where we were as an organisation, and that it would help in our development. The report also recognised the improvement work that had

been undertaken, including risk, complaints, ward healthcheck, staff engagement and communication.

The Trust produced a framework and response to the actions that the Trust must and should take to improve quality and safety. Partner organisations were given opportunity to consider the Trust's response and to offer ways in which they could provide support to enable these actions to be implemented. It was recognised that some of the actions would require some investment both in the medium and longer-term, particularly relating to staffing and equipment replacement.

Action Plan

An action plan was developed in response to the recommendations identified in the report which has been regularly reviewed and updated with management leads during 2014/15, and also discussed at regular meetings with the TDA. Subsequent reports on progress have been provided to the Quality Committee and Trust Board, and progress has been discussed with commissioners at NHS Leeds West CCG at the monthly quality meetings. The actions plans were also reviewed at Scrutiny Board for Health in September and December 2014.

The CQC identified 17 actions the Trust must take to improve quality and safety, 13 of which were mapped against specific Regulations set out in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These were described in the action plan under the following headings:

- Staffing
- Training
- Risk and Safety
- Governance
- Communication
- Human Resources
- Mental Health
- Equipment

It was acknowledged that the majority of the recommendations related to broad topics that were subject to improvement plans already in place and would take some time to fully embed across the organisation; some of these recommendations would also be subject to continuous monitoring for improvement, e.g. medical and nurse staffing, training, handover, appraisal and application of the Mental Health Act. It was agreed at the Quality Summit meeting in June 2014 that the Trust would identify immediate actions to ensure that the Trust was compliant with the essential standards of quality and safety for each of the Regulations identified in the report where the Trust must take action. These initial actions have been completed. It was agreed with commissioners and the TDA in December 2014 that the Trust would integrate these actions into existing programmes of work.

We have continued to monitor progress against the actions identified in the report during 2014/15 and we have welcomed the very detailed feedback received from the CQC inspection to help us make further improvements in the care we provide for our patients.

4.7.2 NHS Litigation Authority

The NHS Litigation Authority (NHSLA) was set up to help NHS trusts manage risk, reduce claims, and help finance the cost of claims against the NHS. The NHSLA set standards for safe care. These were created to assist trusts with improving the safety of clinical and non-clinical services, and thereby reduce the number of adverse incidents and claims. There were three levels of accreditation; Level 1 (initial - baseline), Level 2 (intermediate) and Level 3 (highest level).

The Trust was most recently assessed in November 2011 and retained its Level 1 accreditation under the NHS Litigation Authority (NHSLA) Risk Management Standards for Hospital Trusts (acute services). Level 1 was also achieved by maternity services in September 2012.

The risk management standards and process for accreditation have now been replaced by the NHSLA following a comprehensive review. In their place, the NHSLA has established a new Safety and Learning Service. This service has the same aims as the standards in that it will continue to support all trusts in improving patient and staff safety, and reducing harm. During 2014/15 there were three specific focus areas, namely: Maternity Services, Surgery, and Accident and Emergency care. Whilst these changes are introduced the Trust will retain its Level 1 accreditation.

The annual contribution for claims discount relating to the level of NHSLA accreditation will be replaced by a specific claims reduction plan, as part of a Safety Improvement Plan that is linked to the Sign up to Safety Campaign (see section 4.8.3).

4.7.3 Dr Foster Hospital Guide

The Trust has reported in its Quality Account for previous years the finding of the Dr Foster Hospital Guide. In 2014 Dr Foster did not produce a National Hospital Guide. Details of the Trust's recent mortality indicators can be seen in section 4.10.1.

4.7.4 Information Governance and Data Quality

Statement on relevance of Information Quality and actions to improve

The Trust ensures that it holds accurate, reliable, and complete information about the care and treatment provided to patients. Clear processes and procedures need to be in place to give assurance that information is of the highest quality. High quality information is important for the following reasons:

- It helps staff provide the best possible care and advice to patients based on accurate, up-to-date and comprehensive information
- It ensures efficient service delivery, performance management and the planning of future services
- It ensures the quality and effectiveness of clinical services are accurately reflected
- It ensures the Trust is fairly paid for the services we provide and care we deliver

Assessing the quality of data has been a significant part of the work of the Trust's Information Governance Team in the past year. The Trust has established a Clinical Information and Outcomes Group, which is a senior level forum, to review and co-ordinate issues impacting on the recording, accuracy and quality of clinical and corporate information recorded within Trust's information assets.

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2014/15.

The Trust is fully committed to ensuring that personal information is protected and used appropriately. It is constantly reviewing its existing processes to significantly reduce the likelihood of data loss.

NHS Number and General Medical Practice Code Validity

We continue to use the national data quality dashboard tool to support a review of the accuracy and quality of data submitted, and benchmark against the rest of the NHS. As with previous years, we submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are published nationally.

The percentage of records in the published SUS Data Quality Dashboard to January 2015 which included a valid NHS number was:

Percentage of records in the published SUS Data Quality Dashboard which included a valid NHS number

Type of care in the NHS	% of records	% above the national average
Admitted patient care	99.8%	0.6%
Outpatient care	99.8%	0.5%
Accident and emergency care	96%	0.8%

The percentage of records in the published SUS Data Quality Dashboard to January 2015, which included a valid General Medical Practice Code was:

Type of care in the NHS	% of records	% above the national average
Admitted patient	100%	0.1%
Outpatient	100%	0.1%
Accident and emergency	99.9%	0.7%

Clinical Coding

Ensuring that the clinical information recorded for our patients is complete, accurate and reflective of the care and treatment given, is important to the effective management of the quality and effectiveness of our clinical services and the recovery of income for the care we deliver. The Trust has a continuous programme of audit and training in place to ensure high standards of clinical coding are delivered. The programme involves audits by CSU to ensure a general overview of all areas.

The Trust participated in the national Payment by Results (PbR) clinical coding audit during May 2014, undertaken by the Audit Commission. These audits provide a summary of the accuracy of clinical coding across the NHS and help inform improvements in practice. The Audit involved Paediatrics and Rheumatology day cases. The Trust accuracy rates reported for primary and secondary diagnosis and treatment coding in the preliminary report are shown in the table below.

Trust accuracy rates reported for primary and secondary diagnosis and treatment coding

Areas of Clinical Coding	LTHT Rate
Accuracy of clinical coding	91.7
Primary diagnosis	91.2%
Secondary diagnosis	95.0%
Primary treatment	90.6%
Secondary treatment	61.5%
Coding accuracy that attributed to the correct Health Care Resource Group	93.9%

According to the Audit Commission, this places the Trust higher than average, but not in the top 25% of Trusts.

Recommendations from the May 2014 audit were:

- All errors found through the audit should be fed back to the coding staff and training provided to ensure they are aware of the common coder errors found. In response, verbal feedback was subsequently provided to relevant members of the Coding Team.
- Provide feedback to clinicians where discrepancies are identified and ensure diagnoses in the clinical record correspond with those on discharge letters and proformas. The coding team have;
  - Delivered presentations around the Trust to the clinical teams
  - Expanded ward based coding to enable closer links to the medical staff
  - Attended regular meetings with clinicians to review coding
  - Attended junior doctor induction days
  - Worked with areas to improve accuracy, documentation and information access.

The timeliness of accurately coded data is of particular importance to the Trust in terms of income recovery via the national Payment by Results (PbR) process. The clinical coding department has improved on the timeliness of the coded data during 2014/15 and has achieved the target of 100% completion at the final PbR submission date in every month through 2014/15. There has been steady progress in working towards 100% completion by the fifth working day, bringing the Trust in-line with the best peer performance.

Timeliness of Accurately Coded Data

	Apr-13	Jan-14	Jan-15
Month End	66.4%	76.2%	86.95%
5th Working Day (after Month End)	80.3%	89.3%	91.2%
Payment by Results Flex Date	86.4%	95.9%	100%
Payment by Results Freeze Date	99.9%	100.0%	100%

Information Governance (IG) Toolkit

The Information Governance (IG) toolkit is an annual self-assessment audit that the Trust is required to complete to ensure that the necessary safeguards are in place for managing patient and personal information.

A scoring system ranks a Trust from level 0 to 3, with 0 being the lowest score. Leeds Teaching Hospitals NHS Trust is required to achieve a minimum standard of level 2 against all 45 standards, which we achieved. Initiatives included within the measured areas include:

- Information Governance Management
- Confidentiality & Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance.

The IG toolkit is self-assessed by the organisation and in 2014/15 the Trust maintained its overall level 2 rating. This demonstrates to patients and service users that the Trust has robust controls in place to ensure the security of patient and staff information.

IG Toolkit Final Ratings

Assessment	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Grade
Version 12 (2014-2015)	0	0	25	20	45	81%	Satisfactory
Version 11 (2013-2014)	0	0	23	22	45	82%	Satisfactory
Version 10 (2012-2013)	0	0	33	12	45	74%	Satisfactory
Version 9 (2011-2012)	0	0	42	3	45	68%	Satisfactory
Version 8 (2010-2011)	0	0	45	0	45	66%	Satisfactory

4.8 Quality Improvement Programme

4.8.1 Integrated Care Improvement Programme

Over the last 18 months, the Trust has been actively involved in the Integrated Care Improvement Programme led by the Leeds Institute for Quality Healthcare (LIQH).

The programme promotes a cross-city approach to improving quality of care by:

- enabling clinicians to develop shared expertise, and
- developing a rigorous approach to professional accountability using data to review variation and decision-making.

This focus creates a culture of best quality clinical care at the best value, with patients, service users and carers as partners in decision-making, across Leeds.

The three clinical priorities for 2014/15 have been:

Cardiology (chest pain and arrhythmia), with the aim of:

- Improving the management of chest pain and reducing unwarranted attendance at the rapid chest pain clinic
- Optimise outcomes and quality of care for people requiring interventions/treatment for suspected/confirmed arrhythmia, and to prevent inappropriate use of secondary services
- Improving the physical and psychological health of patients post-MI, focusing on new or existing anxiety and/or depression.

Chronic Obstructive Pulmonary Disease (COPD), with the aim of:

- Supporting people with COPD to manage their own condition and to reduce the likelihood and impact of exacerbations
- Reducing variation of approach to COPD patients in crisis, with a view to understanding admissions per GP practice
- Improving the early and accurate diagnosis of COPD whilst improving patient experience.

Fractured Neck of Femur (NOF), with the aim of:

- Preventing the incidence of fractured neck of femur among people over 65.
- Understanding and reducing clinical variation on patients on the emergency NOF pathway, with a view to reducing deaths, reducing length of stay, and mobilising patients sooner after an operation.

These will continue into 2015/16 and three new programmes will also be started, looking at Cancer, Diabetes and Dementia.

The improvement model has been developed from that used successfully at Inter Mountain in the USA, where they have demonstrated that the improvements they have made to quality did actually save money too. It is based on clinicians working collaboratively in primary and secondary care, with third sector providers, underpinned by service user involvement at every level.

This LIQH programme is already bringing about system wide changes focusing on quality, with strong leadership and common goals. It is also presenting new opportunities for the third sector. This system wide engagement in choosing priorities, matched with a strategy of change, is unique, and the ambition, commitment and behavioural/attitudinal change is already starting to spread beyond the programme.

4.8.2 Scaling up Improvement:

Reducing harm and improving patient safety culture by integrating daily patient safety huddles on wards

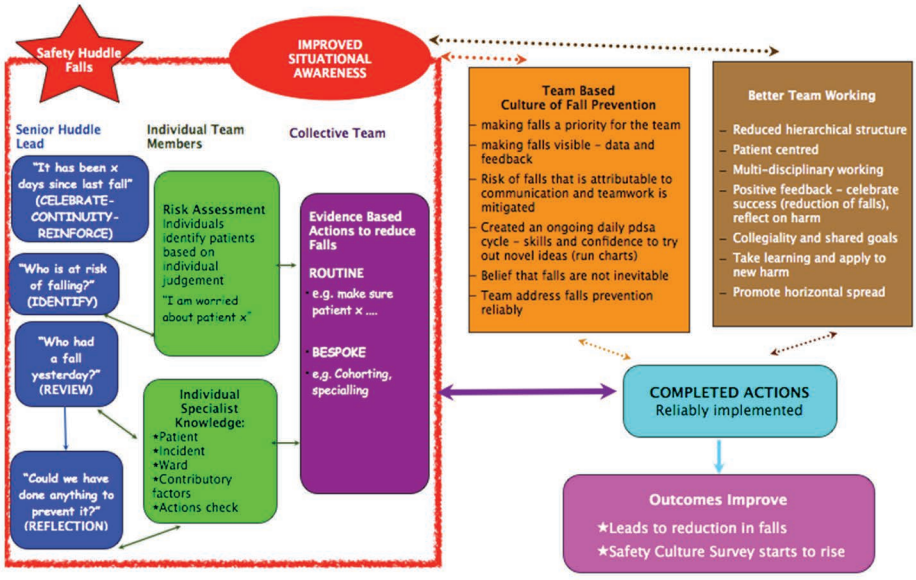
International studies consistently show ~10% of hospitalised patients experience harm. In the past, multiple initiatives have been designed to improve safety but few have demonstrated convincing evidence that patients are suffering less harm. We believe this is in part because the work has not consistently addressed safety culture and the behaviour of frontline clinical teams.

The Yorkshire and Humber Improvement Academy has been working with frontline teams at the Trust to develop and support interventions led by frontline staff to reduce harm and improve team safety culture. The results of using a patient safety 'huddle' as a tool to share learning and improvement by frontline teams have been impressive.

How huddles work in reality

Huddles involve all members of the ward based multidisciplinary team. The huddles, led by clinicians and locally adapted, take place daily as part of the ward routine. Team members develop confidence to speak up and jointly act on safety concerns.

Activities occurring as a result of the safety huddle



Given that wards are so busy, and often without consistent membership across the team, pilot work at the Trust suggests the richness of discussion within huddles can be conveyed to the next huddle in a number of ways; specific learning from the day before is captured in feedback and discussion, incidents are reviewed, success is celebrated and some teams may use visual methods to display information, tailored to their specific patient safety focus.

The figure below provides an outline of the types of activities occurring as a result of the safety huddle. This is the model for falls, however, it is anticipated that most harms could be substituted.

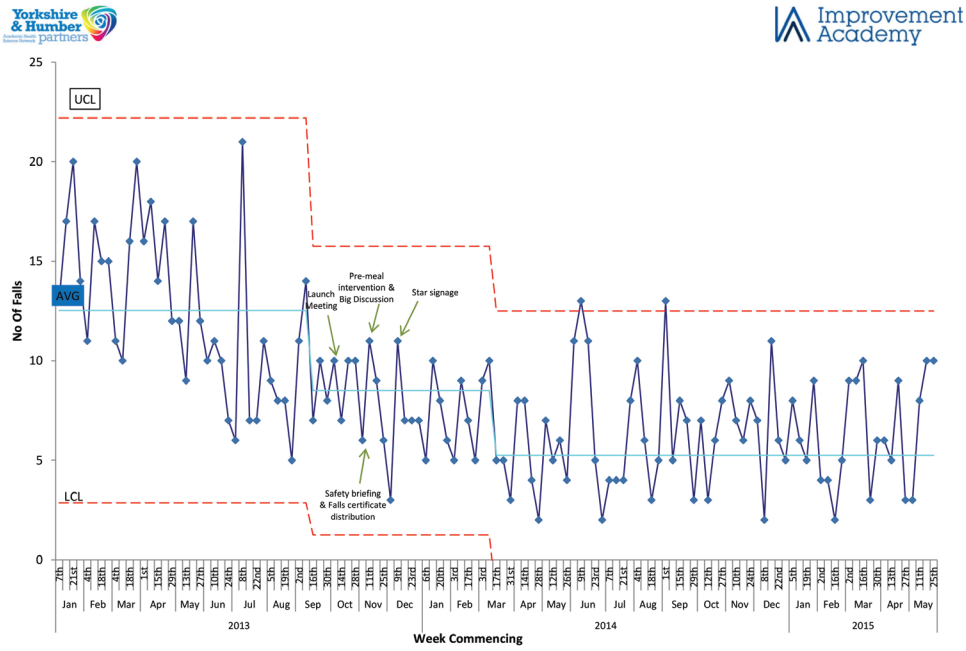
Impact

The work started in September 2014 on four wards at the Trust, but has now naturally spread to eight other wards, and learning from this in our hospitals has helped the introduction of huddles to five other Trusts in the Yorkshire and Humber region.

All wards are showing a reduction in falls. An example Statistical Process Chart is shown below.

In March 2015 ward J17 achieved 40 days without a fall; the work is delivering results even the staff did not truly believe was possible. Cultural surveys have also shown improvements in 23 of the 27 measures.

Number of Falls per week for wards J26, J27, J28, and J29



Next steps

In January 2015 the Trust was awarded a £500,000 grant from the Health Foundation to learn how to scale up safety huddles across the whole of the Trust (and 2 other hospitals in the region). Our approach will preserve the ward-level ownership throughout the implementation as this is one of the critical elements underpinning the success seen to date, understand barriers and enablers to implementing safety huddles in different ward environments, and we will also draw out the implications of this for the Trust in striving to become a high-reliability organisation. The scale up will begin on our wards in April 2015 and the project will last two and a half years. The work is contributing to the Trust's growing reputation nationally for delivering frontline safety improvement.

4.8.3 Sign up to Safety Campaign, and the Trust Safety Improvement Plan

During 2014/15 a new campaign was launched by the Secretary of State for Health called the Sign up to Safety Campaign. Sign up to Safety's 3 year objective is to reduce avoidable patient harm by 50% and save 6,000 lives across the NHS.

Those Trusts who signed up to the campaign were required to develop a Safety Improvement Plan (SIP) which sets out the actions each Trust will take to reduce patient harm and improve safety over the next three years.

The Trust signed up to the Campaign in August 2014 publishing our five pledges on our website, which can be found in this link:

http://lthweb/sites/patient-safety/safety/Sign_up_to_Safety_July_2014.pdf

Our pledges centred on putting safety first, continually learning, honesty, collaboration, and support.

The Trust's Safety Improvement Plan sets out the organisation's plans for the next 3-5 years in relation to quality and safety, and builds on existing quality improvement work as outlined in the Quality Improvement Strategy 2014-2017. Our Safety Improvement Plan has identified the quality and safety priorities to be implemented that will significantly reduce patient harm at the Trust. The themes were identified through a prioritisation process which involved reviewing safety measurement and monitoring data, including the Trust's claims profile. These are all identified as priority quality goals for improvement in 2015/16 and are described in the improvement priorities described in section 4.3.

Our Safety Improvement Plan was submitted to the NHSLA in December 2014.

Funding for Maternity

As part of their involvement in the campaign the NHS Litigation Authority, who indemnify trusts for clinical negligence and personal injury claims brought against them, has offered trusts the opportunity to bid for funding of Safety Improvement Plan (SIP's) that show how they will reduce the harm which results in claims.

The Leeds Teaching Hospitals NHS Trust bid for funding to support the Maternity aspect of the SIP in 2015/16. Maternity Services across the NHS have an established high risk profile and the Trust has one of the largest maternity units in the country, delivering a complex tertiary care service to a diverse population.

The three areas of focus within Maternity services in its bid for funding support were:

- Improving screening services to detect foetal abnormalities, including a bid for enhanced staff training, and increasing the number of ultrasound scanners.
- Reducing the number of pregnancy losses, including a bid for increasing capacity to provide additional parent education on smoking cessation, obesity, substance abuse, and a bid to enable the service to enhance cardiotocography (CTG) interpretation training even further.
- Reducing care delivery events (e.g. developmental delay, cerebral palsy), by improving training and education of staff in relation to monitoring fetal wellbeing in the period from the onset of labour to the end of the third stage of labour; provision of

enhanced neonatal life support training and roll out of CTG interpretation master class training for all core midwifery delivery suite staff and medical staff.

We were delighted to be notified in March 2015 that our bid for funding was successful.

4.9 Patient Safety

4.9.1 Nurse Staffing

We recognise that the availability of the right staff, in the right place, delivering the right care has a direct impact on the quality of care for our patients. Last year you heard of the work we had started to improve the staffing levels of registered nurses and healthcare support staff.

This year, a number of documents have been released nationally aimed at increasing public knowledge about safe nurse staffing. For our hospitals this involved developing posters to help patients and the public understand which uniform each nurse wears and the role they occupy. These are now in each ward area and are specific to adult, children's and maternity services.

In July 2014, the National Institute for Health and Care Excellence (NICE) released the first in a series of guidelines providing guidance on safe staffing for nursing. Safe Staffing Guideline 1 was focused on Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals.

The recommended approach to setting the Nursing Workforce by ward is the same as the Trust undertook in the comprehensive review of 2014/15. This has been reviewed every 6 months as planned, using the same evidence based tools.

Monitoring and reporting staffing levels

There are occasions where wards will not have the staff on duty required to meet the patients' needs, this is managed by the Senior Sisters in the first instance with a clearly defined escalation process that enables the swift movement of nursing staff across the Trust to provide mutual aid where it is required. The Director of Nursing (Operations) and Chief Nurse are involved in this escalation process and, where significant risks remain, they will agree the approach to be taken.

Recruitment: Registered Nurses

The team held open days throughout the year, attended 4 RCN recruitment events and the 3 day RCN Congress, and will be attending a similar number of these events in the year ahead.

The result of this activity has been 494 Band 5 Staff Nurses newly appointed to the Trust between 1 April 2014 - 31 March 2015. As part of pursuing a career we do have a number of leavers, with the average turnover at Band 5 being 200 – 250 per year.

Two new ventures took place this year:

- The recruitment of 9 nurses who are returning to practice following a break from their nursing career. This is being run in partnership with Bradford University who provide the theoretical component.
- In partnership with our temporary nurse staffing provider, NHS Professionals, the Trust saw the first 10 of 30 Italian nurses begin work within the Trust, with the other 20 expected in late June 2015.

The nursing and midwifery recruitment teams in 2014/15 have successfully recruited 124 students from the Leeds universities, who are due to graduate in September 2015. Also 153 nurses who are experienced and soon to graduate are being offered positions within the Trust due to the open days that have taken place. Beyond this the team are constantly looking for new and innovative ways to recruit nurses, and are using radio and social media advertising as adjuncts to the more traditional approaches.

Clinical Support Workers

The number of Clinical Support Worker apprenticeship places has been increased to 220 per year, with 10 intakes across the year, and prove very popular with ward teams.

In March 2015 Corporate Nursing held a Trust graduation ceremony for the most recent group of Assistant Practitioners that completed their training in September 2014.

Participants of the Trust graduation ceremony

The work undertaken last year to develop a clear, eye catching nursing 'career ladder' within the Trust, from Band 1 through to Band 5 and beyond, has come to fruition and is now available for all to see on the Trust's award winning career website.

Matching Staffing Levels to Patient Needs

For the first time in 2014 a tool to measure the acuity and dependency of patients in our Emergency Departments became available. This was used at 6 monthly intervals across the year and consistently demonstrated a need to improve our nurse staffing levels. This requirement has been supported by the Trust Board and will be achieved in the year ahead.

Ongoing Commitment to Investing in Nursing

The investment into nurse staffing secured by the Chief Nurse in January 2014 from the Trust Board sees an additional £5 million investment into nursing and midwifery staffing for 2015/16. The investment is being used to achieve the following:

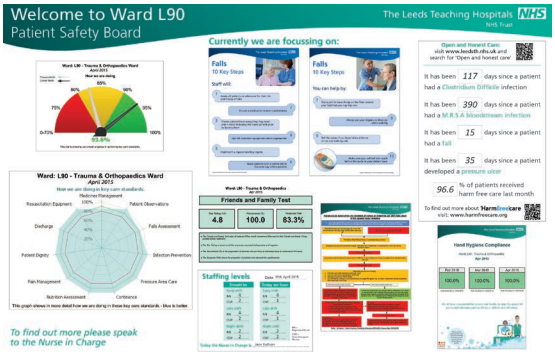
- To have inpatient wards staffed to levels recommended from the outcome of the Safer Nursing Care audit
- To have staffing levels in specialist areas that meet the recommendations of national guidance for Maternity Services, Paediatrics, Emergency Departments and Critical Care
- The provision of additional time for supervisory leadership for Sisters, Charge Nurses and Team Leaders.

4.9.2 Ward Healthcheck

The Ward Healthcheck was launched in January 2013 and has continued to be developed over the last year. The metrics programme and audits have now rolled out to all inpatient areas (94 areas), and emergency departments, and are currently being piloted in theatres. The programme collects information independently about the standards of assessment for each individual patient, where needs have been identified whether there are plans of care in place to reduce the risk, and if so whether they are they being evaluated to ensure they are working. We have modified the standards and their content to reflect changing practice and recommendations. Information from the metric audits is electronically fed into the Ward Healthcheck, which is a visual tool to inform ward teams how they are doing against a range of indicators focusing on patient outcomes, safe care and experience.

The information generated from the Ward Health Check audits are produced in a dial and spider diagram displayed on each ward on the Patient Safety Boards. Other key ward information displayed is the 10 Keys Steps (improvements the wards are working on), staffing levels, Open and Honest Care, Friends and Family results, and cleaning and infection prevention audits.

Patient Safety Board (Healthcheck)



4.9.3 Reducing rates of Healthcare Associated Infections (HCAI)

Our aim is to eliminate all avoidable hospital associated infections, such as those due to MRSA and Clostridium difficile (CDI). This has remained challenging in 2014/15, although we have continued to make good progress with ongoing reductions in the number of patients who developed infections whilst in our care.

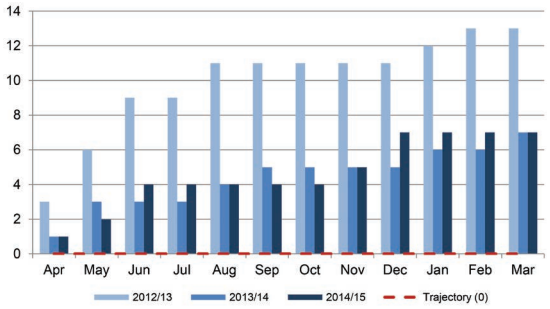
The key objectives achieved in 2014/15 included:

- Enhanced roles and responsibilities for Clinical Service IPC Groups and the way they interact with the Trust's over-arching Infection Prevention & Control Committee
- A shift from 'reactive' to 'proactive' IPC interventions
- Collaborative working with our commissioners about the review and understanding of CDI cases.
- Greater integration of the Lead Infection Control Doctor into Clinical Leadership meetings
- Improved IPC assurance mechanisms in relation to decontamination
- Introduction of new guidance to manage carbapenemase-producing organisms
- The introduction of a new CQUIN to reduce the incidence of intravascular catheter-related bloodstream infection
- Increased use of patient feedback about hand hygiene performance of our staff
- Increased provision of hand washing facilities at ward entrances
- Continued development / expansion of the hydrogen peroxide vaporisation programme
- Increased frequency of toilet cleaning in high risk areas
- Use of the Safety Thermometer to reduce catheter-associated urinary tract infections
- Improved IPC-related training for junior doctors.

MRSA

In 2014/15, 7 patients developed an MRSA bacteraemia whilst in our care, which disappointingly mirrored performance in 2013/14 and highlights the ongoing challenges in preventing health-care associated infections. Nationally each NHS Acute Trust continues to have a trajectory set at zero. The last MRSA bacteraemia occurred at the end of 2014, with no subsequent recorded MRSA bacteraemia prior to the end of March 2015. This shows that we can achieve our aim of zero avoidable MRSA bacteraemias.

Progress against the MRSA target (cumulative)

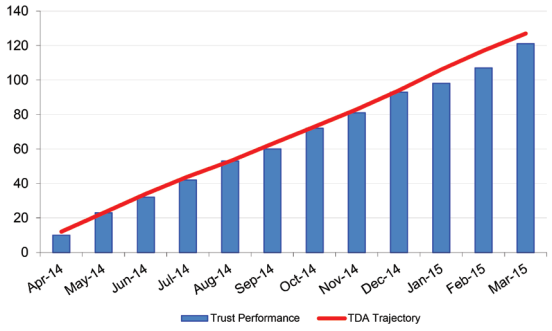


CDI

We have continued to reduce the number of patients who developed CDI in our hospitals. For 2014/5, there were 121 cases against the trajectory that we were set of 127, which means we delivered the target that was set and demonstrates the good progress that continues to be made. This total is a 16% reduction on the number of cases, 144, in 2013/14. Moreover, of these 121, at least 18 were agreed as "unavoidable", with no significant lapse in patient care by the Trust identified following detailed review of the individual circumstances in conjunction with our commissioners.

Some CSUs have achieved substantial reductions in the numbers of their patients suffering CDI, notably Children's services which went from 17 in 2013/14 to 1 in 2014/15, a 95% drop, and even that one case was adjudged unavoidable by our commissioners.

Number of CDI cases attributed to the Trust



Number of CDI cases attributed to the Trust

2014/15	CDI cases (Trust-apportioned)	TDA Trajectory	CDI Cases (cumulative)	TDA Trajectory (cumulative)
April 2014	10	12	10	12
May 2014	13	11	23	23
June 2014	9	11	32	34
July 2014	10	10	42	44
August 2014	11	9	53	53
September 2014	7	10	60	63
October 2014	12	10	72	73
November 2014	9	10	81	83
December 2014	12	11	93	94
January 2015	5	12	98	106
February 2015	9	11	107	117
March 2015	14	10	121	127

CDI Rate per 100,000 bed days (Patients 2+)

Reporting Period	Trust Performance	National Average	National Range
2013/14	25.6	14.7	0.0 to 37.1
2012/13	26.1	17.3	0.0 to 30.8
2011/12	28.6	22.2	0.0 to 58.2
2010/11	37.2	29.7	0.0 to 71.2

Objectives for 2014/15

In terms of infection prevention and control, we want to be one of the top performing health organisations in the country.

The targets we have set for 2015/16 are:

- Zero avoidable MRSA bacteraemia
- No more than 119 cases of CDI.

The Trust will take the following actions to improve on the reduction, and management, of HCAIs and the quality of care provided to patients;

- Change routine first line CDI treatment for high risk patients
- Optimise treatment pathways for CDI patients by centralising CDI care where clinically appropriate
- Implement a stratified Trustwide approach to MRSA screening, in line with the revised national guidance
- Evaluate the impact of targeted MSSA screening in high risk patient populations
- Enhance the preservation of blood vessel health Trustwide, to reduce the risk of infections associated with intra-vascular devices
- Enhance roles and responsibilities for Clinical Service Units to strengthen antimicrobial stewardship
- Focus on back to basics to provide assurance that standard precautions are routinely used to ensure IPC resilience for new emerging infections
- Implement the publicly available specification for the planning application and measurement of cleanliness
- Sustain delivery of the hydrogen peroxide vaporisation programme
- Strengthen the HCAI assurance process by developing an HCAI dashboard
- Implement the new national guidance on Antimicrobial Stewardship (NICE and Public Health England's Start Smart then Focus, Health Education England Framework for Education and Training on Antimicrobial Resistance).

4.9.4 Reducing harm from preventable venous thromboembolism (VTE)

We know that venous thromboembolism (VTE), or blood clots, can be linked to preventable deaths in the UK. Assessment of adult patients at admission for their risk of developing blood clots or their risk of bleeding helps us decide how best to care for each patient.

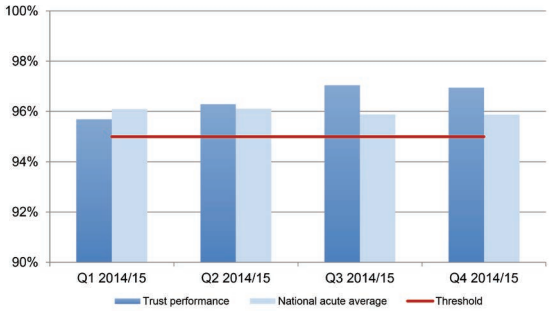
The Trust has continued to achieve the target of ensuring that 95% of adult patients are risk assessed for VTE within 24 hours of admission in 2014/15, consistently achieving this level of performance. The table below shows the percentage of patients who have had a VTE risk assessment in 2014/15.

Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)[1]

Reporting Period	Trust Performance	National Acute Average	National Acute Range
Q4 2014/15	96.95%	95.87%	79.23% - 100%
Q3 2014/15	97.05%	95.88%	81.19% - 100%
Q2 2014/15	96.29%	96.11%	86.37% - 100%
Q1 2014/15	95.69%	96.09%	87.25% - 100%

[1]Excludes independent sector providers

Percentage of admitted patients risk assessed for VTE



In December 2014 our new clinical nurse specialist in VTE prevention joined the team. She is working on improving all areas of VTE prophylaxis, especially with regard to mechanical methods such as anti-embolism stockings and foot pumps.

An audit of appropriate VTE prophylaxis (prevention) in 2014/15 showed that 87% of patients were on appropriate preventive treatment (thromboprophylaxis), which is calculated according to their weight and renal function. The main learning point was that all patients should be weighed on admission and the weight recorded on the prescription chart. Patients who are over 100kg should have a higher dose of thromboprophylaxis prescribed which is sometimes missed. Work is underway to improve this, and dosing guidance will be included in the eMeds electronic prescribing project to improve prescribing in this area.

We agreed a standard with our commissioners as part of the local CQUIN scheme for a Root Cause Analysis (RCA) to be undertaken when a patient develops a VTE during or within 90 days of their hospital admission. This was started in 2013/14 but we felt it was important to continue as we were still learning, and using this learning to prevent further events. The table below shows that the Trust is meeting the targets set for RCA completion in 2014/15. Our aim is to further increase the numbers of RCAs completed and ensure regular learning from these events is shared across the Trust.

VTE Incidence

		Q1	Q2	Q4
No. of Hospital Admissions	Contextual Metrics	55210	56238	55042
No.of VTE identified cases		122	142	164
No. of New HAT (Hospital Associated Thrombosis)		48	54	40
No. of HAT as % of Admissions		0.09%	0.10%	0.07%
No. of HAT as % of VTE identified cases		39.34%	38.03%	24.39%

	% RCA Target	Q1	Q2	Q4
No. of HAT requiring RCA (Root Cause Analyses)	Q2 ≥ 60% Q4 ≥ 80%	48	54	40
No. of RCA completed		15	33	33
% of RCA completed		31.25%	61.11%	82.50%
No. of HAT considered preventable		1	1	2

4.9.5 Preventing harm from misplaced nasogastric tubes

2014 saw further improvements within our hospitals to improve standards and safety for those who require nasogastric tubes for feeding (NGTs).

In December 2013 a new safety system was implemented, with all plain film radiographers being trained in x-ray assessment after NGT insertion. In the first 6 months of 2014 this system resulted in the removal of 84 misplaced NGTs within the radiology department, with a further 237 advised to be removed on the ward (after portable x-rays). 183 tubes needed to be corrected in the radiology department and a further 198 were advised to be corrected on the ward (portable x-rays). This system is having a great impact on the safety of patients requiring NGTs, with misplaced tubes being identified and removed efficiently to ensure we provide safe care to patients.

Key messages related to NGT safety were highlighted in a Quality and Safety Matters Briefing written by the NG Steering Group, and circulated to all staff members in August 2014.

In August 2014, the annual junior doctor (FY1) induction saw the training and competency assessment of all new starters. This programme ensures that all new junior doctors are aware of the Trust policy, and equipped with the knowledge and skills to care for a patient with a nasogastric tube, before they start on the wards.

4.9.6 Safeguarding vulnerable people

2014/15 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to safeguard our most vulnerable patients and develop a culture that puts safeguarding at the centre of care delivery.

The Trust Wide Safeguarding Adult and Children's Steering Groups formed in 2013/14 have become established with a clear work plan and focus providing challenge and assurance with regard to the safeguarding arrangements within the Trust.

The Trust has continued to increase its capacity to provide specialist safeguarding advice with an increase in the provision of named doctor resource for safeguarding children.

During 2014/15 the Trust has focused on those areas where we recognised that further improvement was needed.

- A focus on staff education and training has resulted in a significant improvement in the proportion of staff who have received safeguarding training with compliance

for Level 1 training, reaching 93% for safeguarding adults and 93.1% for safeguarding children training.

- To ensure that the views and experiences of service users are captured, revisions have been made to safeguarding referral processes and our complaints policy. In May 2014 the Trust introduced the Friends and Family test (FFT) for children and young people, and the Trust has established a youth forum.

In January 2015 the Trust presented its Annual Safeguarding Assurance Statement to the Leeds Clinical Commissioning Groups. This statement provides a comprehensive assessment and evidence of compliance against the required standards, with the Trust being fully compliant with the majority of the standards.

Trust senior managers are fully engaged and involved in the work of the Local Safeguarding Adults Board (LSAB) and Local Safeguarding Children's Board (LSCB). The Chair of the LSCB undertook an Annual Assurance Visit in January of 2015, providing positive feedback to the Trust Chief Executive on the Trust's commitment and the progress that has been made over the year.

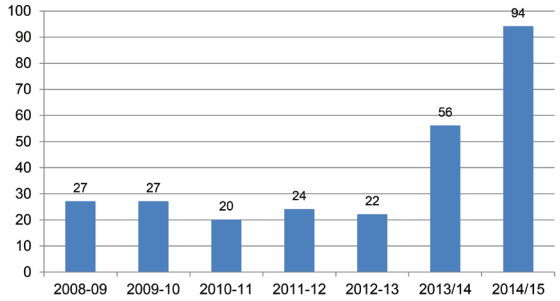
4.9.7 Serious Incidents

We are committed to identifying, reporting and investigating serious incidents, and ensuring that learning is shared across the organisation and actions are taken to reduce the risk of recurrence.

A weekly meeting is held with the Chief Medical Officer, Chief Nurse, and the senior team to review all potential serious incidents and complaints to ensure appropriate investigations are arranged and immediate actions have been taken to reduce the risk of recurrence. The Trust Board receives a report in public on new serious incidents and the actions taken to reduce the risk. A more detailed discussion on serious incidents, including the lessons learned, takes place at the Quality Committee, led by the Chief Medical Officer.

This year has seen an increase in the total number of serious incidents reported. This has been primarily due to the fact that from January 2014 we began reporting category 3 pressure ulcers as a Level 3 serious incident, in line with all hospitals across West Yorkshire, as part of the programme of improvement to reduce the incidence of harm from more severe pressure ulcers (in addition to category 4 pressure ulcers).

Number of serious incidents reported (by year)



In addition, from November 2014 we started to report all falls where the patient has suffered harm requiring surgical treatment for a fractured neck of femur, or head injury, as a serious incident. This is consistent with our improvement programme to reduce harm from falls in our hospitals. We have reported 7 incidents involving harm from a fall in the final quarter of 2014/15, and have reported 56 hospital acquired category 3 pressure ulcers in 2014/15. Both falls and category 3 pressure ulcers are subject to Root Cause Analysis investigation, led by the responsible specialty team, to support learning.

The Trust receives a 6 monthly report on patient safety incidents. The most recent summary that has been published is set out in the table below.

We have introduced a process where we undertake a detailed review of all incidents that are reported in the category serious harm or death with our clinical teams, to ensure these incidents are both reported and managed appropriately.

Patient safety Incidents (NRLS) April - September 2014

Indicator	Trust Performance	Average Acute Teaching Hospital Performance	Acute Teaching Hospital Range
Rate of patient safety incidents (per 100 admissions)	9.86	8.72	4.63 - 14.91
Percentage of patient safety incidents that resulted in severe harm or death	20	22.75	0-69
Number of patients safety incidents that resulted in severe harm or death	0.01%	0.357%	0 - 0.9%

Learning from incidents

In 2014/15 the Trust moved forward with a working group looking at ways to increase the effectiveness of learning lessons from serious incidents. The group has developed a multi-modal approach for sharing lessons from themes of serious incidents, with the same message being cascaded using different routes over one week, including a video (available on YouTube), a screensaver, newsletters and social media messages. The feedback we received from staff through a survey we conducted on sharing learning showed that all these tools appeared to be effective vehicles for the communication of safety messages to front-line staff; we will develop a protocol to reflect this.

The Trust has published fortnightly bulletins since December 2013, under the heading "Quality and Safety Matters". These have focused on a series of topics arising from serious incidents and complaints, to highlight the reasons why it is important that these things are managed appropriately and the actions that need to be taken to help reduce the risk. These have been sent to all wards and departments within the Trust to ensure that all staff are aware of these risks and what they need to do about them. The topics included in 2014/15 were as follows:

- Never Events
- Pressure Ulcers
- Falls
- Safeguarding
- Staffing
- Deteriorating Patients
- Patient Experience
- Whistleblowing
- Positive Identification of Patients
- Nutrition and Hydration
- Dementia
- Controlled Drugs
- Safe Transfusion
- Cardiopulmonary Resuscitation
- Safe Storage of Medicines
- Friends and Family Test
- Venous Thromboemolism
- Infusion Pumps
- Nasogastric Feeding Tubes
- Mental Capacity Act
- Duty of Candour
- Sepsis
- Patient
- Communication
- Inpatient Referrals
- Deprivation of Liberty Safeguards
- Incident Reporting
- Transfer and Handover of Care
- Safeguarding Patients
- Care of the Dying Patient
- Fluid Matters
- Point of Care Testing
- Nutrition and Hydration

Never Events

The National Patient Safety Agency (NPSA) published guidance on Never Events, which took effect from April 2009. Never Events are defined as:

"Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented."

The NPSA list of Never Events was expanded in 2011, from the original 8, following engagement with the NHS, patients and the public. During 2014/15 there were 25 Never Events in total on the list, although a shorter list will come into effect on 1 April 2015. The Never Events list provides an opportunity for commissioners, working in conjunction with Trusts, to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur. Nationally the most commonly reported Never Events relate to retained foreign objects after surgery, wrong site surgery, and wrong implant.

We have reported six Never Events during 2014/15 under the following categories:

- Wrong site surgery
- Retained surgical item

All of these Never Events were reviewed with the Trust's Chief Medical Officer and Chief Nurse, and also with our commissioners at Leeds West CCG. These have also been reviewed with the clinical teams to ensure immediate actions to reduce the risk of recurrence, and investigated in line with our serious incident procedure.

The Trust has reviewed an assurance framework looking at how the risks of all 25 Never Events have been addressed to ensure that we have the right controls in place to prevent these from happening. Actions are being taken, not only to address the gaps where these have been identified through investigations into Never Events within the Trust, but also to minimise the risk of those which have not occurred within the Trust. The Trust has been working on the themes from Never Events to identify and reduce all risk factors involved, including development work on the culture and human factors aspects. New guidance on accountable items in operating theatres has been published, and the Trust is confident that this, with the changes in behaviour now implemented, will significantly reduce the risk of retained surgical items.

Our theatre team has led on a programme of work to reduce Never Events in our operating theatres, focusing on the role of human factors that lead to this. They also hosted a regional event to share experience and learning from Never Events in March 2015. Our dermatology team has also improved their processes for identifying the correct site for skin biopsies.

Duty of Candour

The Duty of Candour Regulation was introduced in November 2014. Trusts are required to behave in an open and clear way in relation to care and treatment provided to patients. As soon as reasonably possible after becoming aware that a safety incident has occurred which has caused moderate harm or above to a patient, hospital staff must inform either the patient or their carer/family. There are certain requirements under the duty:

- The patient, carer or family must be told in person that a safety incident has happened and an apology given;
- The hospital must provide all the details of the incident as they are known at this time;
- The hospital must advise the patient/family/carer what further enquiries are going to be made and all of the above should be confirmed in writing;
- Subject to the patient's/family/carer's wishes, a written summary of the findings and actions must be sent at the conclusion of the enquiries along with a written apology;
- Throughout the process the hospital must ensure that the patient/family/carer is appropriately supported.

Before the legislation came into force, the Trust had already started implementing steps to ensure that we have systems in place to capture all patient safety incidents resulting in moderate harm or above and processes in place for notification and support for patients/families/carers. We have created a system which ensures we identify relevant patient safety incidents on a weekly basis and follow these up to make sure that the Duty of Candour has been followed on all occasions.

4.10 Clinical Effectiveness

4.10.1 Hospital mortality

There are two national trust-level mortality indicators:

- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the observed number of deaths following admission to the Trust and the expected number of deaths based on the England average, given the characteristics of the patients treated (risk adjusted). It is produced and published quarterly by the Health and Social Care Information Centre (HSCIC).
- The Hospital Standardised Mortality Ratio (HSMR) developed and published by Dr Foster, compares the number of observed deaths at the Trust with a modelled (risk adjusted) expected number.
- The HSMR differs from the SHMI in a number of respects, including:
  - The SHMI includes all deaths, while the HSMR includes a basket of 56 diagnoses (around 80% of deaths).
  - The SHMI includes post-discharge deaths (30 day), while the HSMR focuses on in-hospital deaths.
  - The HSMR is adjusted for more factors than the SHMI, most significantly palliative care, and social deprivation.

Both the SHMI and HSMR are used by the Care Quality Commission (CQC) in their Intelligent Monitoring tool publication (quarterly) and form part of the calculation for the Trust's overall banding. The CQC also use these measures, at a more detailed level and in conjunction with a more involved methodology, to raise mortality alerts with Trusts.

The SHMI the Trust HSMR rates have consistently fallen within the 'as expected' or 'lower than expected' band for the last 5 years.

The table below shows the Trust's latest published SHMI, for period July 2013 to June 2014 published by the HSCIC in February 2015: also shown is the HSMR for the same period. The Trust continues to fall within the 'as expected' banding for both measures, including the in-hospital only version of the SHMI.

LTHT SHMI & HSMR Jul-13 to Jun-14

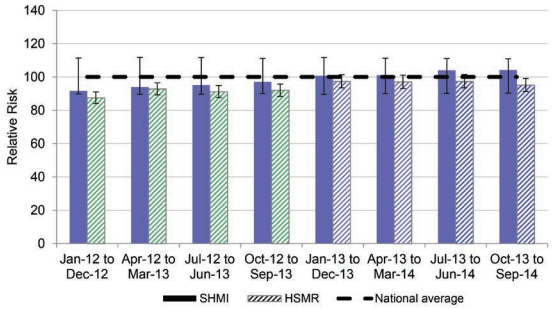
Trust level mortality, Oct 13 - Sept 14	Spells	Observed deaths	Expected deaths	Value	95% Confidence Interval
SHMI published banding (95% CL with over-dispersion)	123,299	3,810	3,661	104.06	90.23-110.83
HSMR	58,657	2,264	2,275	99.54	95.48-103.72

Higher than expected	As expected	Lower than expected

SHMI Indicator

Indicator	Reporting Period	Trust Performance	National Average	National Range
SHMI	Oct 13 to Sep 14	104.06	100	59.7-119.8
	Jul 13 to Jun 14	103.93	100	54.1-119.8
	Apr 13 to Mar 14	101.02	100	53.9-119.7
	Jan 13 to Dec 13	100.76	100	62.4-117.6
Percentage of deaths with palliative care coding	Oct 13 to Sep 14	23.2	25.3	0-49.4
	Jul 13 to Jun 14	22.8	24.6	0-49
	Apr 13 to Mar 14	21.7	23.6	0-48.5
	Jan 13 to Dec 13	17.5	22	1.32-46.86

Trust level SHMI and HSMR (basket of 56 diagnoses) by rolling 12 month period



Following the reporting of the SHMI score, a review was undertaken, including:

- Dr Foster were commissioned to undertake a detailed review of the SHMI data alongside the HSMR which has been reviewed by the Mortality Review Group.
- Early review identified a number of 'diagnostic' groups and in line with Trust (National) procedure, a coding and recording audit was carried out. The findings indicated that the clinical coding was broadly accurate, and the results are being used for further work.
- HSCIC has provided support and access to the detailed data underpinning the SHMI score to help us identify any further areas for review.
- The Trust Mortality Improvement Programme includes a rolling programme of training on the Improvement Academy mortality case note review tool.

Mortality Review Group and Mortality Improvement Programme

In June 2014, the Trust established a Mortality Review Group which reports directly to the Quality Committee. One of the Group's aims is to promote a better understanding of mortality across the Trust, and to seek to improve the Trust mortality rate to be in the top 20% of all NHS Trusts in England: it has active and wide spread clinical engagement. The Group is overseeing the work around mortality across the Trust, including refining and further embedding the mortality review process and overseeing the work of the mortality improvement programme.

The Trust's Mortality Improvement Programme was launched in autumn 2014 and meets monthly. It is a key part of the Trust's Quality Improvement Strategy, reporting into the Mortality Review Group. This is a multidisciplinary group with representatives from all CSUs:

The Programme's overall aim is to reduce avoidable deficiencies in care associated with patients who die by 50% by 2018, consistent with the aim of the 'Sign up to Safety' campaign. An important part of this will be the introduction of a new case note review process, informed by National best practice.

Weekend Care

Weekday and Weekend HSMR

The table below illustrates the HSMR and includes a split for Emergency HSMR by Weekday and Weekend. The HSMR is different between weekdays and weekends however is either within expected range or better than expected. These metrics are the CQC Intelligent Monitoring Metrics published in December 2014.

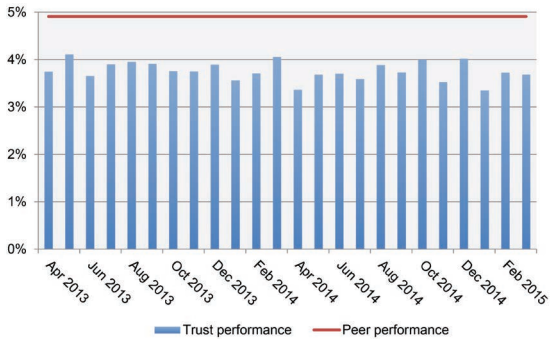
July 13 - June 14	Spells	Observed deaths	Expected deaths	Value	95% Confidence Interval
HSMR	56,565	2,292	2,285	100.31	96.25-104.50
HSMR Weekday	24,484	1,547	1,590	97.27	92.48-102.24
HSMR Weekend	8,050	546	519	105.11	96.48-114.31

4.10.2 Readmissions

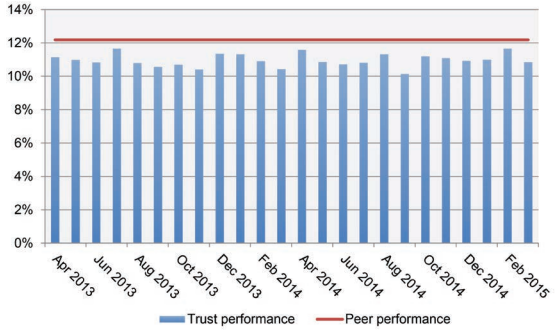
The Trust performs better than our peers with lower readmission rates following an elective or non-elective admission. Sometimes, after patients are discharged from hospital, they may need to be re-admitted again for a variety of reasons. Some readmissions are unavoidable, such as for patients returning following cancer treatment or for some cases the relevant care in the community may not be available. Nevertheless, it is important that hospitals closely monitor their readmission rates to ensure that these are as low as possible.

The graphs below show monthly readmission rates for patients who had originally been in hospital for planned care (elective) and those who had originally been in hospital as an emergency (non-elective). The average performance for our peer hospitals is also shown. It is clear that our rates are consistently lower than other teaching hospitals for both categories of patients.

Readmissions to the Trust within 30 days of discharge: elective spells



Readmissions to the Trustwithin 30 days of discharge: non-elective spells



4.10.3 Patient Reported Outcomes Measures (PROMs)

Patient Reported Outcome Measures (PROMs) aim to measure improvement in health following certain elective (planned) operations. This information is derived from questionnaires completed by patients before and after their operation. It is therefore important that patients participate in this process, so that we can learn whether interventions are successful.

Over the last two years we have worked hard to improve our participation rates, the results of which can be seen in the table opposite. (Note that the 2014/15 data is still provisional; the final signed-off data will not be available until Summer 2016.) At an overall level we have improved considerably since 2012/13 and have made significant progress in participation rates for varicose vein procedures. Work is currently underway in investigating performance for groin hernia.

Information relating to patients reporting improvements following these procedures was last published for the period April 2012 to March 2013. This showed that the Trust was above the national average in terms of patients reporting improvements following hip and knee replacement and hernia repair, but below average regarding improvement following varicose vein procedure.

Pre-operative participation rates

	2012/13 (signed off)		2013/14		2014/15 (provisional)	
	LTHT	National	LTHT	National	LTHT	National
Total	61%	74%	73%	75%	70%	72%
Groin hernia	45%	58%	61%	63%	44%	55%
Hip replacement	80%	83%	94%	83%	79%	83%
Knee replacement	89%	90%	95%	91%	88%	91%
Varicose vein	28%	44%	38%	39%	70%	38%

Source - HSCIC: 2013/14 & 2014/15 as at May 2015

4.10.4 Dementia

Improving the care and outcomes for patients with dementia

Dementia is a condition which affects approximately 800,000 people in the UK: one in three people aged over 65 will develop dementia, and as life expectancy increases, more and more people will be affected by this condition. In 2013 the Prime Minister set a challenge to increase the number of people with a firm diagnosis of dementia to two-thirds by the end of March 2015 as this is the essential first step to ensure that people with dementia and their carers receive better care and support. Leeds is well on its way to reaching this target, and by improving its assessment processes, Leeds Teaching Hospitals has played a significant part in helping the city in achieving this important target. The Trust is committed to improving the care of people with dementia. Over the past year it has continued to make significant improvements to the services it provides for this important client group and their carers.

Key Achievements in 2014/15

Improving the Identification of People with Dementia and other Memory Problems

The Department of Health introduced a Dementia CQUIN in April 2012 which required all hospitals to assess people aged 75 years and over, admitted acutely to hospital for the possibility of dementia.

Hospitals are required to achieve a compliance rate of 90% for all 3 stages of this initiative namely: identification, assessment and investigation, and when appropriate to consider referral to memory services for more detailed assessment. The Trust achieved this target in December 2012 and has continued to achieve it every month since then.

As a result of this assessment process 50 new patients (who were not previously known to have memory problems) are being identified each month. Once they are over their acute problem they are referred back to their GP for a further review in the community and to consider referral to a memory clinic if their memory remains poor.

The Trust is an active member of the Leeds Integrated Dementia Board and has been working with Commissioners and colleagues from Leeds and York Partnership Foundation Trust (LYPFT) to use the CQUIN data to help redesign the Memory Assessment Pathways in Leeds with the intention that this will help reduce the waiting time for people to be seen by memory clinics and ensure they get a more person-centred approach to their management.

Supporting Carers of People with Dementia

Two thirds of people with dementia live at home (not in residential homes) with much of their care delivered by unpaid carers, many of whom are under considerable strain and/or have health problems of their own. The Trust continues to seek the views of carers through

its carer surveys and has a carer representative on its Dementia Strategy Committee.

Some of the themes which continue to emerge are:

- Carers would welcome more flexibility with visiting hours and many want to be more involved with their loved one's care
- Carers feel more could be done to assess their needs as carers
- Carers feel they could be provided with more and better quality information about their loved one's problems and plans for the future, including better co-ordination of discharge arrangements.

Appointment of Support Worker for Carers

Recognising that we could do more to support carers, in conjunction with Carers Leeds (a Third Sector agency in Leeds), we appointed a Carer Support Worker (CSW) in 2013. This appointment has been an extremely successful initiative and has been very well received by carers. Feedback has been so positive that Commissioners have agreed to the appointment of a second CSW, based at the Leeds General Infirmary, to enable an even more timely and effective service to be provided.

There have been a number of other initiatives to support carers in the Trust, including coffee mornings and get-togethers on ward J14 at St James's Hospital and some of the Trauma and Orthopaedic wards at the LGI.

Staff Who Are Skilled to Deliver Care

In 2014, to coincide with 'Dementia Awareness week', the Trust launched a 'Delirium and Dementia' section of its Intranet site as an educational resource for staff.

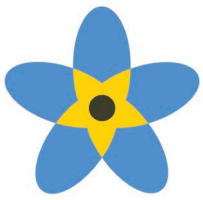
The Dementia CQUIN was extended in April 2013 to include Education and Training of staff in dementia and the Trust has established 3 levels of dementia training which are commensurate with Health Education England's (HEE) recommendations. Key trainers have been identified and priority for training is given to staff in areas where patient contact is high. By the end of December 2014, 3290 members of Trust staff had received training in dementia to at least Level 1. The Trust also actively participates in Yorkshire and Humber's HEE regional steering committee on education and training in dementia.

Improving Person-Centred Care

The 'Know Who I Am' document, introduced in 2013, enables carers to provide better background information on the person with dementia. It is now being used for patients with dementia throughout the Trust, facilitating staff to provide better person-centred care.

In 2014 we introduced the Forget-Me-Not scheme to raise staff awareness that a person has dementia and that they should therefore modify their approach accordingly. This scheme was initially introduced on the Medicine for the Older People wards and some of the Trauma and Related Services wards. The results of this early implementation scheme were very encouraging and it is being further evaluated with the intention of being rolled out onto other wards within LTHT.

Staff who wear the 'Forget-Me-Not' badge have had extra training to support people with memory difficulties



Leeds has a large population of people from Black, Asian and other Minority Ethnic (BAME) groups. The Trust recognises the importance of providing services which are tailored better to meet the needs of people with dementia from these communities. Trust representatives have had a number of meetings with local Third Sector agencies catering for BAME groups, such as Touchstone, and the Trust also actively contributed and participated in the BAME Dementia conference held in Leeds Civic Hall in November 2014.

Creating Environments which are more Dementia Friendly

There is good evidence that making the hospital environment more 'dementia friendly' improves patient care and patient and carer satisfaction.

Last year one of our key actions was to make ward J14 at St James's Hospital more 'dementia friendly'. Since then this ward has been given a 'makeover' with improved signage, paintwork and pictures. The WRVS has also organised a number of recreational activities and events for patients on this ward which have proved popular.

The Trust has introduced 'dementia friendly' (DF) crockery, which we found improves patient nutrition as patients with dementia wasted less food. Blue plastic DF crockery is available for all wards for patients who would benefit from it

'Dementia friendly' crockery

Also, menus in a photographic format (to enable people with dementia to recognise meals better) have been introduced on Medicine for the Elderly wards and can be downloaded from the Trust Intranet for other wards who want to use them.

Photographic menus to help people with dementia to recognise meals better

In 2015/16 we will do the following:

1. Work with other key stakeholders in the city to improve Memory Assessment Services and ensure more people in Leeds get a timely diagnosis of dementia, and that they and their carers get better care and support
2. Further improve person-centred care by: ensuring 'Know Who I am' continues to be promoted and routinely used throughout our hospitals, rolling out the Forget-Me-Not scheme to other wards in the Trust, and ensuring greater awareness of dementia friendly crockery and picture menus
3. Continue to increase the number of Trust staff trained in dementia
4. In conjunction with Carers Leeds, appoint the second Carer Support Worker.

4.10.5 Medicines Management

Helping patients get the most out of their medicines was the focus of our medicines management work during 2014/15.

A guideline to help all hospitals achieve this goal was published in early 2015 by the National Institute for Health and Care Excellence (NICE), and they called this "Medicines Optimisation". We will be working during the coming year to see what more we can do to optimise the use of medicines at Leeds Teaching Hospitals.

We increased the range of information about medicines used in Leeds that is contained in our on-line Leeds formulary (www.leedsformulary.nhs.uk) to make it easier for hospital doctors, GPs, pharmacists and nurses, as well as members of the public, to find information about our use of medicines. We hope this helps people caring for patients, and patients themselves, to get answers about medicines quickly and efficiently and help everyone get the best from their treatment with medicines.

Our hospital pharmacy teams introduced a new tool called MaPPs (Medicines: A patient profile summary) that is now being used by doctors, nurses and pharmacists to give patients, who would like it, individualized written information about their medicines.

In 2014/15 the pharmacy teams with the help of all the hospital staff, developed and promoted a city wide campaign, 'Your Medicines, Your Health'. We wanted to encourage more patients to bring their own medicines into hospital with them as we thought that this would help us all reduce any waste with medicines. We also hoped that this would reduce duplication and potential confusion for patients and help all the healthcare services in Leeds make better use of our medicines' resources. The work involves many partners (everyone in the hospital and the ambulance services, community matrons, social services, community pharmacies, patient support groups and GPs), all working together. The feedback we have had suggests that the 'Your medicines, Your Health' campaign has made it simpler for patients to understand their medicines and has also helped staff in the hospital prepare patients' discharge medicines sooner during their hospital stay.

There is a website that supports the campaign and it can be found at:

www.bringyourmedicinesleeds.nhs.uk

Our Medicines Information helpline (0113 206 4376) continues to provide a telephone point of contact for patients or relatives and carers to speak directly to a member of the pharmacy team to ask for advice or information about their medicines. The helpline received 791 telephone calls from patients last year. In 2015 a patient satisfaction survey will be undertaken and the helpline will be reviewed in light of the results.

Improving services with medicines for Hospital Outpatients

The pharmacy team recognised that a new model of working was required to enable access to experts in medicines optimisation seven days a week. In February 2015 we began our partnership with Boots Alliance and opened a pharmacy at Leeds General Infirmary with a further two pharmacies opening on the St. James's site in 2015. This new service will greatly increase access to medicines for patients attending our clinics and urgent care services. It will also allow patients access to a pharmacist who can help with choices in medicines and respond to patients' symptoms with a selection of medicines being available to buy.

In 2015/16 we will be working with Boots to have Dementia Friendly pharmacies and to support the Trust's Public Health agenda on smoking cessation. Boots are also working with the Trust to offer some patients the opportunity to pick up their medicines from a local Boots store rather than wait in the hospital.

Electronic Discharge and Prescribing

Our electronic discharge information system, called the eDAN, continues to be used throughout our hospitals to provide clear information to GPs about changes made to patients' medicines whilst they have been in hospital. By the end of 2014/15 over 80% of patients had their information transferred to their GP within 24 hours of their discharge from hospital. We will continue to work improving this percentage and to provide copies of this information for patients.

During 2015/16, we are planning to start the implementation of an electronic system to support the prescribing and administration of medicines across our hospitals. The benefits of an electronic system are that prescribing mistakes are reduced and medicines doses are less likely to be missed as doses due to be taken are easily identifiable.

Self-administration of medication

Self-administration of medicines schemes allow patients to continue to take their own medicines while in hospital. It moves patients towards greater independence in making decisions about management of their condition thereby promoting empowerment and better patient experience. This maintains patients' independence and routines, and enables health professionals to offer advice and support in medicine taking.

In some areas, such as in wards with acutely ill patients, factors such as short length of stay and patient dependencies mean opportunities for assessing patients to self-medicate are limited. As a result, patients who could benefit from this may be overlooked. Our aim is to make sure that all appropriate patients are recruited to the self-administration scheme, where this is judged clinically safe.

Patients will be informed about the scheme, and clinical staff encouraged to use the new prescription booklet and procedure to promote self-administration of medicines.

4.11 Patient Experience

4.11.1 Friends and Family Test (FFT)

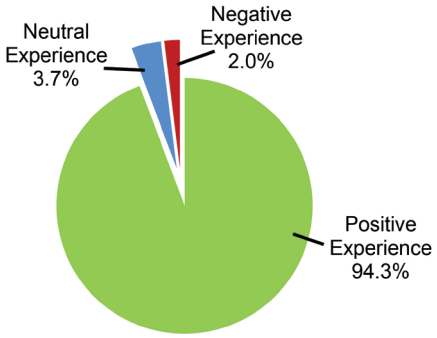
The Friends and Family Test (FFT) is a national initiative to help us understand what our patients feel about their experience in our Trust. In September 2014 we completed the roll out of the test to all our services. All adults and children now have the opportunity at discharge, to give us some feedback about their care, and to rate their overall experience.

Since we started the test in April 2013 we have received over 115,000 responses and comments from patients using FFT cards, text messaging, interactive voice messaging, electronic tablets, and also online. The percentage of respondents recording a positive experience of care is 94.3%.

Inpatient Friends and Family Test Results

July 13 - June 14	2013/14	2014/15
% who would recommend the Trust to friends and family if they needed similar care or treatment	91.6%	92.3%
% Who would not recommend the Trust to friends and family if they needed similar care or treatment	1.1%	1.2%
% Who responded "Neither likely or unlikely" or "Don't know" when asked if they would recommend the Trust to friends and family if they needed similar care or treatment	7.3%	6.5%

Patient Evaluation of their Experience of Care (2014/15)



Over the year we have worked hard to encourage as many patients as possible to use FFT to tell us about their experience. Over 30% of our inpatients feedback using the test every month.

Although we have had the test available on our wards for a while, in August and September 2014 we rolled out to all our outpatient and day-case services. This was a fantastic achievement and means we can now capture feedback that relates to an additional 1.4 million patient episodes each year.

We know that some people such as children, young adults and people with learning disabilities require a different approach for their views to be clearly heard.

Using feedback we received through trying FFT in our Teenage Oncology Unit, and from our Children's services, from May 2014 we introduced a dedicated children's FFT process. This included the use of child/adolescent friendly forms and a 'Children's App' which can be used on an electronic tablet. In addition, posters and business cards have been introduced into the areas which contain a unique code that can be scanned, and leads to a dedicated website where feedback can be left. We have also worked closely with our local groups to develop an easy read version of the FFT form and to ensure we can learn from the views of people with learning difficulties and learning disabilities.

All Friends and Family Test feedback, including free text comments, are available to local teams within 24-36 hours of a patient leaving their feedback. This is made possible by the Trust's Ward Healthcheck Electronic Dashboard which allows teams to easily search and analyse their own feedback. This provides local teams with the right information to make changes to respond to the concerns that their patients raise.

Examples of Friends and Family Test feedback

"As the Senior Sister I ensure the information and comments we receive are escalated to the team for action where appropriate. In team briefings the team are very positive about the effect this has had on patient experience. Issues such as improved bathroom cleaning have been addressed as a direct result of feedback from FFT"

"One of our colleagues who recently joined us from another Trust has commented on how much more focused the team are on FFT and how keen everyone is to learn from the comments we receive."

"FFT is a good idea – positive feedback boosts morale and improves communication between the Sister and the Ward team, improving all round care"

"The Ward sister prints out the information and it is put on a notice board in the corridor for everyone to see, including patients and relatives. The information we have received from FFT has made us more focused on the service and care we give to our patients. This has created a good team dynamic."

"It is discussed at team briefs. We look at how we can improve our services individually and to the team. The feedback we have had has resulted in us sharing and discussing more information with patients."

4.11.2 Staff Friends and Family Test

Following the successful introduction in 2013 of the Friends and Family Test (FFT) in clinical areas, to measure patient satisfaction, the facility was extended to staff for the first time from April 2014, as a means for staff to provide ongoing feedback about their Trust.

The survey was made available to all staff, students and volunteers at three points during the year and provided a range of opportunities to complete the on-line survey.

The Staff FFT includes the following questions:

- How likely are you to recommend the Trust as a place to receive care or treatment?
- How likely are you to recommend the Trust as a place to work?

The feedback is presented in the table below. The results have shown a gradual improvement in the response rates throughout the course of 2014/15, and also in the scores for both a place to receive care and to work.

Staff Friends and Family response rate

	Response from Quarter 1 (May 2014)	Response from Quarter 2 (Sept 2014)	Response from Quarter 4 (March 2015)
Response Rate (numbers of staff, students and volunteers)	750	1507	1514
How likely are you to recommend LTHT to Family and Friends if they needed care or treatment?	72.7%	81%	84.5%
How likely are you to recommend LTHT to Family and Friends as a place to work?	56.9%	65%	68.2%

NB. As the same questions are included within the National Staff Survey which is conducted annually in Quarter 3, the organisation did not complete the separate Friends and Family Test for Staff during this period. The results from the National Staff Survey in 2014 are shown below

National Staff Survey results 2014

Indicator	Reporting period	Trust performance	National average[2]	National range
Percentage of staff who would recommend the Trust as a provider of care to their family or friends (staff survey)	2014	63%	65%	38 to 89%
	2013	58%	64%	40 to 94%
	2012	47%	62%	35 to 94%
	2011	55%	62%	33 to 96%

4.11.3 National Patient Surveys

We believe it is important that we listen and respond to the feedback that we receive from patients. This is collected in many different ways, including through the Friends and Family Test. Alongside this, and in conjunction with the Picker institute, the Trust takes part in a number of National Patient Surveys, some of which are mandatory and some of which we undertake voluntarily so that we can check what patients think about their experiences with us. They also allow us to see whether actions we have put in place in response to previous surveys are having the desired effect and improving our services.

National Inpatient Survey 2014

We take part in the National Inpatient Survey annually. It asks patients specific questions about their admission to hospital, what to expect after procedures and about their experience of discharge. The results of the 2014 survey were published in March 2015. Compared to our previous inpatient survey results, we did significantly better on five questions and only performed significantly worse on one question (see table below). That question related to an increase in the number of patients stating that, during a planned admission, their specialist was not given all the necessary information. In the next year, we will examine why patients thought this and will look at ways to improve the way we do this in our hospitals.

Inpatient Survey: significant changes since last year's survey (lower scores are better)

	2012	2013	2014	National Trust Average
Areas in which we have got significantly better since last year (survey question)				
Hospital: toilets not very or not at all clean	5%	7%	4%	5.6%
Care: not always enough emotional support from hospital staff	50%	50%	41%	41.8%
Care: not always enough privacy when discussing condition or treatment	28%	30%	24%	24%
Overall: not treated with respect or dignity	25%	24%	17.5%	18.5%
Overall: not asked to give views on quality of care	81%	72%	64%	67.7%
Areas in which we have got significantly better since last year (survey question)				
Planned admission: specialist not given all the necessary information	No data	2%	5%	2.6%

Discharge

In 2013/14 many of the areas of concern which arose from the inpatient survey related to patients' experience of discharge. As a result we carried out some focused work to improve communication regarding discharge, and to ensure that patients' home circumstances and needs on discharge are taken into account. As a result of this work we have seen improvements in performance across many of the questions relating to discharge.

Unfortunately, we still have a high number of patients answering the survey reporting that their discharge was delayed. This particular score was worse than in 2013/14 and worse than the national average. As a result we will continue to look at ways of ensuring that our processes on the day of discharge are more efficient than they are at present.

We will be analysing the survey report from 2014 in more detail over the next few months to identify other areas where we need to improve.

Accident and Emergency Survey 2014

The Trust chose this year to take part in a voluntary survey to check progress and improvement since a mandatory Accident and Emergency (A&E) Survey was undertaken in 2012. The survey looked at all aspects of the patient experience in A&E including arrival, waiting, staff, care and treatment, and the environment. Compared to 2012 the A&E department compared significantly better in five areas.

In 2012 some of the areas in which we performed poorly related to the quality of information provided prior to patients leaving the department. The Accident and Emergency Department has worked hard to try to improve communication at point of discharge, and as a result five out of six scores showed significant improvement between 2012 and 2014.

Accident and Emergency Survey: significant changes since 2012 survey (lower scores are better)

	2012	2014	National Trust Average
Areas in which we have got significantly better since last survey (survey question)			
Doctors / Nurses: not enough time to discuss health or medical problems	36%	27%	28.3%
Doctors / Nurses: did not fully listen to patient	30%	18%	22.7%
Care: not always able to get help from staff when needed	51%	40%	39.6%
Care: staff contradict each other	25%	16%	17.1%
Hospital: emergency department not very or not at all clean	4%	1%	4.6%

Equality

All of our survey results are monitored to look for areas of inequality that need addressing. This is achieved through the personal profiling questions that are asked as part of the survey. By looking at these we can identify if we receive different responses from different groups of people. We can also do the same when we ask specific questions about dignity and respect.

In 2014, neither the Accident and Emergency nor Inpatient Survey results identified inequalities that needed addressing. We do appreciate however, that survey responses do not necessarily represent the views of all groups of people living in Leeds and being cared for in the Trust. As a result, the Trust is looking at alternative methods to understand if we are achieving equality for our patients. One method identified to date is through using a West Yorkshire wide piece of work produced in 2013 by Public Health England which identified areas of inequality within the hospitals across West Yorkshire.

In 2015/16, the Trust will work collaboratively with:

- Other hospitals across West Yorkshire to monitor patient experience across specific age groups and minority groups.
- The Picker Institute, our national survey provider, to commission further analysis of national surveys to try to ascertain if the 2013 inequalities reflect the feedback we are receiving now; and to ensure that any new inequalities are identified.
- Other major service providers across Leeds, through the Leeds Equality Network, to collectively engage with disadvantaged groups and to find out what we can do to make our services more accessible and better suited to their needs.

4.11.4 Listening to our patients

Patient Stories

One of the best ways for us to improve the care we give to people is by listening to the stories of patients and families we care for. We continue to have been helped this year by many people who have given up their time to tell us about their experiences. We share this information in a variety of ways; this includes inviting people to forums and events to talk to staff, and also through the use of video.

Two examples of improvement from patient feedback:

After hearing how vital receiving emotional support is throughout patients' diagnosis and treatment, the Robert Ogden Macmillan Centre at the Trust introduced a cancer support group which is run on an evening. This now allows patients and carers greater access to a trained professional to offer a range of help and advice.

The Trust have also been working with the Maggie's charity this year, to build one of their centres on the St James's site, close to Bexley Wing where many cancer patients receive their treatment. This new purpose built Maggie's Centre will offer a range of services to provide psychological and emotional support for cancer patients, and will complement the existing care already provided by the Robert Ogden Macmillan Centre. The architect for the building will be Thomas Heatherwick who is famous for designing the Olympic Cauldron and the new London Garden Bridge. The Maggie's Centre is due to open in 2015 /16.

Video stories we have filmed this year have covered a range of topics: the experiences of carers are helping us take forward work on improving partnerships between carers and hospital staff so that we care more effectively for patients with dementia and other cognitive impairments. We also considered the needs of diverse communities including Black, Asian and Minority Ethnic groups, and the Lesbian, Gay, Bisexual and Transgender community.

Video stories have also contributed towards development of our Trust Equality and Diversity strategy, which is in progress and will be completed in 2015/16. Some patient stories we film are very positive about the care we provide, while others show how we need to improve: they help departments and individual staff members think about their own practice and how they can improve in the future.

A patient story being filmed

All Trust Board and many senior level meetings begin with the showing of one of our filmed patient stories: these patient stories, and examples of improvement, are currently available to the public via the Trust's 'Open and Honest' monthly publication on the website. In the next year we will be looking to create a bank of patient story videos which will be easy to access via the Trust home page.

Action taken in response to complaints

Examples of the actions that have been taken by the Trust this year in response to concerns raised, can be seen below:

"The Surgical Assessment Unit has made significant changes in improving patient waiting times. They have introduced a surgical nurse practitioner team to the unit, who work alongside the medical staff to assess patients. The unit has also appointed more medical staff, particularly over busier periods such as evenings".

"A Physiotherapy discharge advice note has been introduced and is now given to patients clearly stating the outcome of their physiotherapy input and what follow-up has been arranged".

"The Haematology Day Unit has introduced a process which identifies a plan for each patient having regular transfusions. The plan identifies the number of units of blood to be prescribed and transfused, and includes a date for review by the consultant medical staff. The plan also indicates when it would be appropriate to check with the consultant about the number of units of blood to be transfused." This is in response to a complaint where a patient did not receive the correct number of units of blood and there was lack of clarity about what the plan had been.

"Ward L18 now has a Clinical Support Worker each shift who is responsible for checking on all patients who may be waiting in the day rooms for family to collect them." This was in response to a complaint where a patient was left for a long period of time in a day room without being offered a drink or a blanket.

Additionally, this year we received a number of complaints across the Trust relating to discharge. Work we have done, which should improve the experience of patients in the future who leave our care, includes the introduction of a Discharge Pack on wards and a Ticket Home. The Ticket Home helps us talk to patients, from an early point in their admission to us about when they should expect to leave our hospital, this means they can think about the kind of things they will need to have in place to help them when they leave, and also allows them to prepare early on for their discharge. It also helps all staff understand the discharge date that is being aimed for.

4.11.5 Patient and Public Involvement

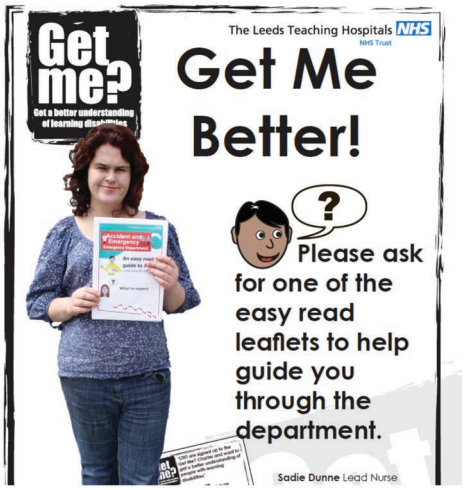
Working with People with Learning Disabilities

An easy read patient information leaflet was launched in February 2015 to support patient journeys through our A&E departments. This leaflet is offered to anyone attending A&E who needs information in an easy to read and understandable format. The leaflet explains what questions are likely to be asked in A&E, why they may have to wait to be seen and who they will see.

The leaflet was developed by our 14 'Get Me Better' Champions, a group of people with learning disabilities who support LTHT staff to understand what reasonable adjustments are and how they can be put in place.

Some of our 'Get me Better' champions

They are currently helping to develop other easy read patient information for the audiology department and the Children's service: they also provide support for patients and visitors with Learning Disabilities and, in addition, some of them have been involved in our recruitment of staff, and are participating in Apprentice CSW assessment days.



Bereavement

The aftercare of families and carers when they are bereaved is really important to the Trust. Some communities have experienced care from us that has not been as good as expected. The Muslim community have encountered difficulties at weekends and bank holidays when they have tried to arrange a quick funeral, in line with their religious requirements. In response, we have developed a bereavement policy to ensure individual needs are met, and also provide information to help staff understand the cultural and religious requirements of different groups of people when they are experiencing bereavement. The changes that have been made will not only improve the support offered to the Muslim community but also to the Jewish community, who have expressed similar concerns in the past.

We also recognised that, to respond to all families in a timely manner and reduce unnecessary waiting for paperwork, it was important that we supported staff in the hospital to work as efficiently as possible. This meant making sure the Bereavement Office opened for longer each day so the doctors had more time to attend the service and complete necessary documentation to assist families with funeral planning. As a result, in October 2014 we extended the Bereavement Office closing time from 3pm to 4.30pm, Monday-Friday. This has made a big difference to hospital staff and bereaved families, and we are aiming to trial opening on a Saturday morning in 2015/16 to see if this further improves the service we offer.

Working with partners

We continued to build on relationships with local stakeholders such as Advocacy Groups, Community Forums, and involvement groups. We have supported Healthwatch Leeds in making visits to our hospitals and a diverse range of clinical specialties. During visits, the Healthwatch team have independently surveyed patients, families and carers to help us get feedback on their experience of care in our hospitals. Healthwatch Leeds have used their findings to develop an action plan that requires the Trust to provide feedback that any required actions have been completed, to help us make further improvements in our services.

In 2014/15 the Healthwatch team:

- Visited our Accident and Emergency Departments, (Adults and Children's)
- Visited our Children's Hospital
- Identified patients to help them with specific pieces of work aimed at improving services outside the hospital
- Obtained the views of people who use our Sexual Health services.

We have welcomed this support from Healthwatch Leeds and we will continue to work with them to extend the ward and department visits in 2015/16.

Our Head of Patient Experience has attended the Patient Voices Group (PVG) that has been established by Healthwatch Leeds in 2014/15. This is an important forum for building relationships with other organisations and identifying opportunities for working with partners to help improve the experience of people who use our services. One of the things we have done, resulting from this, is to develop an approach to respond to community concerns relating to the food that is provided within the hospital environment, and we will continue to implement this programme for improvement in the forthcoming year.

Leeds Involving People (LIP) has continued to work with the Trust to organise listening events. In September 2014 a joint Healthwatch/LIP British Sign Language Event helped the Trust to learn about the problems the deaf and hard of hearing encounter when using our services.

Members of the Deaf and Hard of Hearing Advisory group visiting A & E

As a result of the feedback we are now working closely with our Deaf and Hard of Hearing group, and the Leeds Deaf Forum, to make sure that our services are developed with the needs of those with hearing disabilities in mind.

In December 2014, LIP also supported a local community group looking at hospital food. Members of local Black, Asian and Minority Ethnic communities met with Trust staff to raise awareness of problems encountered by some minority groups in accessing and enjoying food in a way which meets their cultural needs. We are planning to bring together the Hospital Food Group, and participation from a wider and more diverse community, to help improve the experience of our patients.

Patient, Carer and Public Involvement Framework

In 2014/15, the Trust Public and Patient Involvement Strategy included the development of a toolkit to incorporate patients' views in the development of services within the Trust. This toolkit is currently being piloted in four of our areas and we will make it available to more of our services in 2015/16. The work is supported by an independent panel of patients, carers and representatives from organisations outside the Trust.

Spiritual Support

In 2014 the Trust Chaplaincy department developed a five year plan to focus on the spiritual needs of patients who do not identify with a particular religious belief. In July a pilot project in Chemotherapy Pre-assessment offered patients the opportunity to meet with a chaplain. The project received 17 referrals and 15 face-to-face meetings. As a result, some patients have been able to practice their religious beliefs and develop their spiritual reflection.

Some have been referred to other professionals, while the vast majority of patients and carers have simply been able to share their emotions in a safe, confidential setting. Even when patients have been unavailable to meet face to face, chaplains have been able to offer support over the telephone and provide the reassurance that spiritual care is there for all patients to access at any stage. This work will be evaluated with a view to extending it to other areas of care in the near future.

4.11.6 Carers

We know that carers make a huge contribution to supporting the people they care for and as a Trust we are committed to improving carers' experience of our services.

Following carer feedback:-

- We are communicating more effectively with carers of patients with dementia and other cognitive difficulties to ensure they are included in care planning and discharge planning.
- We have amended our nursing documentation to make sure that the assessment of a patient's admittance takes into account whether they are cared for by someone, or have caring responsibilities for someone else. This enables us to know right from the beginning that a patient has a carer who will need to be involved in decision making.
- We are in the process of trialling and implementing the 'Ticket Home' to notify patients and their carers of their planned discharge dates in good time.
- As a result of feedback from one carer, we are reconsidering our opening hours on wards to make it easier for carers to support our patients at different times of the day.
- We have made sure that we have representation on the Trust dementia group from carers, who are helping us identify important issues and work on ways to improve them.

- We have continued to work with the Carers' Strategic Partnership (CSP) and have contributed to the citywide Leeds Carer's Strategy 2015-18, which will be published and launched in April 2015, and takes account of the provisions of the Care Act 2014.
- In 2014/15, we hosted an onsite Dementia Carer Support Worker working with the city's commissioners and Carers Leeds. During her time in post she has offered practical support and advice to more than 200 carers. In recognition of the success and value of this role, we have secured funding for a further year, and will now host two Dementia Carer Support Workers, one based at LGI and one at St James's Hospital.

Carer support workers

Case Study - Support offered by Dementia Carer Support Worker

Initial contact	• Carer attends drop-in session at the carers' room at St James' Hospital • Struggling to cope for husband at home- worried about him returning home from hospital
Ongoing support	•Discussed with staff nurse about getting Intermediate Care Team in place upon discharge (this was subsequently arranged) •Supported carer to get sitting service in place •Supported carer to fill in Time for Carers application • Referred carer to Housing 21 Carers' Emergency Service
Post- discharge support	• Carer received £250 through Time for Carers for a break • Carer linked into other Carers Leeds' services e.g. Call Cos You Care • Carer given information for local Neighbourhood Network

4.11.7 Volunteers

Ensuring that LTHT becomes "a great place to volunteer"

Volunteering is a key priority for 2015/16 as part of our wider People Strategy. We recognise the enthusiasm and commitment of the 300 volunteers who are currently providing services and support across our hospitals.

Our volunteers undertake a variety of roles for example; assisting with mealtimes on wards, trolley services, signposting visitors, and chaplaincy and within our A & E departments. We have proactive plans to develop our opportunities for recruitment, selection, training and recognition of volunteers.

One of our Lincoln Wing reception volunteers giving information to a prospective volunteer

In response to feedback, our plan is to double the numbers of our volunteers, develop the diversity of our volunteers to reflect the communities and patients we serve, and develop new and exciting volunteering roles. For the first time, we have also piloted a staff volunteering programme to enable our own staff to volunteer in patient facing roles in the Trust.

4.11.8 Complaints and Patient Advice and Liaison Service (PALS)

During 2014/15 we have continued to make improvements to our PALS service and the way we handle complaints. The PALS service is the first port of call for patients with concerns, queries or compliments. The PALS team has attended, or has scheduled visits arranged,

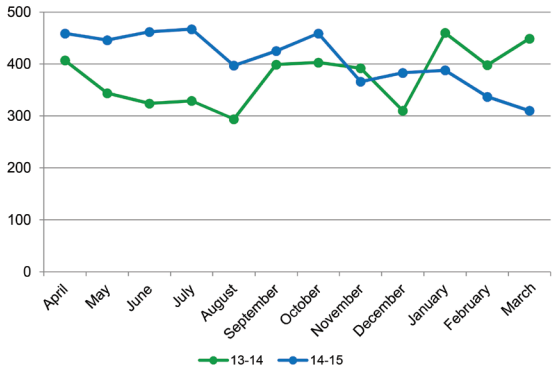
to Black, Asian and Minority Ethnic (BAME) forums, Learning Disability Groups, Advocacy services, organisations for Gypsies and Travellers, and Dementia groups. This includes forums for Blind, Partially-sighted, Deaf and Hard of Hearing service users.

PALS Officer Shazia Mamoon attended a women's forum at The Leeds Islamic Centre and describes the positive response to her visit:

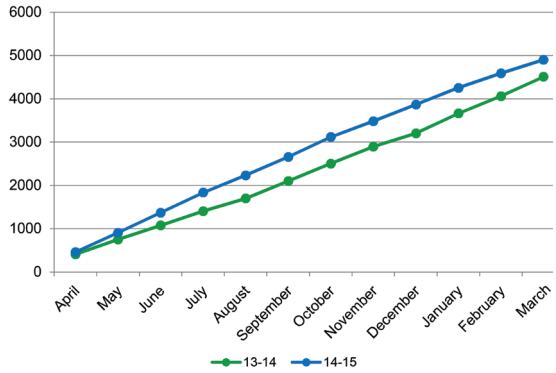
"The reception I received from the women's group at the Al-Khidmet day centre, when promoting PALS in the community was incredible. The feedback they gave me was that they felt it was important to have a face that represented their community who also understood their cultural and religious beliefs. They were confident they would not be judged thus resulting in them trusting me and having the confidence in me to listen to their individual concerns and issues. I was able to reach out and engage with the group by speaking in Mirpuri and Urdu as well as English. This was very well received and they expressed a need for a regular drop in session for PALS to keep them updated and where they could, if need be, speak to someone face-face".

We have seen an 11.5% increase in the number of PALS enquiries received this year when compared to those received last year.

Number of PALS enquiries received (by month) in 2014/15 compared to 2013/14



Number of PALS enquiries (cumulative) received in 2014/15 compared to 2013/14



Our vision for the PALS service is for it to become more visible by offering a place to go and a person with whom the public can discuss what is concerning them, at the point that they have a concern. This year we have begun the work to achieve this goal by expanding the PALS team and, moving forward, we will be establishing an accessible base on the St James's and LGI sites to allow patients and visitors with concerns to 'drop in' for face to face advice.

4.11.9 Improvements in patient and carer information

Providing good quality information and leaflets for patients and carers is an important part of delivering the high standards of care we expect at the Trust. In 2014/15 we began a project to ensure all leaflets are electronically stored in one place, and understand which leaflets are used within each of our services. It will also help us keep our leaflets updated and relevant.

In response to patient feedback, we are reducing the number of leaflets that repeat the same information. This reduction prevents any unnecessary overload of information for our patients. Our work next year will look at how our information is presented to patients and carers, to ensure it is user-friendly and of a high quality. We have also set up a patient information group to support this work and will be seeking members of the public to advise on the content of our patient information and any areas for improvement.

4.11.10 #hellomynameis

Last year we described the work that one of our senior doctors had led, involving a campaign to improve the experience of our patients. #hellomynameis aims to make sure that care is personalised at all times through raising awareness of the importance for health care staff to always introduce themselves by name to patients.

Dr Kate Granger has been receiving treatment for terminal cancer at our Trust and she has shared her experience of treatment and care to help us learn from this, and to make a difference across the NHS. Kate launched #hellomynameis - a social media campaign which is about seeing the person behind the condition, making a human connection, and building trust.

The #hellomynameis campaign launched in July 2014 and has been really successful, resonating with people not just in the UK but across the world. Around 7,000 people at LTHT have signed up to the campaign so far and are proudly wearing their #hellomynameis name badges. Staff at the Trust feel passionately about this campaign and we know we have much to learn from it to ensure we provide care that is person-centered and compassionate at all times.

4.11.11 Engaging with our Members

In 2014/15 we have engaged with our Members; these are public and patient representatives from our local community, who provide support to the Trust. We have provided a series of events for our members in a programme, building on our Medicine for Members programme that was established in 2013/14.

These free sessions have been arranged for our public members, and include presentations from a health expert within the Trust. The sessions provide the opportunity for members to put forward questions and suggestions for quality improvements to members of staff, including clinicians and managers. The topics of the sessions are based on some of our members' most popular interests, as indicated by the results of the last Public and Patient Involvement (PPI) Questionnaire.

In 2014/15 we have included a wider range of new and interesting topics, together with information and advice about preventative health measures, as well as current and future developments. The topics have included our public health strategy, helping people to stop smoking, drink sensibly and lose weight, brain aneurysms and stroke, cancer and radiotherapy treatment, bowel screening and cancer, kidney and liver transplantation, robotic surgery, and presentations on patient safety and quality. This is an important forum for us to engage with our public, including people who use our services, and we will continue this in 2015/16.

4.12 Performance against national priority indicators

The Trust's performance against the national priority indicators is summarised in Appendix E.

4.13 Quality Account Appendices

Appendix A

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

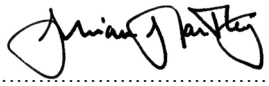
- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

NB: sign and date in any colour ink except black

29/06/2015 ..... Date  ..... Chair

29/06/2015 ..... Date  ..... Chief Executive

Appendix B

Statements from Local Stakeholders

Comments from Healthwatch Leeds on
Leeds Teaching Hospitals NHS Trust Quality Account 2014-15

Healthwatch Leeds hosted a session for all the organisations providing NHS services in Leeds who are required to provide annual Quality Accounts and have invited Healthwatch Leeds to comment on them as a part of their statutory duty. Each organisation was invited to present their account with a focus on accessibility, evidence of links between patient feedback or engagement and priorities, the measures of planned improvement and progress and benchmarking. Healthwatch volunteers were also invited to identify areas of good practice. As the actual copies of the QA were not provided by everyone, a general recommendation is to produce a more accessible summary, possibly in easy read that has a focus on the issues identified as important and influenced by patients, service users or their carers.

Leeds Teaching Hospitals Trust provided a clear summary of their Quality Account and was commended for making technical language quite accessible. The commitment for engagement and feedback from patients was a clear theme.There is evidence of improved engagement and how feedback has influenced priorities. Examples of good practice include work with people with learning disabilities and the "golden thread" approach to quality of care and patient safety. The Trust does benchmark and provides examples on how outcomes are measured, some linked to national data. The decision to continue with the same priorities recognising that further work needs to take place is welcomed. The Trust recognises that due to their size the main account may be a challenge to access, we would recommend a summary section or a separate more accessible document.

Letter from NHS Leeds West CCG

NHS
Leeds West
Clinical Commissioning Group

Thank you for giving Leeds West CCG the opportunity to comment on the Quality Account for Leeds Teaching Hospital Trust 2014-15. Our statement is as follows:

NHS Leeds West Clinical Commissioning Group (CCG) welcomes the opportunity to provide this statement for Leeds Teaching Hospitals NHS Trust's (LTHT) Quality Account for 2014-15. The Quality Account has been reviewed in accordance with the National Health Service Regulations. NHS Leeds West Clinical Commissioning Group (CCG) is providing this statement on behalf of all three Leeds CCG's (NHS Leeds South and East and NHS Leeds North) following consultation.

As the organisation responsible for the quality of services commissioned, the CCG continues to develop relationships with our Trust colleagues. The quality of services delivered and some performance measures which impact on this are monitored at the monthly Leeds CCGs and LTHT Quality meetings. These meetings are an opportunity to gain assurance that the Trust has systems and processes in place to promote the delivery of safe, effective and high quality care delivery by staff. We have reviewed the Quality Account and believe that the information published provides a fair and accurate representation of the Trust's achievements over the last year, and its' commitment to continuously improve the quality of care delivered.

Over the last year, the Trust has worked with health and social care partners through the Leeds Institute for Quality Healthcare to improve the experience for patients by redesigning clinical pathways. It is pleasing to note that this work will continue and expand to other clinical conditions in the year ahead.

The CCG is pleased to note that the Trust has committed to the national 'Sign up to Safety' campaign which aims to halve avoidable harm in the NHS. The development of a Trust Safety Improvement Plan will support the progress made to date in working to reduce the number of pressure ulcers and falls, and improve the care of the deteriorating patient. Much of the work carried out in these areas over the last year demonstrates an innovative approach e.g. collaborating in the development of a pressure ulcer assessment tool and the development of a city wide action plan to reduce pressure damage.

The Trust has identified Priority Goals for Improvement for 2015/16. Many of these goals are continuations from 2014/15 and a reduction in the incidence of falls is an excellent example of how identification as a priority goal has resulted in achievements in patient safety. Through collaborative work with the Haelo Group, the Trust has seen a significant and sustained reduction in falls on the selected pilot wards and we look forward to seeing the Trust achieving its' aspiration of serious harm reduction by 50% in the pilot wards. The report details a number of drivers involved in this work and we would be interested to know if medication reviews in patients who fall was considered within these headings.

The CCG acknowledge that there have been significant efforts within the Trust to improve assessment of patients and interventions in order to reduce the number of pressure ulcers acquired both in hospital and across the community setting. In the chart within this section of the report showing the incidence of developed pressure ulcers and rate, it is difficult to identify the improvement as described in the accompanying narrative.

A reduction in harm in Maternity Services is a welcome patient safety priority and it is pleasing to see that the aim of the improvement plan is a 50% reduction in the incidence of harm at birth and loss of baby. It would be helpful to include the current levels of harm within this section to give the reader some understanding of the level of improvement needed to achieve this.

It is good to see that in the coming year there is an overall focus on the testing of actions from previous work and sharing learning across the Trust, as this will support sustainable, long term improvement.

The Trust has achieved important improvements in dementia care, such as, working with mental health partners in helping to redesign Memory Assessment Pathways, supporting carers of people with dementia and improving the diagnosis rate. We look forward to seeing the Trust meet the challenge of increasing this diagnosis rate in the coming year.

Good progress has been made by the trust in the handling of complaints. Whilst the target of responding to 80% of complaints within 40 days was not met, we note there have been good improvements in the numbers of formal complaints received and also a reduction in re-opened complaints when compared to the previous year. We hope this level of improvement in complaints handling continues into the coming year.

The report details the Trust's commitment to Clinical Effectiveness through a programme of clinical audit and the CCG is pleased to see initiatives improving the quality of care delivery implemented as a result of this. The development of a Delirium guideline is a good example, which will be supported by the implementation of a Trust wide clerking booklet to improve the recognition of delirium in patients. We are interested to know when the booklet will be launched across all relevant specialities in the Trust. We are also pleased to see that clinical coding is part of the audit programme and we support the improvement work in this area.

We welcome the fact that the Trust, whilst not participating in the 2015/16 CQUIN scheme remain committed to delivering the required improvements in the areas of Sepsis and Acute kidney Injury.

The report accurately reflects the outcomes of the CQC inspection in 2013/14 and gives a thorough representation of the visit; this was included in the 2014/15 Quality Account because the CQC findings were not published until June 2014.

We are pleased to read about the implementation of safety huddles and are interested to learn more about how these will be rolled out across all areas of the Trust and the resulting improvements in patient safety. The Trust has been successful in receiving funding grants which will help to accelerate the work and we congratulate them on their successful bids for this and additional funding for Maternity Services.

We acknowledge the development and progresses made on the Ward Healthcheck, and have witnessed this information being available to patients and visitors in ward areas during our CCG quality visits to the Trust.

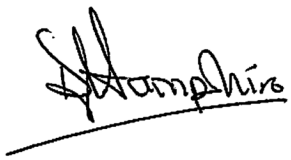
The approach to learning from incidents outlined in the report is reassuring. It is good to share learning externally where possible. We welcome the approach taken to learning from Never Events and the sharing of this learning across the region. We acknowledge that the changes made to the national guidance may result in an increase in some serious incidents being identified as Never Events. We would particularly like to see a reduction in Never Events relating to dermatology services and retained surgical items. We believe that the Trust has robust processes in place to ensure they are compliant with the Duty of Candour in relation to incidents and we are confident this will remain a Trust priority.

The work being undertaken by the Trust on mortality is welcome and will help to reduce avoidable deficiencies in care which are associated with patients who die by 50% and complements other improvement programmes such as Sign up to Safety.

Whilst the report acknowledges that there have been problems identified with the hospital discharge process, it does not explore in detail some of the continuing problem areas relating to discharge as identified by the CQUIN in 2014/15. The CCG would like to see more information about how the Trust plans to address some of these issues in the coming year. We would also value more information about how Trust Safeguarding processes have incorporated the requirements of the Care Act (2014), and making safeguarding personal to the individual.

Overall, the CCG would like to compliment the Trust for the open and transparent way in which they present their data, and the frank dialogue we are able to have with their senior staff. We look forward to continuing to work in partnership with LTHT in delivering high quality, effective care for our patients.

Kind regards



Diane Hampshire

Director of Nursing and Quality

Independent Auditor's Limited Assurance Report to the Directors of The Leeds Teaching Hospitals NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of The Leeds Teaching Hospitals NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections; and
- Friends & Family Test (FFT) patient element score

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014/15 issued by the DH in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April2014 to May 2015;
- papers relating to the Quality Account reported to the Board over the period April 2014 to May 2015;
- feedback from Commissioners dated 30 May 2015;
- feedback from Local Healthwatch dated May 2015;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 26 September 2013;
- the latest national patient survey (2014) dated February 2015;
- the national staff survey 2014;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2015;
- the annual governance statement dated May 2015;
- Care Quality Commission Intelligent Monitoring Report dated December 2014; and
- the results of the Payment by Results coding review dated May 2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of The Leeds Teaching Hospitals NHS Trust.

We permit the disclosure of this report to enable to Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Leeds teaching Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

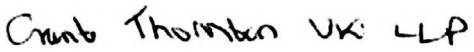
The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Leeds Teaching Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.



Grant Thornton UK LLP

No.1 Whitehall Riverside, Leeds LS1 4BN

3 June 2015

Appendix C: Glossary of Terms

2222 call: A crash call to summon an emergency care team to a patient suffering a cardiac arrest.
Acute Hospital Trust: An NHS organisation responsible for providing healthcare services.
Board (of trust): The role of the Trust's Board is to take corporate responsibility for the organisation's strategies and actions.
Care Quality Commission (CQC): The independent regulator of health and social care in England.
CQC Intelligent Monitoring Report: The CQC Intelligent Monitoring tool has been developed to give inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust or a specialist NHS trust. The system is built on a set of indicators that look at a range of information including patient experience, staff experience and performance. The indicators relate to the five key questions that will ask of all services: are they safe, effective, caring, responsive, and well-led?
Clinical Commissioning Group (CCG): Cinical led NHS bodies responsible for the planning and commissioning of health care services for their local area.
Clinical Audit: Clinical audit measures the quality of care and services against agreed standards, and suggests or makes improvements where necessary.
Clinical Service Unit/Clinical Support Unit (CSU): The Trust is made up of 19 CSUs, which are groups of specialties that deliver the clinical services the Trust provides.
***Clostridium Difficile* Infection (CDI):** A type of bacteria which causes diarrhoea and abdominal pain, and can be more serious in some patients.
Commissioning for Quality and Innovation (CQUIN) payment framework: A framework which makes a proportion of providers' income conditional on quality and innovation.
Cardiotocography (CTG): measures the baby's heart rate and contractions in the womb (uterus). CTG is used both before birth (antenatally) and during labour, so doctors and midwives can see how the baby is doing.
Department of Health (DoH): A department of the UK Government with responsibility for Government Policy for health, social care and NHS in England.
Dr Foster Hospital Guide: Annual national publication from Dr Foster containing data from all NHS Trusts in England & Wales highlighting potential areas of good and poor performance. The Guide's focus changes each year but consistently contains measures of Hospital Mortality.
Friends and Family Test: a national NHS tool allowing patients to provide feedback on the care and treatment they receive and to improve services. It asks patients whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment.
Haelo: Haelo is an innovation and improvement centre.
Healthwatch Leeds: Healthwatch is the independent consumer champion that gathers and represents the public's views on health and social care services in England. It ensures that the views of the public and people who use the services are taken into account
Hospital Standardised Mortality Ratio: An indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Information Governance Toolkit: The NHS Information Governance Toolkit ensures necessary safeguards for, and appropriate use of, patient and personal information.
Hospital Episode Statistics (HES): a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.
Infection Prevention Control (IPC): Healthcare professionals required to prevent the transmission of communicable diseases in all health care settings

Leeds Involving People: An organisation that represents the independent voice of people through the promotion of effective involvement. It involves the community in the development of health and social care services by ensuring their opinions and concerns are at the centre of decision making processes.
Leeds and York Partnership Foundation Trust (LYPFT): provides specialist mental health and learning disability services to people within Leeds, York, and parts of North Yorkshire.
Methicillin Resistant Staphylococcus Aureus bacteraemia (MRSA): A bacterial infection.
Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSA): Bacteria that usually cause skin infections, but can also cause pneumonia, and other serious types of infections.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Reviews clinical practice across England and Wales, and makes recommendations for improvement.
National Early Warning Scoring Systems (NEWS): A guide used by hospital nursing and medical staff to determine the degree of illness of a patient, and is based on physiological measurements.
National Institute for Health and Care Excellence (NICE): An independent organisation responsible for providing national guidance on promoting good health, and preventing and treating ill health. It produces guidance for health care professionals, patients and carers, to help them make decisions about treatment and health care
National Institute for Health Research (NIHR): An organisation which aims to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
National Payment by Results (PBR): The payment system in England under which commissioners pay healthcare providers for each patient seen or treated.
The NHS Litigation Authority (NHSLA): A not for profit organisation which handles negligence claims and works to improve risk management practices in the NHS.
National Patient Safety Agency (NPSA): An agency which leads and contributes to improved, safe patient care by analysing trends in incidents, informing and supporting the health sector..
National Reporting and Learning System (NRLS): Enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.
Never Events: Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
Patient Advice and Liaison Service (PALs): Offers support, advice and information on NHS services to patients, their carers, the general public and hospital staff.
Patient Reported Outcome Measures (PROMs): A measure of quality from the patient's perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre and post-operative surveys.
Payment by Results (PbR): The tariff system that governs payments to hospitals by local NHS commissioning organisations. It seeks to ensure fair funding for hospitals for the work they do.
Quality Summit Meeting: a group of healthcare quality experts meet to discuss quality initiatives to improve health care.
Root Cause Analysis (RCA) investigations: provide a systematic framework for reviewing patient safety incidents, claims and complaints. Investigations can identify what, how, and why patient safety incidents have happened in order to reduce the risks of incidents happening again.
Safety Thermometer data collection tool: A local improvement tool for measuring, monitoring and analysing patient harms and harm free care.

Secondary Uses Service: Provides anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
The Summary Hospital-level Mortality Indicator (SHMI): An indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC)
Trust Development Authority (TDA): Provide support, oversight and governance for all NHS Trusts on their journey to delivering high quality services.
Venous thromboembolism (VTE): A condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vein can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT).

Appendix D Trust Participation in NCEPOD and National Audits

Summary tables of participation in NCEPOD Studies and DoH recommended national audits

National Confidential Enquiry	Participation Rate*
Gastrointestinal Bleeding	100%
Sepsis	78%

National Audit	Participation Rate*
Adult Community Acquired Pneumonia	100%
Bowel Cancer (NBOCAP)	100%
Cardiac Rhythm Management (CRM)	95%
Case Mix Programme (CMP)	100%
Congenital Heart Disease (CHD)	100%
Fitting child (Care in Emergency Departments)	100%
Head and Neck Oncology (DAHNO)	100%
Inflammatory Bowel Disease (IBD): Biological Therapy	100%**
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	100%
Mental Health (Care in Emergency Departments)	100%
Myocardial Ischaemia National Audit Programme (MINAP)	Denominator not known
National Adult Cardiac Surgery Audit	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit	82%
National Comparative Audit of Blood Transfusion programme - 2014 Audit of transfusion in children and adults with Sickle Cell Disease	100%
National Diabetes Audit: Core Audit	99%
National Pregnancy in Diabetes Audit	54%
National Emergency Laparotomy Audit (NELA)	94%***
National Heart Failure Audit	70%
National Hip Fracture Database (NHFD)	96%
National Joint Registry (NJR)	94%†

National Lung Cancer Audit (NCLA)	Denominator not known
National Paediatric Diabetes Audit (NPDA)	100%
National Vascular Registry	89%
National Neonatal Audit Programme (NNAP)	100%
Oesophago-gastric Cancer (NAOGC)	100%
Older people (Care in Emergency Departments)	100%
Paediatric Intensive Care (PICANet)	100%
Patient Reported Outcome Measures - Varicose Veins	77%
Patient Reported Outcome Measures - Hernia	46%
Patient Reported Outcome Measures - Hip replacements	82%
Patient Reported Outcome Measures - Knee replacements	96%
Percutaneous Coronary Intervention (PCI)	100%
Pleural Procedures	100%
Prostate Cancer	- ††
Renal Replacement Therapy (Renal Registry)	100%
Rheumatoid and Early Inflammatory Arthritis	100%
Sentinel Stroke National Audit Programme (SSNAP)	100%
Trauma Audit & Research Network (TARN)	63%

* Participation rate is calculated as the number of patients for whom data have been submitted as a proportion of the number for whom data should have been submitted.

** Participation rate in audit for paediatric patients.

*** Denominator not known; reported participation rate calculated using NELA's estimated number of cases per month.

† There are technical issues between our clinical information system supplier and the NJR preventing data submission to this audit at present. This figure represents the Trust's participation rate for data previously submitted and that awaiting submission.

†† Not confirmed at time of publication.

Appendix E: Performance against National Priority Indicators

	Indicator	TDA Thresholds	Jan-15	Feb-15	Mar-15	YTD
Responsive	A&E: 4 hour standard	≥ 95%	93.5%	96.3%	97.9%	95.0%
	A&E: 12 hour trolley waits	0	0	0	0	1
	Referral to treatment within 18 weeks: admitted	≥ 90%	86.63%	82.64%	83.52%	88.33%
	Referral to treatment within 18 weeks: non-admitted	≥ 95%	94.2%	94.3%	93.4%	95.2%
	Referral to treatment within 18 weeks: incomplete	≥ 92%	93.3%	93.2%	94.3%	n/app
	Referral to treatment within 18 weeks: over 52 week waiters (incomplete waits)	0	0	0	0	n/app
	Diagnostic waits within 6 weeks	≥ 99%	98.7%	99.8%	99.7%	n/app
	Last minute cancelled operations not re-booked within 28 days	0%	Q3 2014/15: 10.4%			
	Urgent operations cancelled for a second time	0	0	0	Reported a month in arrears	0
	Cancer 62 days: GP referral	≥ 85%	74.4%	67.2%		75.8%
	Cancer 62 days: referral from screening service	≥ 90%	97.3%	94.3%		94.3%
	Cancer 31 days: first treatment	≥ 96%	94.0%	94.8%		96.3%
	Cancer 31 days: second or subsequent surgery	≥ 94%	89.0%	93.5%		94.0%
	Cancer 31 days: second or subsequent drug treatment	≥ 98%	100.0%	100.0%		100.0%
	Cancer 31 days: second or subsequent radiotherapy	≥ 94%	100.0%	99.1%		99.4%
	Cancer 2 week wait: suspected cancer	≥ 93%	93.9%	96.4%		94.7%
	Cancer 2 week wait: breast symptoms	≥ 93%	96.0%	94.9%		92.4%
	Certification against compliance with requirements regarding access to health care for people with a learning disability	Self-certification	Compliant	Compliant	Compliant	n/app
Effective	Summary Hospital-level Mortality Indicator (SHMI)	National Ave: 100	Oct-13 to Sep-14: 104.06[1]			
	Hospital Standardised Mortality Ratio (HSMR)	National Ave: 100	Oct-13 to Sep-14: 99.54[1]			
	30 day emergency readmissions (Elective & non-elective)	≤ 10.9%	6.5%	6.9%	Reported a month in arrears	6.7%
	Delayed transfers of care	≤ 3.5%	4.1%	3.7%	4.4%	n/app
Safe	Incidence of C. Difficile	YTD: ≤ 127 14/15: ≤ 127	5	9	14	121
	Incidence of MRSA	0	0	0	0	7
	Medication errors causing serious harm	0	0	0	Reported a month in arrears	1
	Harm Free Care (pressure sores, falls, CUTI and VTE): Safety Thermometer (snapshot)	≥ 95%	94.5%	92.9%	94.5%	n/app
	Serious incidents: number	n/app	7	6	8	95
	Serious incidents: rate per 1,000 bed days	≤ 1.23	0.13	0.12	0.15	0.15
	Never events	0	0	0	1	5
	Maternal deaths	14/15: ≤ 1	0	0	Reported a month in arrears	0
	Venous thromboembolism (VTE) risk assessment	≥ 95%	97.4%	96.9%	Reported a month in arrears	96.5%
	Open CAS Alerts (exceeding the deadline for action)	0	1	1	1	n/app
Caring	Friends and Family Test: Inpatient Net Promoter Score	≥ 60.0	70.0	69.1	69.3	72.3
	Friends and Family Test: A&E Net Promoter Score	≥ 46.0	61.1	54.7	49.7	51.3
	Mixed sex accommodation breaches	0	0	0	0	0
Well-led	Friends and Family Test: Inpatient response rate	By Q1: ≥ 25% By Q4: ≥ 30%	30.0%	47.1%	46.8%	40.6%
	Friends and Family Test: A&E response rate	By Q1: ≥ 15% By Q4: ≥ 20%	30.5%	28.2%	24.1%	20.7%
	NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	≥ 61%	2013: 51.0%			
	NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	≥ 67%	2013: 58.0%			
	Staff turnover (12 months rolling average)	n/app	10.5%	10.5%	10.5%	n/app
	Sickness/absence rate (12 months rolling average)	n/app	4.1%	4.1%	4.1%	n/app
	Staff In Post (FTE)	n/app	13,655	13,721	13,830	n/app
	% staff appraised[2]	n/app	96.1%	96.3%	95.6%	n/app

	Indicators Awaiting Clarification:					
Safe	Patient Safety events that are harmful	TBC				
Caring	Complaints: rate per 10,000 occupied bed days [3]	TBC	11.7	13.9	13.3	13.9
	Inpatient Survey 2013, Q68: Overall, I had a very poor/good experience	TBC	7.9 ("average")			
Well-led	Data quality of returns to HSCIC	TBC				
	Variable staffing spend as proportion of overall pay spend	TBC	12.1%	10.0%	13.1%	n/app

Section 5

Financial statement for 2014-15

Accounts for 2014-15

5.1 Independent Auditor's Report to the Directors of the Leeds Teaching Hospitals NHS Trust

We have audited the financial statements of The Leeds Teaching Hospitals NHS Trust for the year ended 31 March 2015 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, theStatement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of The Leeds Teaching Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report which comprises the Chair's and Chief Executive's statement, the Trust's highlights of the year, the operating and financial review, the Directors' report and the section on Patient care and experience to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of The Leeds Teaching Hospitals NHS Trust as at 31 March 2015 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We are required to report if we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 26 May 2015, we referred two matters to the Secretary of State under section 19 of the Audit Commission Act 1998 in relation to:

- the Trust's outturn deficit for 2014/15, and approval of a financial plan which includes budgeted deficits in 2015/16 and 2016/17 and a forecast breakeven position in 2017/18. Over this three year period, the financial plan includes a planned cumulative deficit of £90 million, as a result of which, the Trust will fail to achieve its three year statutory breakeven duty;
- payments to two non-executive directors which breached the maximum remuneration set by the Secretary of State for Health.

We report to you if:

- in our opinion the governance statement does not reflect compliance with the NHS Trust Development Authority's Guidance; or
- we issue a report in the public interest under section 8 of the Audit CommissionAct 1998.

We have nothing to report in these respects.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

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

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial resilience, we identified the following matter:

- The Trust delivered a deficit of £24.4 million in 2014-15 (after receipt of £14 million of non-recurrent provider deficit funding) and is projecting a deficit of £40.2 million for 2015-16. The actual and planned deficits are evidence of weaknesses in arrangements in respect of the Trust's strategic financial planning. The deficit plans in both years have been agreed with relevant stakeholders and include the provision of additional cash support and liquidity requirements.

Qualified Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that in all significant respects The Leeds Teaching Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of The Leeds Teaching Hospitals NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Phil Jones

for and on behalf of Grant Thornton UK LLP, Appointed Auditor

No1 Whitehall Riverside
Leeds
LS1 4BN
28 May 2015

5.2 The Leeds Teaching Hospitals NHS Trust - Annual Accounts 2014-15

Statement of comprehensive income for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Gross employee benefits	10.1	**(632,102)**	(599,030)
Other operating costs	8	**(452,179)**	(422,624)
Revenue from patient care activities	5	**925,514**	875,760
Other Operating revenue	6	**161,124**	169,156
Operating surplus		**2,357**	**23,262**
Investment revenue	12	**111**	87
Other gains and (losses)	13	**112**	53
Finance costs	14	**(12,438)**	(12,759)
(Deficit)/surplus for the financial year		**(9,858)**	10,643
Public dividend capital dividends payable		**(10,130)**	(10,147)
Retained (deficit)/surplus for the year		**(19,988)**	**496**
Other Comprehensive Income			
Net (loss)/gain on revaluation of property, plant & equipment		**(4,558)**	5,050
On disposal of available for sale financial assets		**0**	(5,050)
Total Comprehensive Income for the year		**(24,546)**	**496**
Financial performance for the year			
Retained (deficit)/surplus for the year		**(19,988)**	496
IFRIC 12 adjustment (including IFRIC 12 impairments)		**5,243**	969
Impairments (excluding IFRIC 12 impairments)		**(8,140)**	0
Adjustments in respect of donated gov't grant asset reserve elimination		**(1,501)**	150
Adjusted retained (deficit)/surplus		**(24,386)**	**1,615**

The Trust's financial performance for the year is derived from its retained deficit which is adjusted to take account of the revenue implications of bringing its PFI assets onto the Statement of Financial Position, in line with International Financial Reporting Standards, from 2009/10. HM Treasury guidelines require the Trust's financial position to be aligned with how wider government departmental expenditure is measured. The revenue implications arising from bringing the PFI schemes onto the Statement of Financial Position are therefore excluded from the Trust's reported financial position.

Impairments arising from estate valuation falls are similarly excluded from the reported financial position as a technical adjustment. In 2014/15 the Trust commissioned a full valuation of its entire estate from an independent valuer. See Note 15.3

The retained deficit is adjusted to take account of the costs of a change in the national accounting treatment of donated assets (Note 1.11). The cost represents the difference in value between depreciation on donated assets which, until 2011/12, was funded from a reserve account and donations credited to income in the year which, until 2011/12, were credited to the reserve.

The notes on pages 175 to 211 form part of these financial statements.

Statement of financial position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	15	**615,948**	598,468
Intangible assets	16	**2,225**	840
Trade and other receivables	21.1	**11,165**	11,615
Total non-current assets		**629,338**	610,923
Current assets:			
Inventories	20	**17,484**	17,635
Trade and other receivables	21.1	**61,955**	48,141
Cash & cash equivalents	22	**3,298**	23,236
Total current assets		**82,737**	89,012
Non-current assets held for sale	23	**0**	0
Total current assets		**82,737**	89,012
Total assets		**712,075**	699,935
Current liabilities			
Trade and other payables	24	**(89,469)**	(93,923)
Provisions	28	**(2,292)**	(3,172)
Borrowings	25	**(4,702)**	(4,459)
DH capital loan	25	**(4,927)**	(3,356)
Total current liabilities		**(101,390)**	(104,910)
Net current (liabilities)		**(18,653)**	(15,898)
Total assets less current liabilities		**610,685**	595,025
Non-current liabilities			
Trade and other payables	24	**(2,109)**	(2,315)
Provisions	28	**(5,679)**	(5,517)
Borrowings	25	**(198,069)**	(202,771)
DH capital loan	25	**(44,715)**	(38,642)
Total non-current liabilities		**(250,572)**	(249,245)
Total assets employed:		**360,113**	345,780
Financed by:			
Public Dividend Capital		**332,833**	293,954
Retained earnings		**(49,978)**	(29,990)
Revaluation reserve		**77,258**	81,816
Total Taxpayers' Equity:		**360,113**	345,780

The notes on pages 175 to 211 form part of these financial statements.

The financial statements on pages 171 to 211 were approved by the Board on 28th May 2015 and signed on its behalf by Julian Hartley, Chief Executive.

Statement of changes in taxpayers' equity for the year ended 31 March 2015

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2014	**293,954**	**(29,990)**	**81,816**	**345,780**
Changes in taxpayers' equity for 2014-15				
Retained (deficit) for the year	0	(19,988)	0	(19,988)
Net (loss) on revaluation of property, plant, equipment	0	0	(4,558)	(4,558)
New temporary and permanent PDC received - cash	68,679	0	0	68,679
New temporary PDC repaid in year	(29,800)	0	0	(29,800)
Net recognised revenue/(expense) for the year	**38,879**	**(19,988)**	**(4,558)**	**14,333**
Balance at 31 March 2015	**332,833**	**(49,978)**	**77,258**	**360,113**
Balance at 1 April 2013	**290,811**	**(35,536)**	**81,816**	**337,091**
Changes in taxpayers' equity for 2013-14				
Retained surplus for the year	0	496	0	496
Net gain on revaluation of property, plant, equipment	0	0	5,050	5,050
On disposal of available for sale financial assets	0	0	(5,050)	(5,050)
New permanent PDC received - cash	3,143	0	0	3,143
Other movements	0	5,050	0	5,050
Net recognised revenue for the year	**3,143**	**5,546**	**0**	**8,689**
Balance at 31 March 2014	**293,954**	**(29,990)**	**81,816**	**345,780**

Statement of cash flows for the year ended 31 March 2015

	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities		
Operating surplus	**2,357**	23,262
Depreciation and amortisation	**21,658**	31,842
Impairments and (reversals)	**(2,897)**	0
Interest paid	**(12,437)**	(12,763)
Dividend paid	**(10,370)**	(10,014)
Decrease/(increase) in inventories	**151**	(959)
(Increase) in trade and other receivables	**(14,417)**	(17,282)
(Decrease)/increase in trade and other payables	**(6,825)**	10,053
Provisions utilised	**(2,775)**	(1,269)
Increase in movement in non cash provisions	**2,057**	1,614
Net cash (outflow)/inflow from Operating Activities	**(23,498)**	24,484
Cash Flows From Investing Activities		
Interest received	**111**	87
(Payments) for property, plant and equipment	**(37,229)**	(26,704)
(Payments) for intangible assets	**(1,655)**	(340)
Proceeds of disposal of assets held for sale (PPE)	**269**	5,607
Net cash (outflow) from Investing Activities	**(38,504)**	(21,350)
Net cash (outflow)/inflow before Financing	**(62,002)**	3,134
Cash Flows From Financing Activities		
Gross temporary and permanent PDC received	**68,679**	3,143
Gross temporary and permanent PDC repaid	**(29,800)**	0
Loans received from DH - New Capital Investment Loans	**11,000**	0
Loans repaid to DH - Capital Investment Loans repayment of principal	**(3,356)**	(3,356)
Capital element of payments in respect of finance leases and on-SoFP PFI	**(4,459)**	(4,228)
Capital grants and other capital receipts	**0**	195
Net Cash Inflow/(Outflow) from Financing Activities	**42,064**	(4,246)
Net (Decrease) in Cash And Cash Equivalents	**(19,938)**	(1,112)
Cash and Cash Equivalents at 01 April 2014	**23,236**	24,348
Cash and Cash Equivalents at 31 March 2015	**3,298**	23,236

5.3 Note to the Accounts

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health's Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the financial statements.

1.1 Accounting convention

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

1.2 Going concern

The Trust prepares its financial statements on the basis that for the foreseeable future it will remain a going concern. This policy is reviewed each year by the Directors who consider the financial position and other evidence to determine whether or not it is appropriate to continue to adopt the going concern basis in preparing the financial statements. See note 36.1.

1.3 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. The Trust does not have control over any charitable funds. The Leeds Teaching Hospitals Charitable Foundation is independently managed by its own Trustees and prepares its own financial statements. There is therefore no consolidation.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.41 Critical judgements in applying accounting policies

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

Bexley Wing and Wharfedale Hospital, constructed under the Private Finance

Initiative (PFI), meet the criteria for inclusion in the financial statements as Finance Leases as the Trust bears the risks and rewards of ownership. See paragraphs 1.14 Leases and 1.15 PFI transactions.

1.42 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Plant, Property and Equipment - Para. 1.8 and Note 15
- Provision for Impairment of Receivables - Note 21
- Provisions - Para 1.18 and Note 28

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

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

Goods are sold on an incidental basis. Income is recognised at the point the sale transaction occurs.

1.6 Employee benefits

1.61 Short-term employee benefits

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.62 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust provides certain employees, who are not enrolled into the NHS Pensions Scheme, with cover from the defined contributions scheme which is managed by the National Employment Savings Trust (NEST). The cost to the Trust is taken as equal to the contributions payable to the scheme for the accounting period.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow, or service potential will be supplied, to the Trust;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. In the Trust's case no alternative site has been sought and the valuation covers all of the existing hospital sites.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it

reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets

1.91 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use
- The intention to complete the intangible asset and use it
- The ability to sell or use the intangible asset
- How the intangible asset will generate probable future economic benefits or service potential
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.92 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

"Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval."

1.11 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.14 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

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

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

1.15 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession

arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the Trust through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.17 Cash and cash equivalents

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

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

1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of -1.5% in real terms (1.3% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 28.

1.20 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefit is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into Loans and Receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, or failing that by reference to similar arms length transactions between knowledgeable and willing parties.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are

impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.24 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.25 Value Added Tax

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

1.26 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.27 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 37 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC

to, and require repayments of PDC from the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.29 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS bodies not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 Joint arrangements

Material entities over which the NHS Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

1.31 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.32 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

- IFRS 9 Financial Instruments - subject to consultation
- IFRS 13 Fair Value Measurement - subject to consultation
- IFRS 15 Revenue from Contracts with Customers.

2. Pooled budgets

The Trust had no pooled budgets in 2014/15 or in the previous year.

3. Operating segments

The Trust engages in its activity as a single operating segment i.e. the provision of healthcare. Financial results are reported under the single segment of healthcare. Whilst internally the Trust operates via 19 clinical service units, they each provide essentially the same service (patient care) and face fundamentally the same risks.

The main source of revenue for the Trust is from commissioners of healthcare services which are principally NHS England and Clinical Commissioning Groups (CCGs). The Department of Health has deemed that as NHS England and CCGs are under common control, they are classed as a single customer for the purpose of segmental analysis. No other customer generates in excess of 10% of total revenue.

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. None of these schemes exceed £1 million nor are they otherwise material.

5. Revenue from patient care activities

	2014-15 £000	2013-14 £000
NHS England	**439,566**	411,423
Clinical Commissioning Groups	**456,501**	450,126
NHS Other (including Public Health England and Prop Co)	**1,853**	1,918
Additional income for delivery of healthcare services	**14,000**	0
Non-NHS:		
Local Authorities	**4,197**	4,268
Private patients	**4,832**	4,060
Overseas patients (non-reciprocal)	**656**	335
Injury costs recovery	**3,309**	2,948
Other	**600**	682
Total revenue from patient care activities	**925,514**	**875,760**

The £14 million additional income for delivery of healthcare services was a payment of non recurrent provider deficit funding from the Trust Development Authority.

6. Other operating revenue

	2014-15 £000	2013-14 £000
Recoveries in respect of employee benefits	**9,057**	9,327
Education, training and research	**102,026**	108,765
Charitable and other contributions to revenue expenditure - NHS	**1,102**	1,087
Charitable and other contributions to revenue expenditure - non NHS	**941**	1,020
Receipt of donations for capital acquisitions - Charity	**2,824**	1,223
Non-patient care services to other bodies	**36,916**	36,613
Rental revenue from operating leases	**681**	658
Other revenue	**7,577**	10,463
Total other operating revenue	**161,124**	169,156
Total operating revenue	**1,086,638**	1,044,916

7. Overseas visitors disclosure

	2014-15 £000	2013-14 £000
Income recognised during 2014-15 (invoiced amounts and accruals)	**656**	335
Cash payments received in-year (re receivables at 31 March 2014)	**11**	270
Cash payments received in-year (iro invoices issued 2014-15)	**281**	60
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**291**	182
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	**73**	10
Amounts written off in-year (irrespective of year of recognition)	**194**	212

8. Operating expenses

	2014-15 £000	2013-14 £000
Purchase of healthcare from non-NHS bodies	**11,849**	8,309
Trust Chair and Non-executive Directors	**89**	91
Supplies and services - clinical	**302,187**	263,281
Supplies and services - general	**8,705**	8,803
Consultancy services	**1,161**	2,208
Establishment	**8,009**	7,380
Transport	**3,084**	3,146
Service charges - on-SoFP PFIs and other service concession arrangements	**14,911**	12,195
Business rates paid to local authorities	**4,574**	3,986
Premises	**37,807**	34,773
Hospitality	**154**	217
Insurance	**1,069**	1,134
Legal fees	**663**	502
Impairments and reversals of receivables	**1,401**	774
Inventories write down	**0**	498
Depreciation	**21,388**	31,636
Amortisation	**270**	206
Impairments and reversals of property, plant and equipment	**(2,897)**	0
Audit fees	**160**	162
Other auditor's remuneration - quality accounts	**12**	0
Clinical Negligence Scheme for Trusts - membership contribution	**19,296**	17,006
Education and training	**3,202**	3,143
Change in discount rate	**112**	112
Other	**14,973**	23,062
Sub total	**452,179**	422,624
Employee benefits		
Employee benefits excluding Board members	**630,686**	597,689
Board members	**1,416**	1,341
Total employee benefits	**632,102**	599,030
Total operating expenses	**1,084,281**	1,021,654

9. Operating leases

The Trust has operating leases for items of medical equipment, vehicles and short term property lets. None of these are individually significant. The amounts recognised in the financial statements are:

9.1 Trust as lessee

	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payments recognised as an expense				
Minimum lease payments			**7,859**	6,532
Payable				
No later than one year	1,295	3,489	**4,784**	5,093
Between one and five years	3,502	3,224	**6,726**	7,652
After five years	3,139	75	**3,214**	2,532
Total	**7,936**	**6,788**	**14,724**	15,277

9.2 Trust as lessor

The generating station complex at the Leeds General Infirmary is leased to a third party supplier under the terms of a power generation agreement. The lease has a twenty year term, due to expire in 2015. Annual income is £250k. Other leases relate to various retail facilities provided across the Trust's sites. The lease of the retail facilities at Leeds General Infirmary expires in 2015.

	2014-15 £000	2013-14 £000
Recognised as revenue		
Rental revenue	**681**	658
Receivable:		
No later than one year	**246**	662
Between one and five years	**688**	750
After five years	**2,339**	2,450
Total	**3,273**	3,862

10 Employee benefits and staff numbers

10.1 Employee benefits

	Total £000	Permanently employed £000	Other £000
Employee benefits - Gross expenditure 2014-15			
Salaries and wages	**539,718**	473,032	66,686
Social security costs	**35,687**	35,687	0
Employer contributions to NHS BSA - Pensions Division	**56,089**	56,089	0
Other pension costs	**1,442**	1,442	0
Termination benefits	**55**	55	0
Total employee benefits	**632,991**	566,305	66,686
Employee costs capitalised	**889**	889	0
Gross employee benefits excluding capitalised costs	**632,102**	**565,416**	**66,686**

Employee benefits - Gross expenditure 2013-14			
Salaries and wages	**509,481**	473,305	36,176
Social security costs	**35,078**	35,078	0
Employer contributions to NHS BSA - Pensions Division	**55,011**	55,011	0
Other pension costs	**193**	193	0
Termination benefits	**455**	455	0
Total - including capitalised costs	**600,218**	564,042	36,176
Employee costs capitalised	**1,188**	1,188	0
Gross employee benefits excluding capitalised costs	**599,030**	**562,854**	**36,176**

10.2 Staff numbers

	2014-15 Total number	Permanently employed number	Other number	2013-14 Total number
Average staff numbers				
Medical and dental	**1,922**	1,831	91	1,893
Administration and estates	**2,447**	2,047	400	2,311
Healthcare assistants and other support staff	**3,023**	2,789	234	2,872
Nursing, midwifery and health visiting staff	**4,017**	3,778	239	3,848
Nursing, midwifery and health visiting learners	**9**	9	0	13
Scientific, therapeutic and technical staff	**2,656**	2,559	97	2,555
Social care staff	**12**	12	0	14
Other	**401**	392	9	383
Total	**14,487**	**13,417**	**1,070**	**13,889**
Of the above - staff engaged on capital projects	**19**	19	0	23

10.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total days lost	123,022	123,434
Total staff years	13,225	13,028
Average working days lost	9.30	9.47

Number of persons retired early on ill health grounds	25	20

	2014-15 £000	2013-14 £000
Total additional pensions liabilities accrued in the year	1,238	1,579

10.4 Exit packages agreed

	2014-15			2013-14		
	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages by cost band Number	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages by cost band Number
Exit package cost band (including any special payment element)						
£25,001-£50,000	0	0	0	0	1	1
£50,001-£100,000	1	0	1	0	2	2
£100,001 - £150,000	0	0	0	0	1	1
£150,001 - £200,000	0	0	0	0	1	1
Total number of exit packages by type (total cost)	1	0	1	0	5	5
Total resource cost (£s)	54,935	0	54,935	0	543,712	543,712

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

10.5 Exit packages - other departures analysis

	2014-15		2013-14	
	Agreements Number	Total value of agreements £000	Agreements Number	Total value of agreements £000
Early retirements in the efficiency of the service contractual costs	0	0	1	88
Contractual payments in lieu of notice	0	0	4	456
Total	**0**	**0**	5	544

These disclosures reports the number and value of exit packages agreed in the year. All expenses associated with these departures are recognised in full in the same financial year as the packages are agreed.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that report.

10.6 Pension costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience) and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

10.7 Pension costs - Other scheme

Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme.

NEST is a defined contribution scheme managed by a third party organisation. It carries no possibility of actuarial gain or loss to the Trust and there are no financial liabilities other than payment of the 1% employers contribution of qualifying earnings. This contribution will increase to 2% in October 2017 and 3% in 2018. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. At 31st March there were 122 employees enrolled in the scheme. Further details of the scheme can be found at www.nestpensions.org.uk.

11 Better Payment Practice Code

11.1 Measure of compliance

	2014/15 Number	2014/15 £000	2013/14 Number	2013/14 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**232,738**	**526,444**	209,644	416,828
Total non-NHS trade invoices paid within target	**208,856**	**459,267**	140,055	274,411
Percentage of non-NHS trade invoices paid within target	**90%**	**87%**	67%	66%
NHS payables				
Total NHS trade invoices paid in the year	**6,345**	**60,328**	6,023	50,641
Total NHS trade invoices paid within target	**3,835**	**47,695**	881	7,464
Percentage of NHS trade invoices paid within target	**60%**	**79%**	15%	15%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust has not made any payments under the terms of this legislation in either the current or preceding financial years.

12 Investment revenue

	2014-15 £000	2013-14 £000
Interest revenue		
Bank interest receivable	**111**	87

13. Other gains and losses

	2014-15 £000	2013-14 £000
Interest revenue		
Gain on disposal of assets held for sale (note 23)	**112**	53

14. Finance costs

	2014-15 £000	2013-14 £000
Interest		
Interest on loans and overdrafts	**1,189**	1,272
Interest on obligations under finance leases	**9**	10
Interest on obligations under PFI contracts: main finance cost	**11,203**	11,433
Total interest expense	**12,401**	12,715
Provisions - unwinding of discount	**37**	44
Total	**12,438**	12,759

15.1 Property, plant and equiment 2014-15

2014/15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation:									
At 1 April 2014	20,475	565,739	3,583	12,083	184,032	884	45,311	1,387	833,494
Additions of assets under construction	0	0	0	11,295	0	0	0	0	11,295
Additions purchased	0	3,997	0		14,941	0	7,680	0	26,618
Additions - Purchases from cash donations	0	180	0	35	2,144	0	414	0	2,773
Reclassifications	0	1,594	0	(4,061)	0	0	2,467	0	0
Reclassifications as held for sale and reversals	0	0	0	0	(1,037)	0	0	0	(1,037)
Revaluation	0	(3,327)	(1,231)	0	0	0	0	0	(4,558)
At 31 March 2015	20,475	568,183	2,352	19,352	200,080	884	55,872	1,387	868,585
Depreciation:									
At 1 April 2014	0	50,772	437	0	147,776	818	33,924	1,299	235,026
Reclassifications as held for sale and reversals	0	0	0	0	(880)	0	0	0	(880)
Impairments	0	8,356	0	0	0	0	0	0	8,356
Reversal of impairments charged to operating expenses	(639)	(10,614)	0	0	0	0	0	0	(11,253)
Charged during the year	0	8,641	36	0	8,822	22	3,797	70	21,388
At 31 March 2015	(639)	57,155	473	0	155,718	840	37,721	1,369	252,637
Net Book Value at 31 March 2015	21,114	511,028	1,879	19,352	44,362	44	18,151	18	615,948

2014/15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Asset financing:									
Owned - Purchased	21,114	341,947	1,879	19,317	29,460	44	17,732	18	431,511
Owned - Donated	0	10,931	0	35	5,079	0	419	0	16,464
Held on finance lease	0	649	0	0	0	0	0	0	649
On-SoFP PFI contracts	0	157,501	0	0	9,823	0	0	0	167,324
Total at 31 March 2015	21,114	511,028	1,879	19,352	44,362	44	18,151	18	615,948

2014/15	Land £000	Buildings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Revaluation reserve balance for property, plant & equipment									
At 1 April 2014	310	74,220	0	0	5,953	14	364	955	81,816
Movements (impairments)	0	(4,558)	0	0	0	0	0	0	(4,558)
At 31 March 2015	310	69,662	0	0	5,953	14	364	955	77,258

Additions to assets under construction in 2014-15									
Buildings exc. dwellings				11,295					

15.2 Property, plant and equiment 2013-14

2013/14	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation:									
At 1 April 2013	20,475	549,813	3,583	7,891	179,516	884	44,412	1,437	808,011
Additions of assets under construction	0	0	0	10,470	0	0	0	0	10,470
Additions purchased	0	9,663	0		6,479	0	898	0	17,040
Additions - Purchases from cash donations	0	0	0	0	1,200	0	0	0	1,200
Reclassifications	0	6,263	0	(6,278)	0	0	15	0	0
Reclassifications as held for sale and reversals	(5,050)	0	0	0	(3,163)	0	(14)	(50)	(8,277)
Upward revaluation	5,050	0	0	0	0	0	0	0	5,050
At 31 March 2014	20,475	565,739	3,583	12,083	184,032	884	45,311	1,387	833,494
Depreciation:									
At 1 April 2013	0	32,929	292	0	140,743	796	30,093	1,260	206,113
Reclassifications as held for sale and reversals	0	0	0	0	(2,659)	0	(14)	(50)	(2,723)
Charged during the year	0	17,843	145		9,692	22	3,845	89	31,636
At 31 March 2014	0	50,772	437	0	147,776	818	33,924	1,299	235,026
Net Book Value at 31 March 2014	20,475	514,967	3,146	12,083	36,256	66	11,387	88	598,468
Asset financing:									
Owned - Purchased	20,475	338,201	3,146	12,083	21,215	66	11,376	88	406,650
Owned - Donated	0	11,738	0	0	4,143	0	11	0	15,892
Held on finance lease	0	146	0	0	0	0	0	0	146
On-SoFP PFI contracts	0	164,882	0	0	10,898	0	0	0	175,780
Total at 31 March 2014	20,475	514,967	3,146	12,083	36,256	66	11,387	88	598,468

15.3 Property, plant and equiment

All land and building assets were revalued as at 1st April 2014 by an independent, qualified valuer at depreciated replacement cost using the Modern Equivalent Asset (MEA) approach (Note 1.8). In assessing values, regard was given to various factors, including physical and functional obsolence of buildings and where active markets exist, e.g. land and residences, sales comparison. To assess fair value at the balance sheet date of 31 March 2015 a further exercise was undertaken by the valuer to assess movement in building cost indices since 1st April 2014 and the impact of capital expenditure during the year. The results of this subsequent assessment of value were not considered sufficiently material to warrant changing carrying values.

As part of their inspection and assessment of Trust buildings the valuers advised changes to asset lives. These changes were accepted by the Trust. Building lives which had previously ranged from 23 to 43 years now vary between 1 and 88 years. The average life of a building in the Trust's estate has increased from 29 to 53 years.

Property, plant and equipment assets are depreciated over their useful economic lives. The Trust applies the following standard lives to these classes of assets.

	Min life years	Max life years
Buildings (including dwellings)	1	88
Plant and machinery	5	15
Transport equipment	5	10
Information technology	5	10
Furniture and fittings	5	5

During the year the Trust received donated assets from the following:

	2014-15 £000	2013-14 £000
Interest		
Leeds Teaching Hospitals Charitable Foundation	**1,857**	976
Children's Heart Surgery Fund	**207**	215
Take Heart	**0**	20
Yorkshire Cancer Centre	**68**	0
Macmillan Cancer Support	**66**	0
British Heart Foundation	**113**	0
Others	**513**	12
Total	**2,824**	1,223

16.1 Intangible non-current assets

2014/15	IT - in-house and 3rd party software £000	Computer licenses £000	Total £000
Cost or valuation:			
At 1 April 2014	2,640	704	3,344
Additions - purchased	1,395	209	1,604
Additions - purchases from cash donations	20	31	51
At 31 March 2015	4,055	944	4,999
Amortisation:			
At 1 April 2014	2,367	137	2,504
Charged during the year	102	168	270
At 31 March 2015	2,469	305	2,774
Net Book Value at 31 March 2015	1,586	639	2,225
Asset financing:			
Purchased	1,539	611	2,150
Donated	47	28	75
Total at 31 March 2015	1,586	639	2,225

16.2 Intangible non-current assets

2013/14	IT - in-house and 3rd party software £000	Computer licenses £000	Total £000
Cost or valuation:			
At 1 April 2013	2,608	397	3,005
Additions - purchased	9	307	316
Additions - donated	23	0	23
At 31 March 2014	2,640	704	3,344
Amortisation:			
At 1 April 2013	2,281	17	2,298
Charged during the year	86	120	206
At 31 March 2014	2,367	137	2,504
Net Book Value at 31 March 2014	273	567	840
Asset financing:			
Purchased	233	567	800
Donated	40	0	40
Total at 31 March 2014	273	567	840

16.3 Intangible non-current assets

The Trust's intangible assets are not considered sufficiently material to warrant revaluation. They have been measured at historic cost less amortisation (Note 1.9). Carrying amount if assets had been held at historic cost would be £4,999k.

Intangible assets are amortised over their useful economic lives which are all judged to be finite. The Trust applies the following standard lives to these classes of assets.

	Min life years	Max life years
IT - in house & 3rd party software	5	5
Computer licenses	5	5
Licences and trademarks	5	5

17 Analysis of impairments and reversals recognised in 2014-15

	Total £000	Property, plant and equipment £000
Property, plant and equipment impairments and reversals taken to SoCI		
Loss or damage resulting from normal operations	0	0
Over-specification of assets	0	0
Abandonment of assets in the course of construction	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	(2,897)	(2,897)
Total charged to Annually Managed Expenditure	**(2,897)**	**(2,897)**
Total impairments charged to SoCI - DEL	**0**	**0**
Total impairments charged to SoCI - AME	**(2,897)**	**(2,897)**
Overall total impairments	**(2,897)**	**(2,897)**

All impairments relate to changes in the value of estate assets as a result of the valuation exercise. (Note 15.3)

18. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2015 £000	31 March 2014 £000
Property, plant and equipment	**7,015**	11,591
Intangible assets	**268**	364
Total	**7,283**	11,955

19 Intra-government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
2014-15				
Balances with other Central Government Bodies	2,238	0	20,093	0
Balances with Local Authorities	407	0	157	0
Balances with NHS bodies outside the Departmental Group	396	0	292	0
Balances with NHS bodies inside the Departmental Group	33,688	0	11,147	44,715
Balances with Public Corporations and Trading Funds	0	0	469	0
Balances with bodies external to Government	25,226	11,165	66,940	200,178
At 31 March 2015	**61,955**	**11,165**	**99,098**	**244,893**

2013-14				
Balances with other Central Government Bodies	24,503	0	22,549	0
Balances with Local Authorities	0	0	302	0
Balances with NHS bodies outside the Departmental Group	232	0	99	0
Balances with NHS Trusts and Foundation Trusts	5,165	0	4,882	0
Balances with Public Corporations and Trading Funds	0	0	1,709	0
Balances with bodies external to Government	18,271	11,585	64,382	2,315
At 31 March 2014	**48,171**	**11,585**	**93,923**	**2,315**

20. Inventories

	Drugs £000	Consumables £000	Energy £000	Total £000
Balance at 1 April 2014	**7,045**	**10,407**	**183**	**17,635**
Additions	151,834	98,507	206	250,547
Inventories recognised as an expense in the period	(151,664)	(98,912)	(122)	(250,698)
Balance at 31 March 2015	**7,215**	**10,002**	**267**	**17,484**

21.1 Trade and other receivables

	Curent		Non-current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
NHS receivables - revenue	**29,800**	27,609	**0**	0
NHS prepayments and accrued income	**4,079**	0	**0**	0
Non-NHS receivables - revenue	**12,678**	7,112	**0**	0
Non-NHS receivables - capital	**291**	0	**0**	0
Non-NHS prepayments and accrued income	**6,284**	5,486	**0**	0
PDC Dividend prepaid to DH	**205**	0	**0**	0
Provision for the impairment of receivables	**(2,744)**	(1,726)	**(654)**	(559)
VAT	**1,956**	2,021	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**3,329**	1,905	**8,357**	8,640
Other receivables	**6,077**	5,734	**3,462**	3,534
Total	**61,955**	48,141	**11,165**	11,615
Total current and non current	**73,120**	59,756		

The great majority of trade is with NHS England and Clinical Commissioning Groups. As NHS bodies are funded by Government to buy NHS patient care services, credit scoring of them is not considered necessary.

21.2 Receivables past their due date but not impaired

	31 March 2015 £000	31 March 2014 £000
By up to three months	**5,881**	1,992
By three to six months	**264**	324
By more than six months	**499**	824
Total	**6,644**	3,140

All receivables are reviewed regularly throughout the year to assess their credit risk. Those which are neither past due nor subject to impairment are deemed to represent a low risk of default.

21.3 Provision for impairment of receivables

	31 March 2015 £000	31 March 2014 £000
Balance at 1 April 2014	**(2,285)**	(1,767)
Amount written off during the year	**288**	256
Increase in receivables impaired	**(1,401)**	(774)
Balance at 31 March 2015	**(3,398)**	(2,285)

Receivables are impaired when there is evidence to indicate that the Trust may not recover sums due. This can be on the basis of legal advice, insolvency of debtors or other economic factors. Impaired receivables are only written off when all possible means of recovery have been attempted. The nature of the Trust's business generally means that no collateral is held against outstanding receivables.

22. Cash and cash equivalents

	31 March 2015 £000	31 March 2014 £000
Balance at 1 April 2014	23,236	24,348
Net change in year	(19,938)	(1,112)
Balance at 31 March 2015	3,298	23,236
Comprising:		
Cash with Government Banking Service	3,221	23,094
Commercial banks	60	125
Cash in hand	17	17
Cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows	3,298	23,236
Patients' money held by the Trust, not included above (note 37)	17	5

23. Non-current assets held for sale

	Land £000	Plant & Machinery £000	Total £000
Balance at 1 April 2014	0	0	0
Plus assets classified as held for sale in the year	0	157	157
Less assets sold in the year	0	(157)	(157)
Balance at 31 March 2015	0	0	0
Balance at 1 April 2013	0	0	0
Plus assets classified as held for sale in the year	5,050	504	5,554
Less assets sold in the year	(5,050)	(504)	(5,554)
Balance at 31 March 2014	0	0	0

The Trust purchased a paediatric surgical robot during the year to replace an obsolete model which was part exchanged. The machine disposed of accounts for £150k of the sales in the year with the balance being for minor items of equipment sold. The sales realised a total profit of £112k (Note 13).

24. Trade and other payables

	Curent		Non-current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
NHS payables - revenue	**3,534**	5,751	**0**	0
NHS accruals and deferred income	**2,978**	2,430	**0**	0
Non-NHS payables - revenue	**29,786**	41,189	**0**	0
Non-NHS payables - capital	**7,152**	4,953	**0**	0
Non-NHS accruals and deferred income	**24,577**	19,737	**2,109**	2,315
Social security costs	**5,626**	5,482	**0**	0
PDC Dividend payable to DH	**0**	35	**0**	0
Tax	**6,320**	6,131	**0**	0
Other payables	**9,496**	8,215	**0**	0
Total	**89,469**	93,923	**2,109**	2,315
Total current and non current	**91,578**	96,238		
Included above:				
Outstanding pension contributions at the year end	**8,144**	7,735		

25. Borrowings

	Curent		Non-current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Loans from Department of Health	**4,927**	3,356	**44,715**	38,642
PFI liabilities - Main liability	**4,665**	4,423	**197,622**	202,287
Finance lease liabilities	**37**	36	**447**	484
Total	**9,629**	7,815	**242,784**	241,413
Total other liabilities (current and non-current)	**252,413**	249,228		

Borrowings / Loans - repayment of principal falling due in:			
31 March 2015	DH £000	Other £000	Total £000
0 - 1 years	4,927	4,702	**9,629**
1 - 2 years	4,627	4,957	**9,584**
2 - 5 years	13,880	21,950	**35,830**
Over 5 years	26,208	171,162	**197,370**
Total	**49,642**	**202,771**	**252,413**

The loans from the Department of Health are Capital Investment Loans. Other loans consist of PFI liabilities and a finance lease. (Notes 27 and 30)

26. Deferred revenue

	Curent		Non-current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Opening balance at 1 April 2014	**4,358**	1,756	**2,376**	2,154
Deferred revenue addition	**2,810**	3,858	**1,222**	1,232
Transfer of deferred revenue	**(1,322)**	(1,256)	**(1,307)**	(1,010)
Current deferred Income at 31 March 2015	**5,846**	4,358	**2,291**	2,376
Total deferred income (current and non-current)	**8,137**	6,734		

27. Finance lease obligations as lessee

Finance lease obligations relate to the Catering Receipt and Distribution Unit (RADU) at Seacroft Hospital. The unit was constructed in 2002 by a private partner and will revert to Trust ownership upon expiry of the lease in 2027. The arrangement has been determined as a finance lease on the grounds that the Trust has the substantive risks and rewards associated with control of the facility. Accounting treatment is in line with the policy described in note 1.14.

	Minimum lewase payments		Present value of minimum lease payments	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Within one year	**45**	45	**37**	36
Between one and five years	**179**	179	**153**	150
After five years	**313**	358	**294**	334
Less future finance charges	**(53)**	(62)	**0**	0
Minimum lease payments / Present value of minimum lease payments	**484**	520	**484**	520
Included in:				
Current borrowings			**37**	36
Non-current borrowings			**447**	484
			484	520

28. Provisions

	Total £000	Early departure Costs £000	Legal claims £000	Other £000
Balance at 1 April 2014	**8,689**	4,550	473	3,666
Arising during the year	**2,064**	1,624	284	156
Utilised during the year	**(2,775)**	(366)	(315)	(2,094)
Reversed unused	**(156)**	0	(19)	(137)
Unwinding of discount	**37**	37	0	0
Change in discount rate	**112**	112	0	0
Balance at 31 March 2015	**7,971**	**5,957**	**423**	**1,591**

Expected timing of cash flows::				
No later than one year	**2,292**	370	331	1,591
Later than one year and not later than five years	**1,572**	1,480	92	0
Later than five years	**4,107**	4,107	0	0

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:				
As at 31 March 2015	**164,851**			
As at 31 March 2014	161,769			

Early Departure costs represent amounts payable to the NHS Business Services Authority - Pensions Division to meet the costs of early retirements and industrial injury benefits. Amounts are determined by the NHS Business Services Authority - Pensions Division based on actuarial estimates of life expectancy and there is therefore, a degree of uncertainty regarding the value of future payments.

Legal claims relate to personal injury and other claims where the Trust has received advice that settlement is probable. The final amounts and timings of payments remain subject to negotiation or legal judgement. Included are claims with a value of £258k (£273k in 2013/14) which are being handled on behalf of the Trust by the NHS Litigation Authority who have advised on their status. The reversal of unused legal claims relates to provisions against disputes which are now subject to formal settlement offers from the claimants.

Other provisions include those for employment related claims where the Trust disputes liability but recognises some probability of payment. Provision has been made also to meet the future costs of payments to staff in line with the Trust's pay protection policy. The provision will meet the cost of agreed additional payments to staff who transferred to revised working arrangements in 2013/14.

29. Contingencies

	31 March 2015 £000	31 March 2014 £000
Contingent liabilities		
NHS Litigation Authority legal claims	**(162)**	0
Employment Tribunal and other employee related litigation	**(9)**	0
Other	**(998)**	(418)
Net value of contingent liabilities	**(1,169)**	(418)

NHS Litigation Authority contingent liabilities consist entirely of claims for personal injury (£163k in 2013/14) where the probability of settlement is very low. The NHS Litigation Authority have advised on their status. In all cases, quantum has been assessed on a "worst case scenario" and represents the maximum of any payment which may be made. Other personal injury claims to a value of £418k (£255k in 2013/14) are being managed internally by the Trust. In all cases, the potential payment values have been assessed on a "worst case scenario" basis by reference to independent advice. Settlement of these claims is considered highly improbable but the values quoted represent the Trust's maximum exposure to loss.

The remaining contingent liabilities in "other" relate to an initial assesment of the Trust's potential exposure in light of recent Employment Tribunal decisions which may have future implications for leave related pay. The assesment is based on independent advice and recognises a maximum future exposure. It is not an exposure to current claims against the Trust and the probability of any future payment is highly uncertain, as is the timescale involved.

30. PFI - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts:

	2014/15 £000	2013/14 £000
Charges to operating expenditure and future commitments in respect of on and off SoFP PFI		
Service element of on SoFP PFI charged to operating expenses in year	**14,911**	12,195
Total	**14,911**	12,195
Payments committed to in respect of off SoFP PFI and the service element of on SoFP PFI		
No later than one year	**10,207**	9,976
Later than one year, no later than five years	**43,254**	42,271
Later than five years	**181,228**	192,418
Total	**234,689**	244,665
Imputed "finance lease" obligations for on SoFP PFI contracts due		
No later than one year	**15,625**	15,625
Later than one year, no later than five years	**67,774**	65,472
Later than five years	**267,521**	285,447
Sub-total	**350,920**	366,544
Less: Interest element	**(148,633)**	(159,834)
Total	**202,287**	206,710
Present value imputed "finance lease" obligations for on SoFP PFI contracts due, analysed by when PFI payments are due		
No later than one year	**4,665**	4,423
Later than one year, no later than five years	**26,754**	23,244
Later than five years	**170,868**	179,043
Total	**202,287**	206,710
Number of on SoFP PFI Contracts		
Total number of on PFI contracts	**2**	2
Number of on SoFP PFI contracts which individually have a total commitments value in excess of £500m	**1**	1

31. Impact of IFRS treatment

The information below is required by the Department of Heath for budget reconciliation purposes:

	2014/15 £000	2013/14 £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI)		
Depreciation charges	**4,471**	6,915
Interest expense	**11,201**	11,432
Impairment charge - AME	**5,243**	0
Other expenditure	**14,911**	12,195
Impact on PDC dividend payable	**(765)**	(708)
Total IFRS expenditure (IFRIC12)	**35,061**	**29,834**
Revenue consequences of PFI schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(31,550)**	(28,865)
Net IFRS change (IFRIC12)	**3,511**	**969**

Capital consequences of IFRS : PFI and other items under IFRIC12		
Capital expenditure 2014-15	**1,258**	3,415
UK GAAP capital expenditure 2014-15 (Reversionary Interest)	**2,911**	2,800

32. Financial instruments

32.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust treasury activity is subject to review by its internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 - 25 years, in line with the life of the associated assets.Interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Since the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2015 are in receivables from customers, as disclosed in the trade and other receivables note (Note 21).

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS commissioning organisations, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

32.2 Financial assets

2014/15	Loans and receivables £000	Total £000
Receivables - NHS	30,825	**30,825**
Receivables - non-NHS	16,873	**16,873**
Cash at bank and in hand	3,298	**3,298**
Total at 31 March 2015	**50,996**	**50,996**

2013/14		
Receivables - NHS	27,609	27,609
Receivables - non-NHS	8,742	8,742
Cash at bank and in hand	23,236	23,236
Total at 31 March 2014	59,587	59,587

32.3 Financial liabilities

2014/15		
NHS payables	12,128	**12,128**
Non-NHS payables	59,790	**59,790**
Other borrowings	49,642	**49,642**
PFI & finance lease obligations	202,771	**202,771**
Total at 31 March 2015	**324,331**	**324,331**

2013/14		
NHS payables	13,486	13,486
Non-NHS payables	67,734	67,734
Other borrowings	41,998	41,998
PFI & finance lease obligations	207,130	207,130
Total at 31 March 2014	330,348	330,348

33. Events after the end of the reporting period

There are no events that have occurred after the end of the reporting period that have a material impact on these financial statements.

34. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Leeds Teaching Hospitals NHS Trust.

The Department of Health is regarded as a related party. During the year the Leeds Teaching Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example:

	Income £000	Expenditure £000
NHS Airedale, Wharfedale and Craven CCG	6,212	0
NHS Bradford Districts CCG	9,061	0
NHS Calderdale CCG	5,052	0
NHS Greater Huddersfield CCG	6,387	0
NHS Harrogate and Rural District CCG	5,592	0
NHS Leeds North CCG	83,571	0
NHS Leeds South And East CCG	138,837	0
NHS Leeds West CCG	155,709	0
NHS North Kirklees CCG	7,639	0
NHS Vale Of York CCG	7,820	0
NHS Wakefield CCG	14,545	0
NHS England	448,392	86
Leeds Community Healthcare NHS Trust	3,522	503
Mid Yorkshire Hospitals NHS Trust	3,301	1,817
Bradford Teaching Hospitals NHS Foundation Trust	7,990	945

Leeds And York Partnership NHS Foundation Trust	3,502	122
Sheffield Teaching Hospitals NHS Foundation Trust	7,774	113
Leeds City Council	4,714	5,673
NHS Professionals	0	10,198
NHS Health Education England	73,004	0
NHS Litigation Authority	0	20,062
NHS Blood and Transplant	2,177	8,011
TOTAL	994,801	47,530

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Department for Education and Skills in respect of University Hospitals, Leeds City Council in respect of joint enterprises and the University of Leeds.

The Trust has also received revenue and capital payments from a number of charitable funds, including the Leeds Teaching Hospitals Charitable Foundation. The Trust's Chair, Linda Pollard, is a Trustee of the Leeds Teaching Hospitals Charitable Foundation. The Chairman of Trustees, Edward Ziff, is also Chairman and Chief Executive of Town Centre Securities Plc. The Trust made no payments to Town Centre Securities in 2014/15 but in early 2015/16 awarded a contract with a value of £90k to the firm to provide estates consultancy advice. The financial statements of the Charitable Foundation are published separately and can be obtained from: www.leedshospitalsfundraising.org.uk/index.php

The Trust's Director of Finance, Tony Whitfield is a Trustee of the Healthcare Financial Management Association. In 2014/15 the Trust made payments totalling £63 k to the Association for corporate membership, training materials and attendance at training events.

35. Losses and special payments

The total number of losses cases in 2014/15 and their total value was as follows:

	Total value of cases £	Total number of cases No.
Losses	273,839	740
Special payments	252,272	210
Total losses and special payments	526,111	950

The total number of losses cases in 2013/14 and their total value was as follows:

	Total value of cases £	Total number of cases No.
Losses	317,761	338
Special payments	349,110	197
Total losses and special payments	666,871	535

36. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets

36.1 Breakeven performance

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	2011-12 £000	2012-13 £000	2013-14 £000	2014-15 £000
Turnover	721,415	757,446	793,445	871,680	910,556	934,527	970,709	1,002,444	1,044,916	1,086,638
Retained surplus/(deficit) for the year	309	355	3,093	471	(43,426)	5,799	2,829	1,498	496	(19,988)
Adjustment for:										
Impairments	0	0	0	0	42,075	(5,813)	0	0	0	(2,897)
Impact of policy change re donated/government grants assets	0	0	0	0	0	0	0	353	150	(1,501)
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12	0	0	0	0	2,314	2,065	1,378	1,238	969	0
Break-even in-year position	2,360	355	3,093	471	963	2,051	4,207	3,089	1,615	(24,386)
Break-even cumulative position	(51)	304	3,397	3,868	4,831	6,882	11,089	14,178	15,793	(8,593)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	2011-12 £000	2012-13 £000	2013-14 £000	2014-15 £000
Materiality test (I.e. is it equal to or less than 0.5%):										
Breakeven in-year position as a percentage of turnover	0.33	0.05	0.39	0.05	0.11	0.22	0.43	0.31	0.15	(2.24)
Breakeven cumulative position as a percentage of turnover	(0.01)	0.04	0.43	0.44	0.53	0.74	1.14	1.41	1.51	(0.79)

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

In preparing the financial statements the Directors have considered the Trust's overall financial position and expectation of future financial support. The Trust has put forward a plan to the NHS Trust Development Authority (TDA) which will deliver a deficit of £40 million in 2015/16. The planned deficit is after taking account of cost improvement plans of approximately £67 million in the year. The TDA have agreed to support the Trust in its planned return to breakeven in 2017/18 by providing cash support to enable the Trust to pay its suppliers and staff. The TDA have confirmed this agreement in writing. In light of the fact that there is reasonable assurance that the Trust will be in a position to meet its financial obligations during the next two years and has an agreed financial recovery plan in place, the Directors have concluded that it is appropriate to prepare these financial statements on a going concern basis.

36.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual Capital Cost Absorption Rate is automatically 3.5%.

36.3 External financing limit

The Trust is given an External Financing Limit which it is permitted to undershoot.

	2014-15 £000	2013-14 £000
External Financing Limit (EFL)	62,199	(2,542)
Cash flow financing	62,002	(3,134)
Unwinding of Discount Adjustment	0	44
Other capital receipts	0	(195)
External financing requirement	62,002	(3,285)
Undershoot against External Financing Limit	197	743

36.4 Capital financing limit

The Trust is given a Capital Resource Limit which it is not permitted to exceed.

	2014-15 £000	2013-14 £000
Capital Resource Limit	40,819	22,785
Gross capital expenditure	42,341	29,049
Less: book value of assets disposed of	(157)	(5,554)
Less: donations towards the acquisition of non-current assets	(2,824)	(1,223)
Charge against the Capital Resource Limit	39,360	22,272
Undershoot against External Financing Limit	1,459	513

37. Third party assets

The Trust held cash which relate to monies held on behalf of patients at 31st March as shown below. This has been excluded from the cash and cash equivalents figure reported in the accounts (see Note 22).

	31 March 2015 £000	31 March 2014 £000
Patient monies held by the Trust	17	5

Tell us about your care

Feedback from patients, families and carers is very important to us.

Around our hospitals you will find that many wards and departments ask your opinion or have comment cards that you can use to make your views known. In particular, many departments have started to use the NHS Friends and Family Test, with encouraging results.

If there is a problem, we'd like to know about it so we can put it right and make improvements to our service. Equally, staff value compliments if you have received quality care.

You can also become involved in our drive to become a Foundation Trust by joining us as a member and sharing your views with us.

For membership queries or to make a general comment, please visit our website at www.leedsth.nhs.uk.

Summaries of this document can be made available, by arrangement, in large print, Braille and community languages, from:

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