NHS

**The Leeds
Teaching Hospitals**
NHS Trust

Annual Report and Accounts
2015/16

Incorporating the
Annual Quality Account

hello my name is…

Contents

Statement
from the Chair
and Chief Executive

This year has been one of significant improvement across the Trust. The values of The Leeds Way - patient-centred, accountable, collaborative, fair and empowered - continue to be at the heart of everything we do here at Leeds Teaching Hospitals.

Thanks to the dedication of our staff we begin the next financial year with a financial plan to be marginally in surplus. We have also made huge strides in meeting our service targets and obligations to our patients. Our staff are undoubtedly the drivers of this strong and steady improvement, providing excellent care in a way that gives the best outcomes and experience for our patients.

There is a strong sense of what we can achieve and a shared realisation across the organisation that we have the potential to be one of the best performing Trusts in the country.

Patient safety and high quality care

The quality of care we provide to our patients is at the forefront of everything we do here in Leeds. We were keen to welcome the Care Quality Commission (CQC) back to our hospitals in May 2016 following their previous visit in 2014 so that we could share the progress we have made.

At the time of writing this report we are awaiting the final report from this visit.

The overall picture across the Trust is one of continuous improvement. We have attracted national interest in our new patient safety

huddles. These ward-based, short meetings identify patients at risk of deterioration and the appropriate actions to take. Other patient safety initiatives have resulted in a 30% reduction in 2222 calls for urgent medical assistance on some wards and a 20% decrease in falls. Our ward healthcheck has gone from strength to strength, achieving significant improvements in how we care for patients at ward level.

It has, however, been a tough year and we recognise that despite all the improvements that have been made so far there are still challenges, for example achieving some of our performance targets. There is a lot of work taking place across the Trust to address the things we can influence. However, some of these challenges are representative of system-wide issues and we must continue to work with our partners and commissioners to address them.

We are incredibly proud that the Trust's achievements around better patient care and our commitment to identifying challenges and encouraging positive change is increasingly attracting staff who want to be part of our team. This year we have recruited more nurses, midwives and support staff and reduced the amount we spend on agency administrative staff. These are savings that can be reinvested in patient care.

The Leeds Improvement Method

This culture of improvement is further reflected in the decision taken by the NHS Trust Development Authority, now known as NHS Improvement (NHSI), to choose us as one of only five Trusts in the country to work with the prestigious Virginia Mason Institute on a programme known within our Trust as the Leeds Improvement Method. The aim of this five year programme is for us to be one of the top Trusts for patient safety and efficiency in the country.

Launched in our elective orthopaedics service at Chapel Allerton Hospital, it has brought together front line staff with a range of skills and experience to review and adjust how they work to improve patients' experience of our care, improve quality and increase efficiency. It is already paying huge dividends, reducing waiting and theatre turnaround times. We have already started on our second workstream in abdominal medicine and surgery and, over the next year, we will expand this work to include critical care and outpatient services.

National context

In a national context, this past year has been one of the most difficult in the history of the NHS but delivering compassionate high quality care remains as important as ever.

The last year has seen unprecedented demand on the NHS and the pressures of this have been felt on health and social care systems across the country. We are no different. Our Emergency Care Standard (ECS) reflects the reality of these pressures, both for our staff and the patients who need our care. In 2014/15, we were one of few Trusts to meet the standard but this year we and other Trusts around the UK have found it a challenge. At the end of the year we saw 93.2% of patients within four hours against a standard of 95%. Meeting the ECS is both a national and system-wide issue and we are working across the Trust and with partners in the local health economy as part of a Strategic Resilience Group to improve our patients' flow through their hospital stay and resolve the challenges we are facing.

We would like to thank staff across our hospitals for their tireless commitment to ensuring our patients continue to receive high-quality, safe care during this time of significant pressure on health services across the city.

The NHS Five Year Forward View is now in its second year. One of the proposals to come from this in our area was to prepare a Sustainability and Transformation Plan (STP) for West Yorkshire with a dedicated section for Leeds.

We have worked closely with our partners to develop this STP and, as we also treat patients from across West Yorkshire and further afield, we welcome this opportunity to work more closely with other organisations across the region.

Financial sustainability

This year we have achieved close to £70 million in new savings to help us on our journey to becoming financially sustainable. One of our Trust goals is to be financially sustainable and, thanks to the dedication of our staff, we begin 2016/17 in the best financial position we have been in for a number of years.

Across the Trust, staff have embraced the theme of 'knowing our business' and understanding where and how we spend our money in order to provide excellent care in a way that gives the best value and experience for our patients.

This is evident in their dedication throughout the year and was further highlighted during the 10-week Going for Gold campaign at the end of the financial year. In a bid to save the final £7 million of our annual target, staff shared a series of examples showing good practice, looking at areas where they could refine the way they work to make our services more efficient and cost-effective whilst delivering more for our patients. These included initiatives to make clinics run more smoothly, cutting down on waste in theatres and improvements to patient pathways. These contributed not only to better patient care but also to a saving of £7 million by the end of March, the impact of which will be felt throughout our hospitals.

Complementing this, we are proud to be one of the founding Trusts to be working with Lord

Carter of Coles as part of his review of NHS productivity to spread the learning from this work.

We know that 2016/17 is going to be tough as we still need to make a further £65 million savings whilst continuing to improve our services but we are confident that the commitment of our staff will enable us to do this.

Best place to work

Our people are fundamental to everything we do. As part of The Leeds Way, we have made a commitment to recognise the successes of our people and make sure they continue to feel valued.

In November we held our first Trust-wide awards, Time to Shine, which celebrated the work of our people across all areas of the Trust and encouraged people to share their learning and experience. We were thrilled to receive such high quality entries highlighting some really impressive projects that are being implemented across our Trust to improve services for our patients. The event was inspirational and made us proud to work with such dedicated and selfless people.

We have also made a commitment to recognise the long service of our people. This year we have held two long service events where we presented colleagues who have 20, 30 or 40 years' service at the Trust with a commemorative certificate and badge to celebrate their dedication. It's amazing to hear the tales of how things have changed since they started working with us!

We are incredibly proud to have some of the leading experts in their fields working at our Trust and they continue to receive the very highest accolades in their professions, including national and international acclaim. You can read about some of these later in the report.

In February this year we were delighted to learn that we are the most improved Trust in the country in the 2015 NHS Staff Survey. Findings have significantly improved in 13 key areas, including motivation at work, support from line managers and the number who feel able to contribute to improvements at work,

showing that our staff are living the values of The Leeds Way. Ninety-five percent of our staff reported that they had an appraisal in the last 12 months, making us the top performing Trust nationally in this important area.

We know that a good working environment for staff means better care for patients so we continue to work hard to ensure that the voice of all of our staff is heard. We were one of the very few Trusts to open up the staff survey to all of our staff and not just a small sample. More than half of our employees responded, and we saw an increase in the number of staff responding from groups that are normally thought of as 'hard to reach'. We value the opinion of all our staff so it really means a lot to us that they took the time to tell us their thoughts.

Inviting all staff to take place in the survey and making changes to our appraisal system, which you can learn more about in the Our People section of this report, means we have a reliable way to gauge staff opinion and can confidently build on their input to make the Trust an even better place to work.

Working collaboratively

We are working more closely than ever with our commissioners and our partners locally and nationally to provide excellent health and care services for the people of Leeds and beyond. We are strengthening our relationships with teaching organisations to train the best clinicians and with research partners to develop care and treatments which will improve our patients' outcomes.

We work closely with our local health and social care partners to provide seamless care for patients between primary, community and secondary care services and we are committed to driving forward integrated care in Leeds to ensure that these pathways continue to develop. We are keen to ensure our local Scrutiny Board and Health and Wellbeing Board are kept informed and involved with key decisions we make about the services we provide for local people.

In summer 2015 we launched our quarterly stakeholder newsletter, Trust Matters. This newsletter provides information about the improvements we are making and our achievements across the Trust, as well as being open and honest about the challenges we face and where we need to do more. This allows those we work with to hold us to account, a key part of The Leeds Way.

We are committed to improving the quality of care for patients who present to hospital with mental health conditions. As part of this, we are involved in and support a number of collaborative activities to ensure that patients with mental health needs receive the care they need in the most appropriate place.

Working with our partners across the city will help us to provide an enhanced quality of care and more efficient and responsive mental health services in Leeds.

We were also selected as one of the leading partners in the Yorkshire and Humber region's bid to become a Genomic Medicine Centre (GMC) for the national 100,000 Genome Project. The Yorkshire & Humber GMC is a joint collaboration between Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and us, working closely with all 22 NHS health trusts in the region supported by the Yorkshire & Humber Academic Health Science Network.

The 100,000 Genomes Project is a ground breaking initiative which aims to decode the DNA sequences of 100,000 genomes from people who have a rare disease or condition, their families, and people with cancer. We are delighted to be part of this fascinating work.

Charitable support

Charities play an extremely important role in the Trust and there are many we work with to enhance the care and experience of our patients.

We have continued to work closely with the Leeds Teaching Hospital's Charitable Foundation on how they are supporting the strategic aims and objectives of the Trust. During this year,

around £5 million has been spent on charitable funding across the Trust which really benefits our patients and for which we are extremely grateful. We are delighted to be able to provide free WiFi across the Trust for use by patients, staff and visitors, which has been generously funded by the charitable foundation for the first year. This will make a huge difference to those spending time in our hospitals.

You can read more about the charity's work later in the report.

In July, we were delighted to hear that planning permission has been granted for a new Maggie's Centre to be built on the St James's site. A fundraising campaign has been launched to raise £1million to begin building this centre and we are really pleased that many of our staff and people from our local community have got involved. The Centre will provide free support for patients living with cancer in Yorkshire, will be a huge asset to patients and will complement existing support and the clinical care the Trust provides.

International partnerships

We continue to spread our expertise far and wide and build upon existing international partnerships, including the Ministry of Health in Malta and the King Hussein Cancer Centre in Jordan. We are also actively exploring new opportunities elsewhere in the world as we become known for our exceptional and world-leading work.

These relationships boost our international reputation and have already opened up new sources of income for the Trust as we share our expertise and train medical teams from hospitals around the world.

Our successes are a tribute to the fantastic teams and world class technology we have here at the Trust which are of great interest to our international partners.

Our members

Our membership of people wanting to be involved in the development of our Trust has continued to grow. We now have more than 25,000 people who are keen to hear about the work we do and help us to continuously improve.

We value their input and are keen to keep them informed of developments at the Trust and our progress. Our members' magazine Connect is sent out quarterly and our increasingly popular Medicine for Members engagement events are regularly held across the city on a range of interesting subject areas.

You can find out more about how to get involved in the work of the Trust on our website at **www.leedsth.nhs.uk**.

Research, education and innovation

We believe that being involved in cutting edge research helps us to provide better care to our patients and we continue to be one of the largest providers of research opportunities to patients in the country.

We work closely with our partners at the University of Leeds, the Medical Research Council and charities, including for example Cancer Research UK, to test a wide range of treatments for a number of different conditions. This gives many of our patients the opportunity to be involved.

Last year more than 10,500 of our patients took part in 460 different high quality research studies, making us one of the best performing Trusts in England for projects recognised by the National Institute for Health Research (NIHR).

This year, we also became the only NHS-funded centre in the country for hand and upper arm transplants following a UK-first operation carried out by our team in 2012.

We 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 complete placements with us too. We are extremely proud to be involved in training the excellent doctors and healthcare professionals of the future and preparing them to succeed in a changing NHS.

Overall, this year has been a significant one for us. There have been challenges but we have achieved excellent results, won awards, taken opportunities to develop and made some substantial improvements to the way we work.

We couldn't have done any of this without the hard work and dedication of so many people who we would like to thank on behalf of the Trust Board. This includes all of our staff and volunteers who work tirelessly to provide the best possible care to every patient every time, and our partners across Leeds who are committed to helping us ensure that healthcare across the city is a priority.

As the new financial year begins, we are under no illusions that we have a challenge ahead of us. We also have some exciting plans, including our vision to develop the LGI site to meet the growing healthcare needs of Leeds. The Trust will need to embody the values of The Leeds Way in everything we do and continue to develop our organisation as a great place to work, delivering better quality care, excellent patient access and financial sustainability across every service.

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. We play an important role in the training and education of medical, nursing and dental students and are 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 (LGI)
- 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's 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. Over 40% of our overall income of around £1billion comes from specialised commissioners, NHS England.

We attract specialists at the top of their discipline and this 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
- Major trauma and neurosciences
- Cardiac services
- Specialised transplantation and other specialised surgery

Leeds Children's Hospital

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 of our team at Leeds Children's Hospital 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.

Leeds Cancer Centre

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 teams at the Leeds Cancer Centre 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 we have an enviable reputation and we welcome visitors from around the world to share our experience. The Centre is constantly pioneering new approaches to cancer therapy and care.

Leeds Major Trauma Centre

The Leeds Major Trauma Centre was created at the LGI 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 for patients, and is one of the top three centres for volume of patients and survival rates in the UK.

Leeds Cardiac Services

In heart surgery, Leeds is the largest single centre for Percutaneous Coronary Intervention (Primary PCI) services in 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. PCI services are provided to more than 1,000 patients each year who are admitted with a heart attack.

Specialised transplantation services

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 is committed to delivering the highest quality and safest treatment and care to every patient, every time.

Our vision is to be 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 this vision, we set out our five year strategy for the Trust. Our staff helped to define the values and behaviours that we all work to and that form the foundations of our culture, our ethos and how we will work for the benefit of patients for years to come. This is known as The Leeds Way.

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

This year there have been many fantastic achievements by the Trust and our staff, who work tirelessly to provide the best in patient-centred care. We have been part of clinical 'firsts', invaluable research and many special occasions, showing that LTHT is at the forefront of specialist and integrated healthcare within the UK.

April 2015

The Trust opened its new Gynaecology Assessment and Treatment Unit in Chancellor's Wing at St James's. The new area consists of a gynaecology day-case unit and a joint early pregnancy and acute gynaecology unit, improving care for women in Leeds.

The day-case unit has nine beds, with the gynaecology assessment area offering a six bed bay and a side room. Since opening, more procedures have been taking place in the unit's treatment room, which has helped reduce the length of time patients stay in hospital.

LTHT became the first NHS trust in the UK to carry out a ground-breaking procedure to destroy a renal tumour using a nanoknife. The technique called *image guided irreversible electroporation*, was led by Dr Tze Wah and her team.

This delicate technique had only previously been used on liver and pancreatic cancer tumours, so the procedure was a UK first using the nanoknife technology.

A new Surgical Assessment Unit was opened in Chancellor's Wing. This has significantly improved experiences for patients by offering more privacy and comfort during their stay. The team see on average 40 patients per day with an admission average of 22 patients.

The Unit includes a minor procedures room, enabling staff to perform procedures for patients safely within the unit without having to be referred to acute theatre lists.

May 2015

Public Health England published the final set of flu vaccination figures for 2014/15. LTHT vaccinated 76.4% of front line staff - the highest number across any hospital Trust in England.

We were also one of only 35 trusts nationally to achieve a vaccination rate of more than 75%.

June 2015

LTHT featured prominently in national BBC documentary An Hour to Save Your Life. The three part series followed the work of a small number of specialist Major Trauma Centres in England, including the LGI.

The programme was a great showcase for the expertise and skills of staff and an opportunity to put the Trust on the map for our specialist services and collaboration.

Two patient safety projects were launched this month - the Leeds Falls and Deteriorating Patient collaboratives - as part of the quality improvement programme.

Following months of development, a number of safety packages were developed between ward teams working with innovation and improvement experts, Haélò. This has resulted in a 30% reduction in the number of calls for urgent medical assistance from wards and a 20% decrease in falls.

One of the high points of this month was the annual Nursing & Midwifery conference, which focused on promoting integrated care within Leeds. Discussions looked at closer cooperation between professions and partner organisations, such as the universities, charities and other healthcare partners, to improve health outcomes and care for people across the city.

Many Allied Health Professionals were represented at the conference too. Guest speakers included Sir Alan Langlands, Vice Chancellor of the University of Leeds, and Neil Churchill, Director of Patient Experience at NHS England.

The Abdominal Medicine and Surgery Clinical Service Unit, which has been formed from the merger of Digestive Diseases and Hepatorenal, was launched.

This coming together of services has led to greater collaborative working and more effective use of resources.

The Trust broke new ground when Dr Chris Pepper became the first Cardiologist to commercially use a new wireless pacemaker, which is 90% smaller than those used before.

The pacemaker, which is the size of a household fuse, was implanted directly into the heart of a 68 year old patient, replacing a much larger temporary device. This means that we can carry out a much less invasive procedure and avoid some of the risks associated with wired pacemakers. This should mean an improved experience for patients.

We achieved another important milestone when Mr John Goodden undertook LTHT's 50th Selective Dorsal Rhizotomy (SDR) procedure.

SDR helps to improve the mobility of some children with cerebral palsy, and within the NHS, the service has been pioneered at Leeds Children's Hospital. LTHT is one of only five hospital Trusts in the country to undertake this surgery.

July 2015

LTHT launched the Be a Hero campaign, encouraging people across Yorkshire to sign up to the organ donor register.

The campaign was launched as a result of low numbers of people signing up to be an organ donor in the region and an average of three people a day dying in the UK while waiting for an organ. In the first three months of the campaign there was a 50% increase in the number of people in Yorkshire signing the organ donor register.

This month also saw the launch of the integrated sexual health service, Leeds Sexual Health. The new service brought together the existing services of LTHT and Leeds Community Healthcare with local charity Yorkshire Mesmac.

The new service combines the specialist expertise provided by the Trust and Leeds Community Healthcare to deliver contraception, sexually transmitted infection testing and treatment, and HIV testing across the city.

The stroke rehabilitation ward, L12, was opened with Chief Executive, Julian Hartley, and Chief Nurse, Suzanne Hinchliffe, attending an official ceremony.

This followed a move from St James's to a temporary base at the LGI and finally to their new home in Jubilee Wing. This means that they are now based alongside the rest of the Neurosciences CSU and are able to improve the flow of patients across the hospital, improving patient experience and efficiency.

LTHT was selected as one of five trusts for a prestigious improvement programme led by the NHS Trust Development Authority (TDA) with the Virginia Mason Institute - one of the world's leading healthcare organisations.

The project was created in order to introduce lean working methods and new management techniques to help improve safety, increase efficiency and enhance care.

Following several high profile celebrity endorsements for Be A Hero - including Sir Patrick Stewart, England cricketer Joe Root and cricketing legend Geoffrey Boycott - the campaign received a huge boost when Sarah, Duchess of York, visited the Leeds Children's Hospital to find out more about the importance of organ donation in saving lives.

The Duchess visited children on the transplant and dialysis wards L10 and L11, learning about their conditions and talking about their time in hospital. She also met staff from across the Trust who work with both adult and paediatric transplant patients.

As an added bonus, she also agreed to become the campaign's patron helping to raise the profile of the cause even more.

August 2015

The Trust embarked on a five-year research programme worth £5 million in partnership with Yorkshire Cancer Research and the University of Leeds.

The investment will help Leeds Cancer Centre achieve its vision of becoming one of the leading centres for cancer treatment in the UK and beyond. Throughout the programme, studies are being carried out to improve diagnostic and screening services so that more people are diagnosed at an early stage, when cancer is easier to treat, and to ensure all patients have equal access to gold standard treatments.

The children's and adult teams competing for LTHT at the British Transplant Games brought home a large haul of medals and were a really brilliant showcase for the skills of the Trust's whole organ transplantation service from donation through to surgery and follow-up care.

Consultant surgeon Mr Sanjay Verma and the audiology team successfully undertook their first procedure featuring a new type of magnetic cochlear ear implant. The new device offers a much better patient experience and the recipient, Chris Hatton, was extremely complimentary about how the new device has transformed the quality of his life.

The implant is designed to need fewer follow-up visits so is a great example of how we are using new technology to enhance patient experience and potentially save money by freeing up clinic time.

September 2015

A brand new 'chill-out zone' for young patients was unveiled at the Leeds Cancer Centre. The dedicated space is for people aged between 13 – 25 years old from across the region who are primarily undergoing radiotherapy treatment for cancer.

Offering a quiet area for patients to 'get away and relax', the zone is the first of its kind for the hospital and provides facilities more appropriate for those young people undergoing treatment who would previously have had to use facilities more suited for children.

October 2015

The Brain Attack team reached a milestone when they treated their 500th patient with "clot-busting" thrombolysis.

The Trust launched its 24/7 service at the start of 2014 and has since been transforming outcomes for around 120 patients a year while consistently scoring above the national average in the timeliness of delivery.

Staff from Leeds Children's Hospital pulled out all the stops to deliver a superb inaugural conference, coinciding with the hospital's fifth birthday.

The theme of the conference was "aiming high, delivering the best for children and young people" and feedback on the day was overwhelmingly positive.

Over 250 delegates took part in an inspiring and lively series of talks and workshops, sharing learning and best practice with colleagues across disciplines. Young patients made a significant contribution throughout the day and members of the Hospital's Youth Forum took centre–stage to share their experiences.

The highlight of October – and perhaps the year - was the Trust's first ever *Time to Shine* awards.

The special event took place at the Queen's Hotel in Leeds and was an opportunity to recognise the very best of what LTHT staff do. The Executive Team was joined by 400 members of staff who had been shortlisted for the 14 awards.

Dr George Ballard, a consultant in Adult Congenital Heart Disease at LGI, who tragically died last year was posthumously given an award in a special category to recognise his service to the Trust.

November 2015

We were delighted to welcome Professor Sir Bruce Keogh, NHS England's Medical Director, to the LGI.

Sir Bruce met clinical teams on the children's congenital heart unit, paediatric intensive care and some of the wards. This was an excellent opportunity for Sir Bruce to talk to our young patients and their families, as well as hear about our plans for the Leeds Children's Hospital.

LTHT and partners were chosen by the Government to be part of six centres in the UK to support the development of precision medicine. This important field uses diagnostic tests and data to help clinicians gain a specific understanding of a patient's illness so they can plan more effective treatments.

As part of the Leeds Academic Health Partnership, the Trust is now one of the major partners in this initiative which will have far reaching healthcare benefits for patients in Leeds, the wider region and across the UK.

The Leeds Children's Hospital was chosen to be one of eight hospitals around the UK to join a flagship programme to improve the quality and safety of care for acutely sick children.

The Situation Awareness For Everyone, or SAFE programme, is led by the Royal College of Paediatrics and Child Health and is trialling techniques to improve communication between all the professionals involved in a patient's care to reduce errors and the number of avoidable deaths.

This is an exciting programme which will make a real impact on the quality of care for children throughout the UK.

The Leeds Cancer Centre delivered the 1000th course of SABR (Stereotactic Ablative Body Radiotherapy) treatment. LTHT is the national leader in this field and has treated more patients with lung cancer using this method than any other UK hospital.

December 2015

The Theatres and Anaesthesia service launched its new Admissions Lounge at St James's. The unit receives all elective surgical on the day admissions for several specialities.

The new lounge has helped to improve safety and patient flow in the unit and has made a real impact on quality of care, since it allows patients to stay in the same bay while waiting to be seen by medical staff, surgeons and anaesthetists before their operation.

Leeds was named by NHS England as the new Genomic Medicine Centre (GMC) for the Yorkshire and Humber region as part of the national 100,000 genomes project in mid-December.

This followed a joint application by LTHT with Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's Hospital NHS Foundation Trust to become the Yorkshire and Humber Genomic Medicine Centre in November. In addition to the three lead trusts, the centre also involves all 22 NHS health trusts in the region and is supported by the Yorkshire and Humber Academic Health Science Network.

The Government, through Genomics England, plans to put the UK and NHS at the forefront of genetic testing with a programme to sequence 100,000 genomes from patients with rare diseases and certain common cancers by 2017.

January 2016

LTHT was named by NHS England as the only service provider for hand and upper arm transplants for the NHS.

Professor Simon Kay and his team now work closely with commissioners and NHS Blood and Transplant to ensure the service will be functioning as soon as possible. Over the next five years, the Trust will also work in partnership with experts at Oxford University NHS Foundation Trust who will undertake assessments and the non-surgical elements of follow-up care for patients.

The Trust was one of six sites selected as a demonstrator site for a 24-month programme to introduce new standards, called GS1 and PEPPOL, for inventory management and procurement within the NHS.

This exciting project means that every location, medicine, medical device and even patient will be identified using a unique barcode. This will make it easier to track the patient journey through our hospitals and ensure the Trust only orders the stock it needs. By 2020/21, all hospitals in the UK will be expected to use the system, so early involvement has been viewed as testament to the commitment of the e-Procurement team within Supplies.

The very first 'Report Out' as part of the Leeds Improvement Method took place. This was an opportunity for staff involved in the Rapid Process Improvement Workshop (RPIW) at Chapel Allerton to share their achievements so far and an important stage within the programme.

The RPIW team had identified and tested out solutions for how they could improve the way we schedule patients for theatre. They had even received positive feedback from patients about the improvements they were trialling during the week.

February 2016

The Trust welcomed Her Royal Highness The Princess Royal to St James's. She came to officially open the adult robotic surgery theatre, meet the staff who work in the unit and hear from patients who had benefitted from robotic surgery at the Trust.

During her visit, she unveiled a plaque to mark the opening of the theatre and even tried her hand at using the robot. Professor David Jayne, a consultant at St James's explained how robotic surgery has allowed surgeons like him to deliver incredibly precise procedures and use less invasive techniques, which is better for patients.

The Princess Royal was extremely impressed by the skill and commitment of the theatres team.

March 2016

The brand new, state-of-the-art automated Pathology and WASP labs based in the Old Medical School at the LGI officially opened. It was a fantastic opportunity for the Pathology services to showcase some of the UK-leading technology which is only available at LTHT.

The new labs have been a real collaborative effort and the equipment will help to increase patient safety, improve efficiency and help the Trust to ensure it can continue to provide the very best possible care.

The Medical Devices team, part of Medical Physics, successfully developed a nationally-acclaimed electronic system to record staff training on medical devices. MELVIS (Medical Equipment Learning Verification Information System) allows the Trust to identify areas where additional training is required and target the training at those who need it.

The development led to the team being invited to present MELVIS at national conferences, which has generated a lot of interest. This is an excellent example of LTHT leading the way in health informatics and innovation.

Performance report

Performance report

In 2015/16, LTHT saw and treated 1,146,318 outpatients, 129,775 inpatients, 105,955 day case patients and 204,611 patients attended our emergency departments.

We also delivered NHS services for a population of around 751,500 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 have been working closely with the NHS Trust Development Authority (TDA), now known as NHS Improvement (NHSI) as of 1 April 2016.

We work closely with NHSI, which provides leadership, monitoring and support for NHS Trusts to help them improve their services and ensure they are safe and sustainable. Part of their role is to ensure that we have addressed a number of national and local issues in our annual Operational Plan.

Below are some of our priorities for the next year:

- demonstrate a clear Trust strategy aligned with our partners in other organisations
- agree a realistic demand and capacity plan with our commissioners on the number of patients we will see in 2016/17
- set out our quality priorities in our Quality Account, our Quality Improvement Programme and our Sign up for Safety campaign
- address the Care Quality Commission's

ratings and recommendations for our Trust
- show that we have an effective plan to ensure that patients receive a quality service seven days a week
- present a clear workforce plan with sustainable bank and agency provision
- engage with our staff and volunteers, and invest in their leadership and development
- provide solid financial projections for the year ahead
- using Lord Carter's report, build our programme of financial efficiencies
- present a feasible building, equipment and IT capital plan for the year ahead
- show how we will work more closely with other agencies in Leeds and West Yorkshire, as expressed in the new Sustainability and Transformation Plans (STP)

1.2 Our performance

The Trust's performance is assessed externally against a range of national targets and standards. Last year we made some significant improvements in some areas of our performance. However, there remained challenges as we continued to strive to balance the provision of the care we provide to our patients alongside an increasing workload, and demanding efficiency savings and financial sustainability.

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 Standard (ECS)

The NHS Constitution states that a minimum of 95% of patients attending Emergency Departments (ED) in England must be seen, treated and then admitted or discharged in under four hours. This is often referred to as the four hour standard or the Emergency Care Standard (ECS).

Percentage of patients treated within four hours in A&E
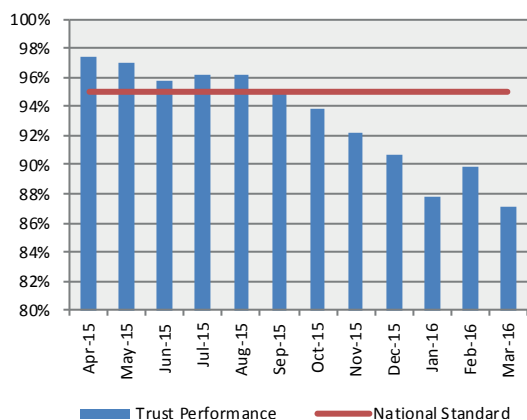
In 2015-16, our performance in ED started well but was not maintained for the year due to the unprecedented demand we faced. Our ED did not see, treat, discharge or admit 95% of patients within four hours and we finished the year delivering care to 93.2% of our patients within the ECS.

A number of factors, including high volume of patients, increased number of complex and very unwell patients alongside some capacity and staffing difficulties, had a significant impact on our ECS.

In March 2016, we saw the highest ever number of attendances at our ED.

Teams across the Trust have worked tirelessly to provide continued high-quality care to our patients during this period of increased demand. The dedication of our people as well as our ongoing approach to improving systems and procedures internally so that we can address concerns has ensured that we have maintained patient safety at all times.

This was further demonstrated when the ED team won the award for 'Excellence in Delivering 24-7 Emergency Care' at the prestigious CHKS healthcare awards. The judges particularly highlighted the fantastic demonstration of effective team working, lack of hierarchy between team members and the clear and shared ownership from all staff in the management and delivery of exceptional patient care.

We will continue to refine our internal approach and work with commissioners and partners to build on our progress throughout 2016/17.

Harm-free care

Harm-free care focuses on preventing patients across our hospitals from harm, including pressure ulcers, falls, hospital-acquired infections and Venous Thromboembolism (VTE) with a goal to deliver 'harm free care' to at least 95% of patients.

Percentage of patients experiencing harm free care
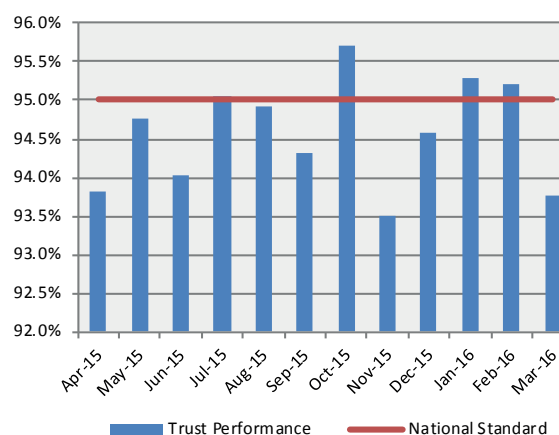
Our goal is to provide harm-free care to every one of our patients. This year, 94% of our patients received harm-free care and this is following an increasing trend. We achieved the national target in four months last year, which we have never achieved before, and this can be attributed to the quality improvement work that we have undertaken to reduce falls and pressure ulcers. We have also put in place a more robust data collection and validation process which has helped. This is testament to the hard work of everyone across the Trust during a difficult winter period. However we always want to do better.

Our priority for 2016/17 is to continue achieving this level of harm-free care in a more sustained way and to work on improving our overall percentage.

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

RTT is the period of time a patient waits to start non-emergency NHS consultant-led treatment. The maximum length of time from 'referral to treatment' is 18 weeks, unless a patient chooses to wait longer or it is clinically appropriate to do so.

Percentage of patients on incomplete pathways waiting over 18 weeks
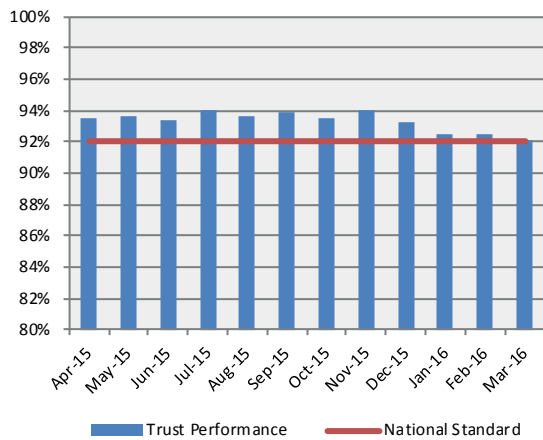
This year, the 18 week RTT waiting times standards were amended by NHS England to remove the requirement to ensure 90% patients are treated or discharged within 18 weeks as an inpatient (Admitted) and 95% of patients are treated or discharged within 18 weeks as an outpatient (Non-admitted).

The remaining standard is to ensure that 92% of patients on our waiting list for non-emergency (elective) care wait less than 18 weeks (the incomplete standard).

The Trust has consistently achieved this standard over the past few years. During 2015/16 this has occasionally been affected by:

- the rise in demand across our elective specialties above the 2015/16 plan in key areas such as restorative dentistry, Ear Nose and Throat (ENT) and Spines.
- the volume of ED and acute admissions across our hospitals towards the end of the year that significantly affected routine surgical throughput
- the continued impact of delayed transfers of care, delayed repatriations and reduced locality step down bed availability which significantly reduced our elective capacity

We have developed plans to ensure we continue to meet the Incomplete 18-week RTT standard in 2016/17. These are detailed in the section, *Factors likely to affect performance in 2016/17*.

Delayed Transfers of Care (DTOC) - lost bed days

A DTOC is when a patient is medically fit to be discharged from hospital but is unable to be discharged for various reasons and so is still occupying an NHS bed. This could be due to a number of factors, including there not being suitable plans in place for their care following discharge, such as a room in a care home.

Delayed Transfers of Care - lost bed days by delay reason
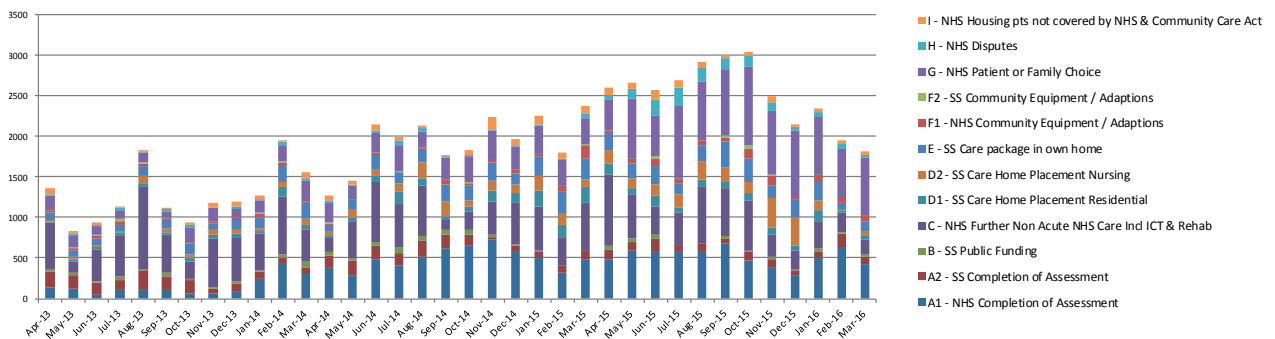
We continue to work with our health and social care partners across Leeds and further afield to ensure that a patient can be safely discharged from hospital as soon as they are well enough.

Cancelled operations

In this context, a cancelled operation refers to operations that are cancelled on the day they are due to take place.

Percentage of operations cancelled on the day

Trust Performance
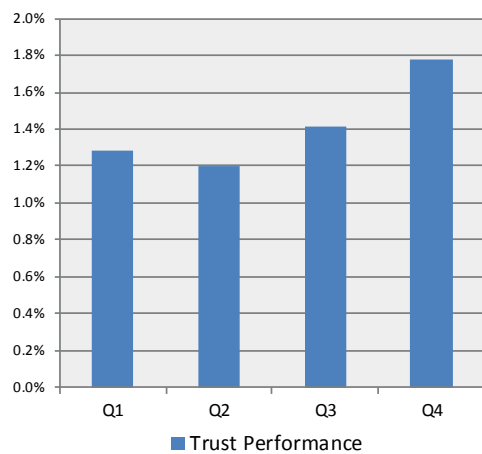
We recognise that last-minute cancelled operations are a distressing experience for patients and have worked to reduce the number of these during 2015/16. Progress was significantly affected by high demand in Q3, however, despite these pressures some improvement was made in Q4.

When patients' operations are cancelled at the last minute there is a requirement to offer them a new date within 28 days. During 2015/16 we have made good progress in reducing the number of patients where this did not happen (79) when compared to 2014/15 (132). We will again focus on achieving better results in 2016/17.

Percentage of patients not treated within 28 days of cancellation

Trust Performance
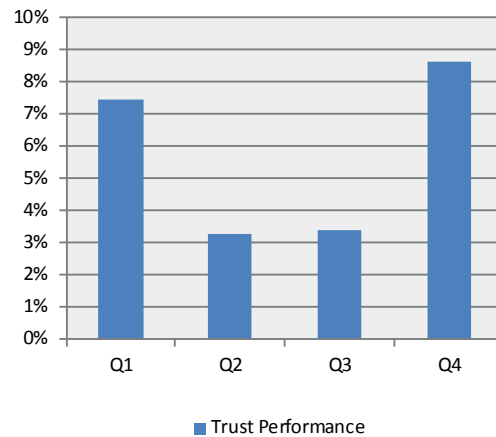
Cancer waiting times

The National Institute for Health and Care Excellence (NICE) sets out that patients who are urgently referred to a specialist with a suspicion of cancer are seen within two weeks. Patients who are diagnosed with cancer must then receive their first treatment within 31 days of a consultant's decision to proceed. Guidelines also state that all patients who have been referred by their GP to be seen within two weeks and then receive a diagnosis of cancer are treated within 62 days of the date of receipt of the referral.

All subsequent treatments (surgery, radiotherapy, drug therapy or palliative care) must be delivered within 31 days of the decision to treat agreed with the patient.

Cancer access target: urgent GP referrals seen within 2 weeks

Trust Performance   National Standard
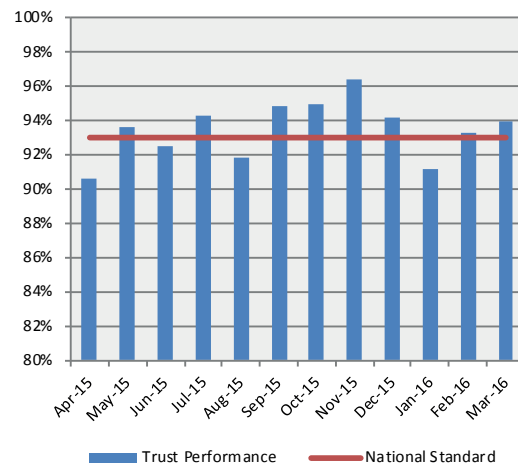
This standard is to see 93% of urgent GP referrals for patients with suspected cancer within two weeks. There were some issues with breast service capacity that affected performance in the first half of the year. Once these were addressed we consistently met this target despite the ongoing increase in demand. The standard was not achieved in January 2016 due to large volumes of patients choosing to defer their appointment over the Christmas period.

Cancer access target: breast symptomatic referrals seen within 2 weeks
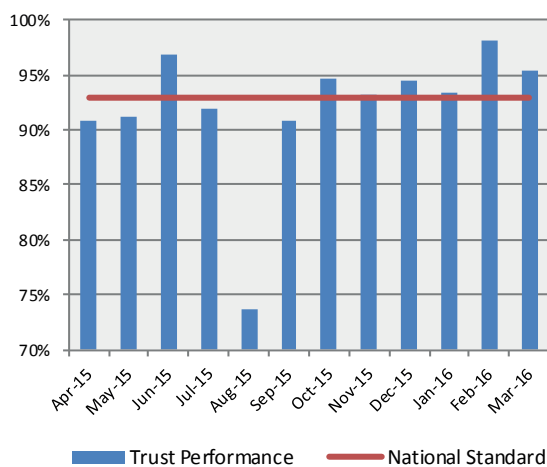
The requirement to see patients referred with breast symptoms within two weeks continued to be affected by staffing issues in Q1. This was also the case for August. However, performance recovered in Q2 and we achieved this standard for the remainder of 2015/16.

Cancer access target: first treatment within 31 days
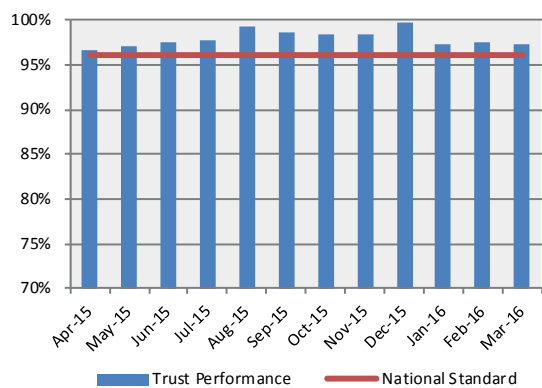
During 2015/16, we consistently achieved the target to treat patients with cancer within 31 days of a decision to treat. This was the case not only for first treatments, but also for subsequent surgery, drug or radiotherapy treatments.

Unfortunately during March 2016, surgical capacity for Melanoma patients affected the 31-day subsequent surgery target for that month only. This has now been resolved

Cancer access target: treatment within 62 days of an urgent GP referral
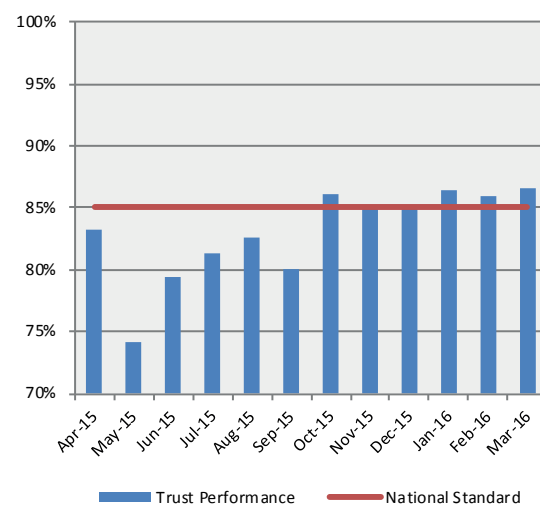
During 2015/16, we began to see our internal performance improve in line with our Trust Board agreed recovery plan, with the standard achieved from Q3/ October 2015 and sustained.

This standard refers to the total number of days from a referral for suspected cancer to the first treatment. This is a shared responsibility with other hospitals that refer their patients on to us for specialist care that they cannot provide. This forms a significant part of our workload and can make managing this standard more challenging as we are reliant on other Trusts referring their patients onto us in a timely manner. If patients are referred late, including after the 62-day period has passed, LTHT will incur the sometimes unavoidable performance breaches. We continue to work with our referring Trusts to ensure that patients are referred to us within appropriate timeframes.

Diagnostic waiting times

The diagnostic standard is that, at month end, 99% of patients should have waited less than six weeks for their test. We must report our performance in 15 tests that are set nationally in three areas - endoscopy, imaging and physiological measurement.

Percentage of patients waiting less than 6 weeks for a diagnostic test at month end
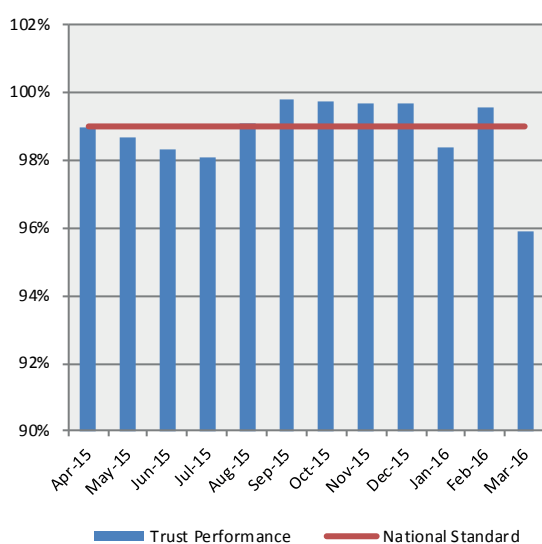
During 2015/16 significant progress was made in addressing and sustaining our diagnostic waiting times performance (standard is for less than 1% of patients to have waited over six weeks at month end), which was achieved from September 2015 - December 2016. During this time performance was also achieved for Endoscopy (September to November).

In January this was lower than normal as some patients chose to wait longer than 6 weeks over the Christmas period. We have also been reliant on partners from the independent sector to help us provide 50% of our routine capacity. Reduced availability from them has had an impact on the number of patients we have been able to see in certain timeframes.

Whilst performance was restored in February, there were similar availability problems over the Easter period which affected March figures.

Continued growth in demand for Endoscopy and MRI scanning, coupled with reduced internal capacity, remain our biggest risks to achieving this standard during 2016/17. We are looking at additional recruitment to help reduce any associated risks.

Hospital acquired infections

Hospital acquired infections refer to incidences of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C difficile) that a patient has acquired during their time in hospital. We aim to have zero cases of MRSA and C difficile.

Number of MRSA cases attributed to the Trust (cumulative)
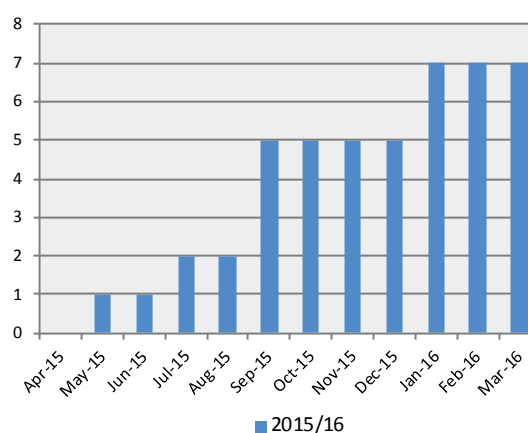
We are committed to reducing the levels of hospital acquired infections and have put in place a number of measures and initiatives to support this.

Reducing the rate of 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 2015/16 we had seven cases of MRSA bacteraemia recorded against a zero tolerance standard. This is in line with our performance in previous years but we want to reduce this further. We will continue to strive to improve in this area and during 2016/17 as we continue to focus on keeping the risk of infections to a minimum.

Number of CDI cases attributed to the Trust (cumulative)
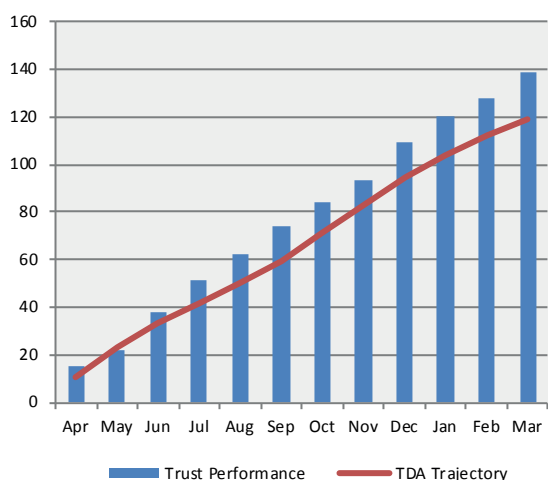
There were a total of 139 cases of C difficile for 2015/16, against a trajectory of 119. This was an increase from 2014/15 levels, however it is in line with the overall national position. We have identified a greater proportion of the cases, in conjunction with our commissioners, as having no 'lapse in care' during their time with us. A detailed infection prevention plan is in place to continue to support our aim to reduce the risk for our patients and staff.

Factors likely to affect performance in 2016/17

Providing patients with the highest quality care 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 Standard

Delivering the four hour target for patients in ED during the year was a pressure for the Trust this year. Recovering our performance in 2016/17 will remain challenging with the continued pressure on beds, patient flow out of the Trust, agency staffing caps and financial pressures. Our aim is to ensure patients receive care in the right place at the right time and are discharged from the Trust in a timely and appropriate way. We will continue to work with our commissioners and partners to address current DTOCs and admissions avoidance schemes.

Referral To Treatment

We want to maintain our progress in reducing the numbers of patients who have waited more than 18 weeks for their procedure and continue to ensure that 92% of patients are treated within the standard. To achieve this, we will continue to work with other providers and our commissioners to make sure pathways of care for patients, both inside our hospitals and across the local health care system, are as efficient as possible. We will ensure that any increased demand on our services, above agreed levels that we have been commissioned to deliver, 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 (2-week-wait referrals) means we have continued to face challenges in creating enough capacity within the Trust to meet demand within the two week timescales.

In 2016/17, we will continue to use our resources as efficiently as we can, as well as working with our commissioners to make plans for the rising demand we cannot currently accommodate.

From Q3 2015/16 we have consistently achieved the standard that a patient with suspected cancer should be treated within 62 days of an urgent GP referral. There remain challenges as a large proportion of our patients are referred to us by surrounding hospitals. We continue to work closely with them to make sure these patients arrive at our hospitals in a timely manner (by day 38) in line with agreed trajectories.

1.3 Improving quality

All patients treated at LTHT should receive only the best, safest and most compassionate care.

Delivering the highest standards of care to 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. Across the Trust we continue to work incredibly hard to improve the quality of the care we provide and we have much to be proud of in our achievements this year.

We have consistently delivered on our 62-day cancer waiting times, have almost halved the number of cancelled operations not rebooked within 28 days from 132 to 69 and are meeting the RTT incomplete standard. All of this means faster, more efficient and better care for our patients.

The quality of our care continues to be our main priority. Our patient safety huddles, which are short meetings involving all ward staff, have received national acclaim for identifying patients at risk of deterioration and taking appropriate action. We have also seen a 30% reduction in 2222 calls for urgent medical assistance and a 20% decrease in falls on pilot wards. The ward healthcheck initiative helps to identify areas where wards are performing well and also those where they can improve. This has helped wards to achieve significant improvements in how we care for our patients.

Our quality improvement work has been further complemented with the TDA choosing LTHT to be one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known to us as the Leeds Improvement Method (LIM).

LIM brings together staff with a range of skills and experience to review how they work to increase efficiency and improve patient experience and we have already seen fantastic results. In the inaugural workstream in our Elective Orthopaedics department at Chapel Allerton Hospital, there has been a reduction in waiting and theatre turnaround times. A second workstream has already begun in Abdominal Medicine and Surgery and, over the next year, we will also start workstreams in critical care and outpatient services.

It is rewarding to see the impact of our improvements becoming embedded in patient care, and the difference this is making to patients' perception of the services we provide. The 2015/16 NHS Friends and Family Test gathered 87,500 views from patients and, of these, 93% said they would recommend the Trust to their friends and family, an increase of 1.67% from the year before.

Our work on improving discharge processes has also started to make a difference and has resulted in a significant decrease in the numbers of patients reporting delays. In addition in 2015/16, new complaints have gone down by 16%.

We have worked with our clinicians, managers and local partners at Leeds West Clinical Commissioning Group and Healthwatch Leeds to identify the following priorities for 2016/17.

Patient safety

- Improvement in the care of patients with sepsis
- Improvement in the care of patients with acute kidney injury
- Reduction in number of hospital acquired pressure ulcers and the incidence of category 3 and category 4 pressure ulcers
- Antimicrobial stewardship

Clinical effectiveness

Leeds Improvement Method (LIM) Value Streams:

- Chapel Allerton Hospital Orthopedic Centre - total hip and knee replacement patients
- Discharge - abdominal medicine and surgery specifically focusing on Trans-Urethral Re-section of Prostate (TURP) patients
- Critical care step-down - starting summer 2016
- Patient services - starting autumn 2016

Section 1
Performance

Patient experience

- Making it easier to hear the patient voice - establishing a Patient Reference Group and Patient Leader Programme

- Improving understanding of our feedback - additional monitoring of the Friends and Family Test (FFT) showing the percentage of people who would recommend LTHT by ward area

- Learning and improving from what patients and families tell us - implementing method of capturing actions arising from FFT data and Patient Advice and Liaison Service (PALS) concerns

- Responding to patient feedback in Outpatients through delivery of programmes to address concerns

Further information on key improvements in our quality of care and patient safety, the Trust's performance against national targets in 2015/16, goals agreed with commissioners and our plans for 2016/17 can be found in our Quality Account, published on page 98.

1.4 Financial review

While the Trust reported a deficit of £30 million in the year which ended on 31 March 2016 it is important to remember that this was consistent with our recovery plan and does in fact indicate that real progress towards our goal of financial sustainability has been made. There is no doubt that 2015/16 was exceptionally difficult for the entire NHS in financial terms and the Trust was not immune to the twin pressures of unprecedented demand and rising costs.

Key financial results

	2015/16 Plan	2015/16 Actual	2014/15 Actual
Revenue Deficit	-£40m	-£30m	-£24m
Capital Investment	£71m	£28m	£42m
Cash held 31 March	£3m	£3m	£3m
Invoices paid in 30 days	95%	93%	90%
Savings required	£67m	£70m	£54m

Revenue summary

At the outset of the year the Trust had a plan to deliver a deficit of £40 million. The plan required savings of £67 million and was agreed with the TDA (NHS Improvement from 1 April 2016) as the second consecutive year of deficit in a longer term strategy to bring us back to sustainable breakeven. During the course of the year the TDA asked NHS Trusts, including LTHT, if they could improve their planned revenue positions through additional efficiency measures. The Trust's "stretch target" was agreed at £3m. Other measures agreed with the TDA further reduced the planned deficit of £40 million to the final reported £30 million as follows:

	£m
Planned Deficit	**-40**
Stretch target efficiencies	3
Non recurrent income support	6
Capital to revenue	1
Reported Deficit	**-30**

Overall, income from patient care activity increased by £18 million compared to the previous year. This very modest growth of less than 2% is a reflection of the mix of activity undertaken during the year and the implications that has for income. Levels of unplanned admissions have been unprecedented, going beyond the point at which NHS Trusts receive less payment for the treatments provided. With only a finite amount of activity that can be delivered in a fixed infrastructure, a higher level of unplanned demand has a knock-on effect of reducing planned activity levels which would have been paid for in full. The graph below gives a breakdown of where the income for the services we provide comes from.

Where each £1 came from

- NHS England, 41p
- Leeds Clinical Commissioning Groups, 34p
- Other Clinical Commissioning Groups, 8p
- Education, Training, Research & Development and Clinical Trials, 9p
- Non-patient Care Services to other bodies, 4p
- Department of Health, 1p
- Other 3p
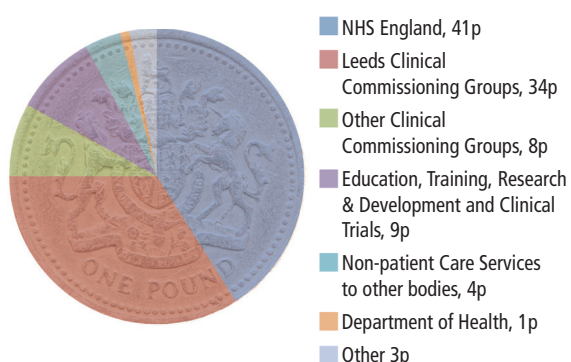
Expenditure on pay increased by £20 million, of which £5m is explained by national pay awards. Most of the increase however is due to an increase in staff numbers

	Movement in WTE*
Employees in post	+771
Bank employees	+35
Agency staff	-189
Net increase	+617

* WTE = whole time equivalent

At a national level there has been a clear focus on reducing reliance on agency staff within the NHS. We have responded positively to this as the figures above demonstrate. It is particularly pleasing to report that the additional staff in post included 180 nurses representing an investment

of £6 million. This is the second consecutive year where very significant financial savings have been found while staff numbers have gone up. The Trust is absolutely committed to achieving financial sustainability without compromising on the quality or safety of patient care.

Non pay expenditure increased by £16 million compared to the previous year. Clearly we were successful in realising our requirement to make significant financial savings but there were still a number of significant cost pressures to be managed as part of that process. Our annual contribution to the NHS Litigation Authority's Clinical Negligence Scheme increased by £10 million. This is an NHS pool which effectively provides medical insurance. The increase reflects the growing value of claims the NHSLA is settling nationally but also the fact that its discount scheme for good risk management measures came to an end. This alone added £3 million to our contribution.

The illustration below shows how we spent the money we received

How each £1 was spent

- Nursing pay, 19p
- Medical pay, 18p
- Supplies & Services - drug costs, 15p
- Supplies & Services - clinical supplies, 12p
- Admin pay, 4p
- Allied Health Professional pay, 3p
- Ancillary pay, 3p
- Management pay, 3p
- Premises, 3p
- Scientific pay, 2p
- Supplies & Services - other, 1p
- Medical and Other Insurance, 3p
- Depreciation, 2p
- Others, 12p
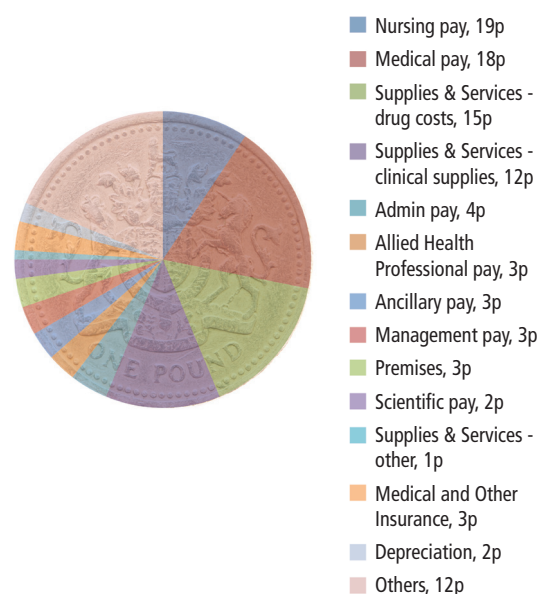
Working Capital

In 2015/16 we borrowed £37 million to cover the cash shortfall arising from our planned revenue deficit. This measure, which followed a similar patter to the previous year when we received £34 million of Public Dividend

Capital, was part of our financial plan from the outset and it enabled us to meet all of our payment obligations as they arose. We paid 93% of our suppliers' invoices within 30 days, an improvement on the 90% we achieved in 2014/15.

As part of our on-going drive towards sustainable finances a number of steps were taken to improve our systems and processes for collecting income due to us. More of our front line services offer "Chip and Pin" payment facilities, more of our chargeable services can be paid online and we have strengthened our approach to pursuing outstanding debt. These measures have helped us to reduce current Trade and Receivables on the Statement of Financial Position by £8 million. There has also been a reduction of almost £1 million in the value of inventories held. Much of the reduction has come from the Pharmacy initiative to contract dispensary management to Boots plc. This is a clear example of a service quality improvement delivering financial benefit.

There will be further improvements to our underlying working capital processes during 2016/17 which will help build future resilience in cash management. In 2016/17, as a direct result of planning our return to revenue breakeven there is no plan to take further working capital loans. There are certain risks to that plan. Our ability to breakeven is dependent upon receipt of £23 million of national "Sustainability and Transformation" funding as well as achievement of our programme of cash releasing savings. To secure the former we will have to demonstrate achievement of a number of qualitative and financial targets throughout the year. We believe that we can meet the requirements of success but in the event that we are unable to realise our full plans then it may be necessary to enter into a further agreement with the Department of Health to draw down working capital support.

The knowledge that cash support is available if needed and the fact that we have plans in place to deliver breakeven in 2016/17, underpinned by signed income agreements with our major

commissioners, has given the Trust directors the assurance they require to complete the 2015/16 accounts on the basis that the Trust is a going concern. The deficits posted in each of the last two financial years were planned as part of a longer term return to sustainable breakeven and cash support was available to meet all obligations.

Capital Investment

Our original plan to invest £71 million in fixed assets (land, buildings, equipment and IT) assumed a level of loan funding which could not be made available by the Department of Health due to other economic pressures. There was uncertainty through much of the year about how much loan funding would be available for distribution but we were successful in securing two important approvals (Generating Station Complex (GSC) at LGI £5million and general investment funding £8m). Only £4 million of these approvals were spent in 2015/16 due to the nature and timing of the schemes involved. The balance will be drawn to complete the projects in 2016/17. A further £1 million of residual borrowing from a 2014/15 approval was drawn in the year but total borrowing of £5 million compares to £11 million the year before. Further pressure was experienced in the reduction of centrally funded Public Dividend Capital from almost £5 million in 2014/15 to £1 million in 2015/16.

All of this meant that priority had to be given to schemes essential to the maintenance of patient safety with a corresponding reduction in our developmental ambitions. It is nevertheless pleasing to note that we were able to attract a £1.5 million increase in grants and donations. Almost £4.5 million was granted to us to help buy medical equipment or upgrade essential clinical systems, most of it from charitable organisations whose continued support is greatly appreciated. Grants and donations are sources of funding which we will be pursuing more robustly in the future to counter the risk that centrally available funds will continue to be subject to economic constraints.

The table below identifies some of the capital investment schemes from 2015/16

Scheme	£m
Electrical infrastructure at St James's - project completion	2
Hyperpolarised MRI - Block 25 LGI	2
E Medicines system	1
Safer Wards	1
Bioinformatics project	1
Ultrasound scanners	0.9
Replacement of Vascular Room 2 - LGI	0.6
Anaesthetic equipment	0.6

Our capital investment programme for 2016/17 is set at £50 million. Borrowing accounts for £17 million of this of which £6 million has already been approved in 2015/16. Of the remaining loan assumption of £11 million just over half relates to further work on the LGI GSC. Formal approval is required but all of the discussions with the regulator to date have been very positive. Other sources of funding for the £50 million are more secure and so we are confident that this planned increase in capital investment is feasible and robust.

Looking ahead

Following two years of planned deficits we will return to financial breakeven in 2016/17 with a small surplus of £1 million. Our ability to meet this objective assumes:

- Delivering £66 million of savings

- Receiving £23 million from the national Sustainability and Transformation by achieving agreed access targets

- Maintaining sufficient capacity to maintain the balance between planned and unplanned admissions

The risks associated with realising these plans have been fully recognised. Executive and Clinical Directors meet regularly to review the savings programme and ensure processes to implement specific schemes are in place. Work to reduce waste, utilising the Leeds

Improvement Method will continue and expand. We will continue to work with our city wide partners to develop our integrated healthcare approach and improve patient flows. All schemes for enhancing efficiency are subject to careful Quality Impact Assessments to ensure that while financial savings can be delivered, access, safety and care quality for patients are not diminished. In addition, the Trust has fully embraced the recommendations of Lord Carter's review into efficiency and is actively continuing with the work it began as one of the original cohort of 22 pilot sites for this important national project.

The Trust has clearly demonstrated its ability to deliver its financial targets and major savings programmes in each of the last two difficult years. With the processes it now has in place we believe the plan to return a small financial surplus in 2016/17 is realistic and achievable.

1.5 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.

In areas where we continue to face challenges due to system-wide issues beyond our control, we continue to work with our partners and commissioners to put plans in place to manage these.

We are committed to providing high-quality, safe care to all of our patients and we will continue to work across the Trust so that we can meet the guidelines set out by the NHS Constitution.

1.6 Future direction

We continue to work on the plans set out in our five year strategy so that we can achieve a sound financial platform and continue to invest in high quality services with accessible waiting times for our patients.

Our vision is to provide the country's best specialist and integrated care. To realise our ambition we have continued to pursue our five goals and embed The Leeds Way values into everything that we do. We are committed to the continuous improvement of our services and getting the best value from our existing resources.

In order to help us improve our services, NHSI has provided us with the opportunity to work with the Virginia Mason Institute to create a programme of work called the Leeds Improvement Method. The Virginia Mason Institute in the USA has world-wide reputation for transforming healthcare by putting patients first and applying a rigorous and consistent approach to safety.This includes reducing medication errors, hospital acquired infections, errors in care and wasteful processes for patents and staff. This improves care for patients and saves valuable resources that can be invested into other services. We have already started this work with two initial workstreams and, during 2016/17, we will also be undertaking an additional two workstreams.

Our strategic approach is to bring together all these pieces of work and, with the excellent commitment of our staff, we believe that we can make real progress towards our ambition.

Delivering our vision

As well as the projects that we are doing within the Trust, the work we do in cooperation with colleagues in other health and social care agencies is of the utmost importance to our future. Patients often receive care from a number of organisations as well as from voluntary organisations, family and friends. Integrating the efforts of all these agencies and carers is essential if patients are to receive high quality care without delay. We will continue working with other West Yorkshire Trusts, the City Council and GP colleagues to assess how well these 'patients' pathways' work and how we can improve them. One area we are focusing on, for example, are the delays that occur in finding suitable accommodation for elderly patients who no longer need to be in a hospital bed.

The Trust welcomed the publication of the Department of Health's Five Year Forward View. This document requires health and social service organisations to work more closely together. Each geographic area will publish a joint Sustainability and Transformation Plan (STP). Although this work is at an early stage, the proposal for our area is to prepare an STP for West Yorkshire with a dedicated section for Leeds. As our patients come from Leeds, West Yorkshire and further afield we welcome this opportunity to work more closely with other agencies across all our catchment areas.

Our Board continues to meet regularly to discuss the strategic plans for our Trust. They also meet regularly with our Clinical Directors who manage the Trust's 18 Clinical Service Units (CSU) which cover all our clinical specialties. A theme that has been regularly discussed this year is the advances in clinical care which mean that many of our patients with routine conditions do not have to spend as long in hospital as they used to. There are also more treatment options available for those with complex conditions and often better prospects for their recovery. This has meant that the patients that we have in our beds now tend to need more medical and nursing care than they may have done 20 years ago.

To keep up with these advances in clinical practice the Board has discussed the changes we need to make to our staffing and facilities. To modernise our facilities we need to have more modern day-case suites for routine cases and better operating theatre and intensive care facilities for those more seriously ill. The Board has spent some time looking at how we can achieve this, particularly with regard to the LGI site. The purpose is to see whether the departments housed in the old Victorian buildings at the LGI can be replaced with new, more effective facilities.

Overall we believe that our future direction is a positive one. We will continue to pursue our ambition to provide the best specialist and integrated care by working with our staff and our shared set of values. We have made significant progress in moving to a position of financial sustainability and we will progress our financial recovery plan with our NHSI colleagues. We will continue to work closely with our partners in other health and social care agencies to develop Sustainability and Transformation Plans for our local area to integrate the pathways of care for our patients. Finally we will use our resources well and look to invest as much as we can in high quality staff and modern facilities for our patients.

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.

Our Risk Management Policy describes our approach to risk management and outlines the formal structures in place to support this. The policy was reviewed and updated this year and sets out the key responsibilities and accountabilities to ensure risk is identified, evaluated and controlled.

Risk management is a core component of governance across the organisation and is a fundamental step towards continuing to build a 'safety culture' across the Trust. During 2015/16, work has continued to strengthen the risk management processes supporting delivery of the Trust's objectives and our continued journey of improvement. Our new governance committee structure is now fully embedded and operating well. Any risks that may impact on the Trust's ability to deliver its strategic objectives are escalated from 'ward to board'.

Throughout the year we have continued to embed and utilise the modules on Datix, the Trust-wide risk management database, to ensure incidents, complaints, claims and inquests are efficiently reviewed and acted upon.

Following the introduction of on-line incident reporting in 2013/14, a small task group was set up to review what was working well and what further improvements could be made. The task group made a number of recommendations which have all been implemented. These changes include simplifications to the on-line form, greater use of drop down boxes to speed up the process of reporting and the development of various user guides which can be used both for the induction of new staff and as refreshers for existing staff. This work has helped improve the accuracy and timeliness of incident reporting.

We have also invested in additional IT equipment which has resulted in significant improvements to the operating speed of the Datix system, meaning incident reports can be reviewed and acted upon much more promptly.

LTHT has introduced significant developments in our processes for identifying, sharing and embedding learning. A Lessons Learned group has been set up, with the main focus being to improve and embed learning Trust-wide. The group is responsible for producing a bi-monthly Lessons Learned bulletin and a Lessons Learned 'YouTube' channel has also been introduced to disseminate short videos of learning. Both have resulted in very positive feedback from staff.

This year, a sub-group of Lessons Learned was also formed called the Patient Experience and Risk Team (PERT). The focus is to identify lessons learned from claims and incident data collated by the Risk Management team, and complaints, PALS and Family and Friends Test data collated by the Patient Experience team. The information is analysed by CSUs and disseminated in poster form so that it is easily accessible to all levels of staff across each department. This initiative has been very well received by frontline staff and actions have been taken to address lessons identified from analysis of the data.

Following the introduction of the Duty of Candour regulation in November 2014, the Trust's Risk Management team has worked hard to support staff across the organisation in understanding and implementing these requirements. Over the course of the year a number of training sessions have been provided and a learning tool has been developed and made available on the Trust's intranet. This work is on-going to support our staff to understand the importance of communicating fully with patients and their families when things go wrong. We have built on our existing processes for being open and transparent and have introduced weekly monitoring of compliance with the regulation to ensure that this becomes the standard within the Trust whenever an incident resulting in moderate harm or worse occurs.

We have taken the opportunity to review some of our risk management-related training including the lead investigator course. This is delivered to staff who wish to learn how to conduct serious incident investigations. The training course has been completely refreshed with a greater focus on practical skills and knowledge. The feedback has been extremely positive and the intention is to re-run this on a regular basis over the next year so that we can expand our pool of trained investigators.

The next step is the development of human factors training across the Trust so that we can better understand the reasons why some incidents occur and develop robust actions to prevent them from happening again. This will be a key focus for the Risk Management team over the next year.

1.8 Research and innovation

LTHT wants to be a global leader in clinical research and innovation which will ensure our patients benefit from access to innovative treatments and diagnostics. Research and innovation is also central to our vision to be the best for specialist care and ensure we secure our future as a leading clinical research centre in the UK.

We are one of the best performing trusts in England for research projects recognised by the National Institute for Health Research (NIHR). This is the highest standard for research and last year we involved more than 10,500 patients in 460 high quality research studies.

We work with a wide range of research partners to undertake clinical trials and translational research, which uses scientific findings to enhance health and wellbeing. The clinical research and trials which take place across LTHT cover all areas of medicine and healthcare, testing treatments for a wide range of diseases. This ensures that the majority of our patients have the opportunity to be involved.

This year we have been involved in a number of leading edge research programmes and we have included a number of case studies to highlight this exciting work.

NIHR Clinical Research Facility (CRF) for experimental medicine

The NIHR Leeds CRF was set up in 2012 to carry out clinical trials and other translational studies in experimental medicine, with a speciality focus in cancer, musculoskeletal disease and cardiovascular disease. The CRF aims to expand its remit to support other disease entities in the future.

Case study: Vitamin D

Dr Klaus Witte presented the findings of his Vitamin D study, known as VINDICATE, at the American College of Cardiology Meeting in Chicago. The study, funded by the Medical Research Council, involved more than 160 patients from Leeds who were already being treated for heart failure. The patients who took the vitamin D3 tablet for one year experienced an improvement in their ejection fraction (the measurement of how much blood is pumped from the heart with each heartbeat), from an average of 26% to 34%.

This is the first evidence that vitamin D3 can improve heart function of people with heart muscle weakness. These findings could make a significant difference to the care of heart failure patients as it may reduce the need for some patients to be fitted with an implantable cardioverter defibrillator (ICD), which are expensive and involve an operation.

Case study: 100,000 Genome Project

The CRF has made a major contribution to the successful bid of the Yorkshire and Humber region to become a Genomics England Limited Genomic Medicine Centre (GMC) for the national 100,000 Genome Project.

This project is a ground breaking initiative which will span two to three years and aims to decode the DNA sequences of 100,000 genomes from people who have a rare disease or condition, their families, and people with cancer.

The project aims to allow the NHS to utilise the most up-to-date technology in molecular pathology to enhance our understanding, diagnosis and treatment of disease. Patients and the public have been widely consulted throughout the development of the project centrally, but also locally within our own centre. The Department of Health has commended our level of engagement and commitment to patient and public involvement.

LTHT recruited the first patient to this project in the Yorkshire and Humber GMC. Donna Proctor, a 49-year-old domestic supervisor at Seacroft Hospital, is being investigated for a rare disease which results in an inherited predisposition to cancer.

NIHR Musculoskeletal Biomedical Research Unit

Leeds Musculoskeletal Biomedical Research Unit (LMBRU) was established in 2008 as part of the NIHR commitment to support translational research in priority areas of high disease burden and clinical need. The unit has been awarded £13 million through this funding until 2017. Based at Chapel Allerton Hospital, facilities include state-of-the-art research-dedicated imaging, including MRI and ultrasound.

LMBRU is a partnership between LTHT and the University of Leeds and aims to be a world leading centre for translational research into individually targeted, patient-focussed therapies across musculoskeletal diseases. These include:

- Immune-mediated inflammatory diseases
  - Inflammatory arthritis e.g. rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis
  - Connective tissue diseases - scleroderma and lupus
- Osteoarthritis - degenerative and mechanical arthritis

Through this partnership, the University of Leeds and LTHT are now the most highly cited English Higher Education Institute and NHS organisation respectively in the area of musculoskeletal diseases.

Case study: prevention of autoimmune rheumatic disease

A key ambition of LMBRU is to develop a research programme for the prevention of rheumatoid arthritis (RA) and other autoimmune rheumatic diseases. Professor Paul Emery and the team have established a large cohort of individuals who are at risk of developing RA. The team have shown that at-risk individuals can be identified in primary care and that clinical, imaging and serological biomarkers can be used to identify those at highest risk of progression to RA. They have also demonstrated that musculoskeletal ultrasound can be used to identify at-risk individuals who will imminently progress to a diagnosis of arthritis. This data is forming the basis for new preventive strategies in RA.

Studying prospective cohorts of at-risk individuals in this way provides the opportunity to accurately characterise the sequence of events before the onset of RA, as well as quantify the risk of different preclinical phenotypes.

Work is now underway to investigate mucosal autoimmunity and the microbiome in this cohort, which will provide important insights into the development of a disease.

NIHR Diagnostic Evidence Cooperative (DEC)

Leeds hosts one of four NIHR DECs in the country. Set up in 2013 to support the evaluation of innovative diagnostics tests, the DEC underpins the delivery of personalised, accurate and timely healthcare at an affordable cost.

The Leeds DEC has an internationally recognised multidisciplinary team of clinicians and methodologists in diagnostic test evaluation and, together with the four other DECs, provides broad and coherent support to the diagnostics and precision medicine industries.

The Leeds DEC aims to reduce the time and costs associated with evaluating and adopting new diagnostic tests in the NHS. This is done through innovations in research methodologies for test validity studies, clinical trials, health economics and medical informatics.

The Leeds DEC is targeting cancer, musculoskeletal diseases and diseases of the bladder, kidney, liver and bowel. Its research will help to improve the quality of life of patients by helping them to access the most appropriate treatments quickly and will lead to improvements in healthcare services by helping the NHS make the best use of its resources.

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. Using input from patients and clinicians, the Leeds HTC will identify where technology could make a difference and then bring together a range of experts, from engineering or nanotechnology for example, to develop a solution.

Case study: Laser test for cancerous polyps avoids pathology delays

Most patients who undergo a screening colonoscopy are classed as low, medium or high risk of developing subsequent polyps or colon cancer. The majority of polyps found during colonoscopy are usually benign, though all are removed for histological confirmation as it can be difficult to visually distinguish between benign and pre-cancerous polyps. For this reason, all polyps have to be sent off for analysis, which can take up to two weeks. Depending on the number and size of pre-cancerous polyps detected, patients are then scheduled for their next follow-up colonoscopy.

The WavSTAT Optical Biopsy System®, developed by medical device company, SpectraScience, connects a fibre optic probe to standard endoscopic biopsy forceps. The device shines light onto the polyp and analyses the fluorescence reflected back from the tissue. Depending on the wavelengths of reflected light detected, the system can determine if the polyp is pre-cancerous or benign and informs the clinician of the result.

Leeds HTC is the only UK centre working with Spectrascience in a Europe-wide multi-centre trial testing the accuracy of the WavSTAT technology. To date, we have recruited over 60 patients and submitted close to 140 polyps as part of an overall Europe-wide target of 1200.

The trial, now nearing completion, provides data on the accuracy of diagnosis using WavSTAT, compared to laboratory analysis. This reduces the risk of missing out any pre-cancerous polyps.

Further work is needed to assess potential cost savings for the NHS and how well the technology enables clinicians to set appropriate follow up schedules. Further UK trials are also likely to be required to ensure the technology can be used effectively by different endoscopy centres across the country.

As well as the generous support from the NIHR we also receive funding from other sources, including 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.

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

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. A partnership between LTHT and the University of Leeds, the MRC is a purpose-built space housing 40 staff, with high tech computational infrastructure and a safe data room.

Leeds Cancer Research UK Centre

The Centre is a partnership between LTHT, University of Leeds and Cancer Research UK which aims to harness the scientific power of Leeds-based cancer researchers to deliver improvements in cancer care at local, national and international level. In particular, it focuses on neuro-oncology, haemato-oncology and cancer immunology.

The Leeds Cancer Research UK Centre covers a broad range of world-class cancer research, with the goal of translating science into benefits for patients. Beyond research, the centre is also keen to build stronger relationships with the local community - with patients undergoing cancer treatment, their carers, cancer survivors and the wider public.

Case study: Viral therapy to treat cancer

We have successfully delivered a proof of principle, window of opportunity study, using oncolytic viruses (OV) as intravenous delivery of Immuno-virotherapy to brain tumours in patients. The study met its primary endpoints and completed early.

We have been able to demonstrate that systemically delivered OV can successfully access and infect tumour cells in the brain. This means that systemically administered OV have potential for treating tumours in the brain, regardless of their precise anatomical location. Immune activation has also been demonstrated, leading to the development of further studies and optimisation of this approach.

1.9 Sustainability report

Environmental Impact Performance Indicators 2015/16

Area		Non-financial Metric	Non-financial Metric		Financial data (£,000)	Financial data (£,000)
		2015/16	2014/15		2015/16	2014/15
Waste minimisation and management	Clinical HTI	*2112* Tonnes	2599 Tonnes	Total Waste Cost	*£1,345*	£1,603
	Clinical - Alternative	*2092* Tonnes	2585 Tonnes			
	Landfill disposal	*1122* Tonnes	1003 Tonnes			
	Recycling / Recovery	*2339* Tonnes	1715 Tonnes			
Finite resources	Water / sewerage	778,877 m³	753,838 m³	Water / Sewerage	£1,372	£1,321
	Electricity	15.04 GWh	15.99 GWh	Energy	£9,767	£10,728
	Gas	318.4 GWh	308.6 GWh			
	Oil	0.35 GWh	2.42 GWh			

Leeds Teaching Hospitals has a vision to become one of the greenest Trusts in the UK by 2020. We have been working towards this goal in a number of ways.

The GRASP campaign

This year we launched GRASP, our sustainability campaign. During the Chief Executive's March Challenge in 2015, staff submitted a number of recycling and money saving ideas. The GRASP campaign was developed as a result of this feedback and is now the overarching drive for the whole of the Trust's sustainability work.

GRASP stands for be Green, Recycle, be Aware, be Sustainable for our Patients. The campaign's ethos is that by engaging with staff and asking them to turn off equipment when not in use, reduce excessive heat and noise, switch off lights to help promote sleep and reduce light pollution, close doors to improve patient safety and privacy and help regulate room temperatures, we can save energy and improve patient experience at the same time.

We now have a number of staff throughout the Trust who have signed up to be GRASP

champions and are promoting the campaign within their work areas.

The first strand of the campaign has focused on saving energy and early results of this drive are encouraging. However, we will be better able to monitor and report on this element of the campaign once energy meters come online early next year.

Recycling and waste segregation

In 2015, we became the first Trust in the country to employ a Specialist Waste Trainer. The introduction of this role pays testament to the Trust's commitment to reduce waste, recycle better and smarter and so reduce our carbon footprint.

In November 2015 we commenced a pilot scheme for Dry Mixed Recycling (DMR) in a number of areas at St James's including: Portering and Patient Environment Teams, Informatics, Finance and Internal Audit, Occupational Therapy, Physiotherapy, Breast Screening, Pharmacy and Theatres. These areas have been assessed and provided with special bins most suited to their waste recycling needs.

The Trust's theatre management, theatre training team and Specialist Waste Trainer with the help of Doctors, Anesthetists and Matrons have formed a waste working group. This is to introduce improved working practices and raise awareness of waste segregation, making it part of theatre culture.

The Trust produces 2,600 tonnes of general waste and, by adopting DMR across our hospitals, we can realistically save £30,000 each year. During 2016/17 this successful pilot will be rolled out across our hospitals.

Waste training has also seen significant growth as our Specialist Waste Trainer now delivers waste management presentations at inductions for health care workers, medical students and estates and facilities staff.

We are also running a single use item trial with the Foot Health department in Beckett Wing that will enable the Trust to become more cost efficient and reduce our carbon foot print through reduced incineration costs. Should the trial prove to be successful, it will be introduced to other clinical areas such as theatres, MRI suites and delivery suites, all of which use a high volume of single use items.

Golden Sharps 'Champion of Champions' Awards

In March 2016 we crowned the Golden Sharps 'Champion of Champions', which recognises departments' efforts to improve safe waste disposal and good segregation. The three shortlisted teams were;

1. **Babies 'R' Us**, Wards L44/45 (maternity wards) at LGI, won an award for implementing seven segregated waste streams to replace the one they had previously, and a second award for their consistent scores at internal and external audits after retraining 140 staff on the new sharps system.

2. **The High Brows**, Bexley Wing Radiology/Fluoroscopy department introduced seven different waste streams. They also identified an innovative way to segregate offensive waste safely and effectively.

3. **The Chapel Apples**, the Radiology department at Chapel Allerton Hospital, won their award for introducing two new waste streams and implementing a self-audit tool, saving £2,880 on their waste bill and consistently scoring above 90% in their waste audits.

The Golden Sharps initiative has ultimately improved segregation across the Trust and reduced the number of sharp containers used by around 16,000, equating to a saving of £19,000.

Energy saving

Next year we will upgrade much of our building energy management systems across the Trust which will lead to further cost savings. Planned work is underway to renew energy contracts at both LGI and St James's over the next few years with a view to delivering significant energy savings and reduction of our carbon emissions.

We are also applying for funding to support significant investment in new controlled lighting that could result in considerable energy and cost savings.

Future plans

We are working towards ISO 14001 accreditation and this environmental management system will enable us to fully measure and improve our impact on the environment.

Over the next three years we will upgrade our Generating Station Complex at LGI enabling us to provide more than enough clean energy to run the hospital, our neighbouring partner the University of Leeds and sell power back into the grid.

Other sustainability initiatives are being explored and include:

- several electrical charging points are being installed in key locations at both LGI and St James's for hybrid cars

- we will introduce computer auto shut down software early next year

- engaging with the local community and schools around sustainability issues

- turning some of the Trust's green areas into allotments and partnering with a mental health charity to grow organic produce

1.10 International partnerships

We continue to share our experience with international colleagues and are actively working to develop new partnerships with healthcare organisations across the world. This kind of collaborative working with our international colleagues means we can develop our global reputation of providing excellence in healthcare and helps us share learning and experience with the very best hospitals from around the world. This will help us to achieve our vision of being the best for specialist care.

UK Trade and Investment (UKTI)

Working with UKTI and other professional contacts, our networking activity has ensured a steady flow of commercial leads. Current discussions include an opportunity in tele-medicine with China and some other work in India.

Ministry of Health, Malta

We continue to work with the Ministry of Health in Malta and have undertaken a training programme for a group of Medical Physicists from the country so that we can share our knowledge and expertise in this area. In May, the first cohort of students completed their 22-month training programme with the Trust. Mr David Berridge, Deputy Chief Medical Officer, presented the students with certificates to recognise their achievements.

Following graduation the students returned to Malta to take up positions in the newly-built Oncology wing of the prestigious Mater Dei Hospital.

We have also used our scientific and technical expertise to assist in the complex commissioning of radiotherapy equipment at a new Oncology centre in Valletta, Malta, and have hosted a training visit from senior nursing staff to assist their learning.

King Hussein Cancer Centre, Jordan

The Memorandum of Understanding between LTHT and the King Hussein Cancer Centre in Amman, Jordan has enabled us to benefit from a fellowship programme which will help us share learning and experience between hospitals. We have also been approached to work with them on the provision of other services.

Ministry of Health, Turkey

A major hospital build programme in Turkey has been identified by the UK government as a High Value Opportunity. LTHT was invited to present at a healthcare summit in Istanbul to support this programme. We subsequently hosted a senior delegation from the Ministry of Health for Turkey and we continue to work with them to explore future opportunities for the Trust.

Section 2

Accountability

Accountability report

We have 16,752 people working across our hospitals in a variety of different roles. This year we have recruited more nurses, midwives and support staff and reduced the amount we spend on agency administrative staff. This is a saving that can be directly invested into patient care. The commitment and achievements of our people are key to the successes of our Trust.

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.

2.1 Members of the Trust Board

During 2015/16, the Board met bi-monthly and in public on the last Thursday of every month (excluding August), at St James's University Hospital. Between the public meetings, informal workshops were held to address such issues as strategy, planning and training and development.

A staff council member is also present at the public 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

There have been no changes to the members of the Board during 2015/16.

Appointment of Non-Executive Directors

The Non-Executive Directors have been appointed by the NHS TDA, now NHSI. 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 ensure independence and to comply with Monitor's Code of Governance.

Termination of the term of office of the Chair would have been undertaken by Sir Peter Carr, during his term as Chair of NHS TDA. Moving forward this would be by Ed Smith, Chair of NHS Improvement.

All Board directors comply with the 'fit and proper person test' that was introduced from 27 November 2014, with reconfirmation at a public Board meeting in January 2016.

Measuring the performance of the Board members

The Chair of the Board was appraised by Sir Peter Carr in January 2016. The outcome was positive, with clear objectives agreed for the coming year. The appraisal process is a thorough review of the assessment of the performance and independence of the non-executive directors, reflecting on their contribution to the Trust during the year. The Trust Board requires all Non-Executive Directors to be independent in their judgement. The structure of the Trust Board and its assurance committees ensures along with the integrity of individual directors that no one individual or group dominates the decision making processes.

The Chair has in turn appraised each of the Non-Executive Directors during the year, set objectives for the coming year and undertaken mid-year reviews. Should the Chair have any concerns about their performance, this would be discussed with NHSI 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 2015. 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 Audit Committee at the year-end which in due course will be received

by the Board. These reports provide a summary on their progress and an evaluation of their performance during the year.

The Board has continued with its development programme during the year and has commenced an externally facilitated 360 evaluation process which will report back to the Board in June 2016. This includes feedback from external stakeholders.

Register of interests

The register of interests for Trust Board members was reported to the public Board meeting at the end of the financial year 7 April 2016. This is available on the Trust's website or by contacting the Trust Board Secretary.

Non-Executive Directors of the Board during 2015-16

Dr Linda Pollard CBE 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 recently joined the NHS Improvement Chairs' Advisory Group.

She has held posts as a former Chair of the West Yorkshire Strategic Health Authority, Bradford District Care Trust, Bradford Teaching Hospitals NHS Trust, Regional Chair of the Learning and Skills Council and Deputy Chair of Yorkshire Forward, the Regional Development Agency.

Linda is also Chair of An Inspirational Journey, an organisation that supports women to reach the top of their professions and seeks to increase their participation at Board level and has recently taken the role of Chair of the Advisory Group of the Balanced Business Forum.

Linda was Regional Chairman of Coutts Bank plc, and 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 marketing and international marketing, and as a director in the family automotive business, 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 Deputy Lieutenant of West Yorkshire and 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.

Caroline Johnstone
Vice-Chair, Non-Executive Director and Chair of the Audit Committee

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

Caroline is a Chartered Accountant and has had a career of 35 years working in professional services, based in Leeds, London and Edinburgh. As a partner with PricewaterhouseCoopers (PwC) until 2009, 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 Non-Executive Director and Chair of the audit committee of Synthomer plc, she provides consulting services to a range of global chemical organisations and is a member of the governing council of the University of Leeds. She is also Chair of BARCA - Leeds, a community-based charity in the city.

Mark Chamberlain
Non-Executive Director

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.

Professor Paul Stewart
Non-Executive Director and Chair of the Research, Education and Training (RET) 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 a 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 and has been involved in 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 10 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 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 hospitals, 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 the 18-week target. 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.

Suzanne formally commenced her new duties as Deputy Chief Executive from 5 January 2015, which includes responsibility for operational services.

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 of 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 Trustee of the HFMA Strategic Costing Committee.

Dr Yvette Oade
Chief Medical Officer
From 1 June 2013

Before joining the Trust, Yvette was the Chief Medical Officer and Deputy Chief Executive of Hull and East Yorkshire Hospitals NHS Trust, a role she took on in 2011.

Originally trained as a doctor in Leeds, Yvette became a consultant paediatrician and has 19 years' experience in this role. She has a special interest in paediatric diabetes and endocrinology.

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. Yvette has extensive experience in leading 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 has been a leading figure in Human Resources (HR) within the NHS for nearly two decades. Chief Executive of NHS Employers since December 2010, Dean came to Leeds Teaching Hospitals mid-2014. Other notable positions have included Director of Workforce and Education at NHS North West and Deputy Director of Workforce for the NHS at the Department of Health.

Following its creation in 1999, Dean was the first HR Director at East Midlands Ambulance Service. He has also worked in hospitals 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 and is a member of Sheffield Business School's Advisory Board as well as a visiting fellow at Newcastle Business School. He is former Chair of the Board of the Chartered Institute of Personnel and Development (CIPD) and was awarded Companionship of the CIPD in 2015. He has 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 for the Corporate Alliance Against Domestic Violence (CAADV). He is a regular conference speaker, published in a number of journals, on the editorial board of Human Resource Management Journal (HRMJ) and the International Journal of Human Resources Development 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 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 the redevelopment programme in a £200m investment in improved facilities on their site. Prior to this he had been the Programme Director for the Salford's Health Investment for Tomorrow (SHIFT) Programme which has seen a whole system remodelling of services underpinned by a series of capital investments in new facilities across the city.

Simon 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.

2.2 Attendance tables

Audit Committee

Name/Date	7 May 2015	27 May 2015	17 Sep 2015	03 Dec 2015	06 Apr 2016
Members:					
Caroline Johnstone	✓	✓	✓	✓	✓
Allison Page	✓	✗	✓	✓	✓
Carl Chambers	✗	✓	✓	✓	✓
Bill Kirkup	✗	✗	✗	✗	✓
In Attendance:					
Jo Bray	✓	✓	✓	✓	✓
Craig Brigg	✓	✗	✗	✓	✓
David Gregory	✓	✓	✓	✓	✓
Julian Hartley	✓	✗	✓	✗	✓
Phil Jones	✓	✓	✗	✗	
Paul Moore	✓	✓			
Perminder Sethi	✓	✓	✓	✗	✗
Mel Simmonds	For TW	✓	✓	✗	✓
Andy Thomas	✓	✗	✗	✓	✓
Tony Whitfield	✗	✓	✓	✓	Sick leave
Steve Appleton	✗	✗	✓	✓	✗
David Berridge	✗	✗	✓	✗	✓
Suresh Patel	✗	✗	✓	✓	✓
Yvette Oade					✓
Dean Royles					✓
Linda Pollard			Observer	Observer	Observer

Board Time-Outs

Name/Date	30 Apr '15	11 Jun '15	25 Jun '15	08 Oct '15	09 Oct '15	10 Dec '15	21 Jan '16	09 Mar '16	10 Mar '16
Linda Pollard	✓	✓	✓	✓	✓	✓	✓	✓	✓
Carl Chambers	✓	✓	✓	✓	✓	✓	✓	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	✓	✓	✓
Yvette Oade	✓	✘	✘	✓	A/L	✓	✓	✓	✓
Dean Royles	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tony Whitfield	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bill Kirkup	✓	✓	✓	✓	✘	✓	✓	✓	✓
Paul Stewart	✓	✘	✘	✓	✓	✘	✓	✘	✓
Simon Neville	✓	✓	A/L	✓	✓	✓	✓	✓	✓
Allison Page	✘	✓	✓	✓	✓	✓	✓	✓	✓
Mark Chamberlain	✘	✓	✓	✓	✓	✓	✓	✓	✓
Mark Ellerby	✘	✘	✘	✓	✓	✘	✘	✘	✓
Caroline Johnstone	✘	✘	✓	✓	✓	✓	✘	✓	✓
In Attendance:									
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Berridge						✓			

Chairs of Committees Committee

Name/Date	25 Jun 2015	17 Sep 2015	10 Dec 2015
Linda Pollard	✓	✓	✓
Carl Chambers	✓	✓	✓
Julian Hartley	✓	✓	✓
Dean Royles	For YO		
Bill Kirkup	✓	✓	✓
Mark Chamberlain	✓	✓	✓
Caroline Johnstone	✓	✓	✓
Jo Bray	✓	✓	✓
Yvette Oade	✘	✓	✓

Finance and Performance Committee

Name/Date	29 Apr '15	27 May '15	24 Jun '15	29 Jul '15	26 Aug '15	23 Sep '15	05 Nov '15	25 Nov '15	21 Dec '15	27 Jan '16	24 Feb '16	06 Apr '16
Members:												
Carl Chambers	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓
Linda Pollard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Ehrhardt	✓	✓	✗	✗	✓	✓	✗	✓	✓	✓	✗	Maternity leave
Julian Hartley	✓	✓	✓	A/L	A/L	✓	✓	✓	A/L	✓	✓	✓
Suzanne Hinchliffe	✓	*	✓	✓	✓	✓	✓	Sick leave	✓	**	✓	✓
Caroline Johnstone	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Mel Simmonds	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓
Simon Neville	✓	✓		✓	✓	✓	✓	✓	✓	✗	✓	✓
Tony Whitfield	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Sick leave
Dean Royles	✓	✓	✓	✓	✓	✓	***	✓	✓	✓	✓	✓
Mark Ellerby	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dave Berridge	✗	✓	✗	✓	✗	✓	✓	✓	✓	✗	✓	✓
Neil Atkinson										✓	✓	✓
In Attendance:												
Steve Spoerry	✓	✓	✓	✗	✗	✓						
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	A/L	✓	✓	✓
Mark Chamberlain							✓					

*SH attending Nurse Director Event for North and Midlands
**SH attending Roles of the COO event with Monitor
***DR attending CIPD Conference

Quality Assurance Committee

Name/Date	06 May '15	08 Jul '15	30 Sep '15	04 Feb '16
Members:				
Bill Kirkup	✓	✓	✓	✓
David Berridge	✓	✓	✓	✓
Craig Brigg	✓	✓	✓	✓
Mark Chamberlain	✓	✓	✓	✓
Yvette Oade	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	Sick leave	✓
Allison Page		✘	✓	✓
In Attendance:				
Jo Bray	✓	✓	✓	✓
Julia Roper	✓	✓	✓	✓

Research, Education and Training (RET) Committee

Name/Date	12 May '15	07 Jul '15	22 Sep '15	03 Nov '15	12 Jan '16	01 Mar '16
Members:						
Yvette Oade	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	*	✓	✓	✘	A/L
Paul Stewart	✓	✘	✓	✘	✓	✘
Stuart Haines	✓	✓	✓	✓	✓	✓
Jacqueline Andrews	✓	✓	✓	✓	✓	✓
Jon Cooper	✓	✓	✘	✓	✘	✓
Claire Gaunt	✓	✓	✓	✓	✓	✓
Andrew Lewington	✓	✘	✓	✘	✓	✓
Dean Royles	✓	✓	✘	✓	✓	✓
Ian Simmons	✓	✘	✓	✓	✘	✘
Stephen Smye	✓	✘	✓	✓	✓	✓
Karen Vella	✓	✘	✓	✓	✓	✘
Heather Iles-Smith	✓	✓	✓	✘	✓	✓
Andy Thomas	✓	✓	✘	✘	✘	✘
Klaus Witte	✘	✓	✘	✘	✘	✘
Adam Glaser	✘	✓	✘	✘	✘	✓
Anne-Maree Keenan	✘	✘	✘	✓	✓	✘
Pam Jones					✓	✘
Mitch Waterman					✓	✓
Kirste Mellish					✓	✘
In Attendance:						
Donna Johnstone	✓	✓	✓	✓	✓	✓
Paul Binnie	✓	✓	✘	✓	✓	✓

*SH - meeting with TDA

Risk Management Committee

Name/Date	02 Apr '15	07 May '15	04 Jun '15	02 Jul '15	06 Aug '15	03 Sep '15	01 Oct '15	05 Nov '15	03 Dec '15	07 Jan '16	04 Feb '16	03 Mar '16
Members:												
Julian Hartley	✓	✓	*	✗	✓	✓	✓	✓	✓	✓	✓	**
Suzanne Hinchliffe	✓	✓	✓	A/L	✓	✓	Sick leave	✓	Sick leave	✓	✓	A/L
Simon Neville	✓	✗	✓	A/L	✓	✓	✓	✓	✓	✓	✓	✗
Dean Royles	✓	✓	Leave of absence	✓	✓	✓	✓	***	✓	✓	✓	✓
Tony Whitfield	✓	***	✓	✓	A/L	✓	✓	✓	✓	✓	✓	✓
Yvette Oade	A/L	✓	✓	✓	✓	A/L	Leave of absence	✓	✓	✓	✓	✓
In Attendance:												
David Berridge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Craig Brigg	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bryan Gill	✓											
Caroline Johnstone	✓	✓	✗	✓	✗	✓	✓	✓	✓	✗	✓	✗
Nigel Lumb	✓	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	✗
Paul Moore	✓	✓	✓									
Mel Simmonds		For TW			For TW							
Jo Bray	✗	✓	✓	✓	✗	✗	✓	✗	✓	✓	✗	✓
Peter Aldridge	✗	✓	✗	✗	✓	✗	✗	✓	✗	✗	✓	✗
David Gregory	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mike Harrop								✓	✓	✓		

Accountability

Board of Directors

Name/Date	28 May '15		30 Jul '15		24 Sep '15		26 Nov '15		28 Jan '16		07 April '16	
Members:	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu
Linda Pollard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Carl Chambers	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓
Mark Ellerby	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	Sick leave	Sick leave	✓	✓	✓	✓
Bill Kirkup	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Caroline Johnstone	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓
Simon Neville	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Yvette Oade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dean Royles	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tony Whitfield	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Sick leave	Sick leave
Paul Stewart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Allison Page	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mark Chamberlain	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓		
In Attendance:												
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Berridge			✓				✓	✓				

2.3 Annual Governance Statement.

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 2016 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 Assurance and Finance & Performance. The Risk Management Committee and Research, Education and Training Committees are executive Committees reporting to the Board of Directors. The Committees have all provided an annual report with attendance of the respective Committee Chair at the Audit Committee at the start of April 2016. 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. Whilst 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 and support 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. The Quality Assurance Committee provides oversight on this process.

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 six 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 reviewed its risk appetite 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, which was revised during 2015/16. 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 and 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 training, regular communications, leadership 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 2016, 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 - ECS, 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 Executive Team has worked with the Training and Development Authority (TDA) and moving forward with NHS Improvement (NHS I) with the aim to return financial sustainability within three years as defined in the recovery plan. We have successfully delivered the second year of this recovery plan. The key risks have been ensuring we are paid appropriately for the activity we deliver, alongside

the rigorous scrutiny of costs to ensure Cost Improvement Plan (CIP) plans are delivered without compromise to clinical safety.

- Fundamental Standards of Safety & Quality - Nurse Staffing Levels, Medical Staffing, C. difficile and MRSA targets, Failure to Rescue a Deteriorating Patient, and pressures to maintain Endoscopy full JAG accreditation.

- Performance & Regulation - A combination of demand and capacity factors giving rise to unsustainable levels of medical outlying and delayed discharges and growing pressures associated with violence due to organic, mental health or behavioural reasons, unserviceable critical IT infrastructure and resilience and issues with corroded heating pipes and power failures due to electrical infrastructure/ resilience with risks to clinical services.

- Strategy – The Sustainable Transformation Plan (STP) needs to address the importance of 'out of hospital care'.

- Detailed risk registers are proactively used throughout the organisation. 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 Assurance 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 Fundamental Standards. There were no unannounced inspections by the Care Quality Commission during 2015/16; 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. Progress has been made and continues in accordance with the plan. The Trust is currently preparing for a follow-up inspection in May 2016.

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.

7.2 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 NHS Improvement 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, regulators (NHS Trust Development Authority/ NHS Improvement) 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. Work is currently underway working with local and regional stakeholders for the development of five year Sustainability and Transformation Plans (STPs) for both the West Yorkshire 'footprint' and the City of Leeds.

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, Finance & Performance Committee and the 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, the Board has approved a Quality Improvement Strategy with progress reports to the Quality Assurance Committee and Board, and published within the Quality Account.

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 and External Audit is overseen by the Audit Committee. I can report there has been a good handover between the outgoing and incoming External Auditors during the year.

10. Annual Quality Account

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 2015/16 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 Assurance Committee (QAC), a formal committee of the Trust Board, which is chaired by a Non-Executive Director. The Quality Assurance 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 Clinical Directors of all CSUs, Executive Directors and Chairs of the Board's Committees (including the Annual Report for each of their respective 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 its assurance 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 & Performance Committee; (ii) Audit Committee, (iii) Quality Assurance Committee; (iv) Remuneration Committee; supported by the executive Committees (v) Research, Education and Training Committee; (vi) and Risk Management Committee. Chairs of the Board's Committees report to the Board at the first available Board meeting after each Committee meeting and 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 2014/15. 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. Progress continued to be made during the year culminating in a 'significant assurance' opinion by the Head of Internal Audit, in line with the previous year. As a result of their work in 2015/16, 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 2015/16, there were ten (out of 40) assignments for which Internal Audit reported the level of assurance as limited for the year ended 31st March 2016. 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. Health & Safety

15.1 In 2015 the Trust received a Royal Society for the Prevention of Accident (ROSPA) Safety Silver Award for its H&S management arrangement; this is a significant achievement for an organisation entering the awards system for the first time. The Trust has participated in this year's programme and has achieved a Gold Award.

16. Significant In-Year Matters

(i) There were 89 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, relating to checking procedures (retained surgical swab, wrong tooth extraction, incorrect lens implant and two incidents involving wrong side anaesthetic block). Each case has been thoroughly investigated and reported to local Commissioners. Detailed action plans are developed and implemented in response to specific incidents.

(iii) There were three formal Prevention of Future Death Reports (formerly known as Rule 43 and now known as Regulation 28 Reports) issued by the Coroner. At the time of report, the Trust had addressed the concerns raised by the Coroner in two of the cases, and is in discussions about possible solutions to address the third which has only recently been received.

(iv) There were 58 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) At an aggregate level the Trust met the national requirement to treat a minimum of 92% of patients within 18-weeks of referral for those patients on the incomplete standard pathway. We closed the year with an aggregate performance at 92.1% with five reporting specialties

not meeting the incomplete this standard (Trauma & Orthopedics, Plastic Surgery, Urology, General Surgery and 'Others'). The main underperformance relates to continued growth in Restorative Dentistry demand which outstrips availability within the Trust by 29%. If the Trust removed the Restorative Dentistry position the overall performance would be reported at a position of 93.1%. It is worth noting that this target was achieved at a time when the Trust has 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.

(vi) The Trust closed the year meeting 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. All cancer waiting times standards were achieved for October, November, December and Q3 for the first time since Q1 in 2013/14. The Trust continues to work closely with neighboring 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. Work is on-going to re-establish a regional Cancer Network to improve communication and address referral and potential capacity/closure issues to services in local acute providers.

The Trust has introduced a process for the monitoring of long waiting patients, i.e. those waiting more than 104 days and still had no treatment. At the beginning of 2015/16 there were more than 100 patients who had waited over 104 days, which has reduced to 21 patients (as at 18th March 2016).

(vii) The Emergency Care Standard (ECS) national target of 95% of patients being seen within 4 hours of presenting in A&E was achieved from April to September 2015. The overall position

was achieved at LGI and Wharfedale with pressures predominantly at the St James's site. 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. There has been progress year on year with 84 breaches of this target at the year end, compared to 132 in 2015/16.

(viii) The Trust met the national requirement to undertake 99% diagnostic tests within six weeks of referral from August to end of December, including achievement at Endoscopy level from September to support the achievement of JAG accreditation. Achievement has been challenging during Quarter 4 particularly with MRI capacity and continuing internal capacity against demand mismatch for endoscopy (the Trust had internal capacity to undertake 9,000 tests but has carried out 17,758 during the year through the use of in reach providers and the independent sector) discussions have taken place during the year with Commissioners to address the on-going internal capacity shortfall for 2016/17. This report includes 15 modalities against this standard.

(ix) The Trust has met the national requirements to see a minimum of 93% of patients within 14 days for i) urgent GP referral for suspected cancer since October 2015 and ii) the breast symptomatic target, from September 2015. However during January the target for suspected cancer was not achieved and further analysis has shown this related to patient choice to defer their appointments over the Christmas period. The Trust closed the year with both these targets being maintained.

(x) The Trust has continued to make progress in controlling hospital acquired infection, reducing the incidence of meticillin-resistant Staphylococcus aureus (MRSA) bacteraemias to a total of six plus one culture contaminant for the year, which is a reduction of over 10% from the previous year, although it is recognised that the nationally set trajectory is zero There was a total of 139 cases of Clostridium difficile disease for the year, against an absolute trajectory of 119; which is an increase on that of the previous year. This is in line with findings nationally for 2015-6. However, this year, we have also identified a greater proportion of the cases, in conjunction with our commissioners, as having no "lapse in care" whilst in our Trust. 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 2015/16, and has delivered a financial year end position of a deficit in line with the plan. The Trust has received support from the Department of Health to fund the deficit during the year. The Trust has achieved the second year of the three year financial recovery plan and the Trust has submitted plans to NHS Improvement to deliver a small surplus of £1.2m for 2016/17.

(xii) The Trust is mitigating on-going challenges associated with the historic legacy of lack of basic investment into capital infrastructure. Hence the high level risks described as; unserviceable critical IT infrastructure and resilience issues along with issues with corroded heating pipes and power failures due to electricity infrastructure/ resilience with risks to clinical services. These have presented challenges during the year.

(xiii) During the Trust has experienced growth in managing the violence towards patients and staff due to organic, mental health or behavioural issues. Joint work is taking place between LTHT and the local mental health trust to address this.

(xiv) In year the Trust has instigated Silver Command to oversee operational issues to manage the impact of industrial action by Junior Doctors. Proactive planning and management has resulted in some numbers of patients being cancelled on the actual days of the strike action.

17. Concluding Remarks

17.1 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. We continue to make good progress to address the financial challenges and have delivered the second year of our three year financial plan against the forecast deficit during 2015/16 we are planning to deliver a small surplus in 2016/17. I and the Executive Team have met monthly during 2015/16 with the TDA to report progress. 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 2016 and up to the date of approval of the annual report and accounts.

Signed

Julian Hartley

Chief Executive Date: 26 May 2016

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).

Section 2
Accountability

2.4 Remuneration report

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 2015/16 was £230-235k (2014/15, £235-240k). This was 8.79 times (2014/15, 8.72) the median remuneration of the workforce, which was £26,659 (2014/15, £26,975). The highest paid director in both 2015/16 and 2014/15 was the Chief Medical Officer.

In 2015/16, one employee (2014/15 nil) received remuneration in excess of the highest-paid director. The banded remuneration of the employee was £275-280k and included payments for additional work beyond contracted hours.

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 2016).

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

Name and Title	2015-16				
	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL
	(bands of £5,000) £000	Rounded to nearest £100	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
M Chamberlain - Non Executive Director	5-10	4	0	0	5-10
C Chambers - Non Executive Director (from 09 December 2014)	5-10	0	0	0	5-10
M Ellerby - Non Executive Director (from 01 December 2014)	5-10	10	0	0	5-10
J.M. Hartley - Chief Executive	225-230	0	0	42.5-45	270-275
Prof S Hinchliffe CBE - Deputy Chief Executive and Chief Nurse	175-180	0	0	20-22.5	200-205
C.A. Johnstone - Non Executive Director (Vice Chair)	5-10	5	0	0	5-10
Dr W Kirkup CBE - Non Executive Director (from 19 May 2014)	5-10	13	0	0	5-10
S.H. Neville - Director of Strategy & Planning (from 01 May 2014)	145-150	59	0	20-22.5	175-180
Dr Y.A. Oade - Chief Medical Officer	205-210	0	25-30	25-27.5	260-265
A.J. Page - Non Executive Director (from 01 January 2014)	5-10	0	0	0	5-10
Dr L. Pollard CBE DL - Chair	40-45	17	0	0	45-50
D.A. Royles - Director of Human Resources and Organisational Development (from 08 September 2014)	165-170	0	0	52.5-55	220-225
Prof P.M. Stewart - Non Executive Director	5-10	0	0	0	5-10
T.A. Whitfield - Director of Finance	175-180	0	0	15-17.5	195-200

Taxable expense payments are rounded to the nearest £100 in the above table. 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.

Taxable expenses for the Director of Strategy and Planning relate to a lease car. All other 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.

B) Salaries and allowances 2014-15 of senior managers who also served in 2015-16

Name and Title	2014-15				
	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL
	(bands of £5,000) £000	Rounded to nearest £100	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
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	225-230	0	0	50-52.5	280-285
Prof S Hinchliffe CBE - Deputy Chief Executive and Chief Nurse	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 CBE - 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 - Chief Medical Officer	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 CBE DL - Chair	40-45	18	0	0	45-50
D.A.Royles - Director of Human Resources and Organisational Development (from 08 September 2014)	90-95	0	0	25-27.5	120-125
Prof P.M. Stewart - Non Executive Director	5-10	0	0	0	5-10
T A Whitfield - Director of Finance	175-180	0	0	162.5-165	340-345

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

C) Pension Benefits

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age as at 31 March 2016 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2015 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real Increase in Cash Equivalent Transfer Value £000
J.M. Hartley - Chief Executive	2.5-5	0-2.5	55-60	160-165	921	984	26
Prof S Hinchliffe CBE - Deputy Chief Executive and Chief Nurse	0-2.5	5-7.5	70-75	220-225	1,433	1,506	28
S.H. Neville - Director of Strategy & Planning (from 01 May 2014)	0-2.5	5-7.5	55-60	165-170	1,062	1,118	21
Dr Y.A. Oade - Chief Medical Officer	0-2.5	5-7.5	80-85	245-250	1,646	1,730	32
D.A. Royles - Director of Human Resources and Organisational Development (from 08 September 2014)	2.5-5	12.5-15	65-70	195-200	1,086	1,230	65
T.A. Whitfield - Director of Finance	0-2.5	2.5-5	85-90	260-265	1,849	1,920	25

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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience ("SCAPE") discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

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 2016, for more than £220 per day and that last longer than six months.

	Number
Number of existing engagements as of 31 March 2016	1
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	2
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	1
Number for whom assurance has been requested	-
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
The total number of individuals both on and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year.	14

The Trust's pay multiples, senior managers pay and pension reports, plus all associated narrative, also form part of our external auditors' review and are covered by the audit opinion in the financial statement on pages 185-187.

2.5 Regulatory ratings

The NHS TDA, now NHS Improvement, placed Leeds Teaching Hospitals NHS Trust in Escalation Level 2. This means that we have had some delivery issues, including clinical and/or financial challenges, which require improvement. We continue to work closely with them to ensure we are delivering the best quality outcomes and experience for our patients, and meeting national performance and financial standards.

In May 2016, we welcomed the CQC back to the Trust to follow up on their visit in March 2014. We were keen to show them the progress we had made on completing the action points stated in their improvement plan and for them to see the improvements across our hospitals. At the time of writing we are awaiting the results of this report.

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 provide 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.

This year, the Information Governance team has supported the development of key Trust projects, including the rollout of PPM+ and Leeds Care Record (LCR).

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2015/16.

The Trust is fully committed to ensuring that personal information is protected and used appropriately. We are also constantly reviewing our existing processes to significantly minimise the likelihood of breaches.

2.7 Our people

Leeds Teaching Hospitals' greatest asset is our people. Their skill and dedication means we have access to some of the country's leading clinical expertise and can offer patients the highest quality care.

The Trust is committed to investing in our people. We actively encourage staff to take part in training and professional development and to share their ideas on how we can improve patient care.

Our people also play a significant role in the development of the Trust and improving staff engagement is one of our key priorities. For the 2015 annual NHS Staff Survey we surveyed all our employees and we received 7,486 responses, which was the highest total number of responses nationally by a considerable margin. The results of the survey showed our overall engagement score increased to 3.76 from 3.66 (on a scale of

up to 5) and overall the results showed we were the most improved Trust.

This really shows that our people right across LTHT have got on board with the values of The Leeds Way and that this is embedded into everything we do.

Workforce statistics

Trust Board

At 31 March 2015

Gender	Job Role	Position Title	No.
Female	Medical Director	Medical Director	1
	Non Executive Director	Chairman	1
	Non Executive Director	Non Executive Director	2
	Nurse Manager	Chief Nurse / Deputy Chief Executive	1
Female Total			5
Male	Chief Executive	Chief Executive	1
	Non Executive Director	Non Executive Director	5
	Senior Manager	Director of HR	1
	Senior Manager	Director of Finance	1
	Senior Manager	Director of Strategy & Planning	1
Male Total			9
Grand Total			14

The gender division of all other employees is included below.

Gender	Head Count
Female	12,623
Male	4,129
Grand Total	16,752

Health and wellbeing

The Trust is committed to improving the quality of working life for staff and recognises the importance of supporting staff to look after their health and wellbeing.

Staff Health and Wellbeing services are being re-branded to provide a more co-ordinated approach, increase awareness of the wide range of our health and wellbeing offers and to improve access to services. This will include a new website, a regular newsletter and telephone advice together with a broader range of services to support emotional well-being, additional healthy lifestyle initiatives such as fitness testing and direct access to physiotherapy services.

In addition, the Trust will be working with on-site suppliers to promote healthy food choices in outlets and dining areas.

The range of services to support staff and promote health and wellbeing include:

- Occupational Health Services
- Staff Physiotherapy service
- Staff Counselling service
- Smoking Cessation
- Weight management
- Staff gyms, fitness tests and exercise classes
- Team sports
- Walking and cycling initiatives
- Cycle to Work scheme

As well as free exercise classes to encourage staff to keep active, we also support team initiatives to keep up motivation. In 2015, over 650 members of staff across 130 teams participated in a successful six week walking challenge called 'Step in to Summer', walking over 100,000 miles between them. This year a similar challenge "Race 2 Rio" is themed around the Olympics to include running, cycling and swimming.

To support staff in balancing their home and work life, three staff nurseries are available for the children of LTHT employees and advice is provided on accessing externally provided care and financial support for example through tax credits, childcare vouchers and nursery salary sacrifice schemes.

Sickness absence

We have been reducing sickness rates across the Trust in 2015/16 and have the lowest sickness absence rate of all Trusts in the Yorkshire and Humber region.

12 month sickness trend April 2015 - March 2016

Education and training

High quality education is one of the strategic goals of the Trust. In partnership with the University of Leeds and Leeds Beckett University, we deliver one of the largest medical education programmes in the NHS with around 1,300 medical students on clinical attachments and more than 950 trainee doctors in the Trust. Medical Education Leeds, the collaboration between the Trust and the universities, aims to deliver high quality medical education, combined with increased opportunities to learn and practice clinical skills that drive improvements in patient safety and compassionate clinical care.

Undergraduate Medical Education

There has been a big increase in the quality of undergraduate medical education in the Trust in recent years. We improved the 'conversation' with CSU leaders about the quality of undergraduate medical education, with better and more timely reporting of quality metrics.

This has enabled us to improve the support we give to clinicians delivering education to students.

During term-time, more than 370 students are on placement in the Trust at any one time. This year, the undergraduate team moved into J34 in Beckett Wing, which has been transformed into a multi-professional undergraduate 'hub' to become the focal point for teaching in the Trust. We also support a multi-professional student forum, which gives clinical students a voice in shaping the future of clinical education in Leeds.

Postgraduate Medical Education

Our postgraduate medical training programme is the biggest in Yorkshire and the Humber and one of the largest in the country. We have more than 950 medical and dental trainees undertaking clinical placements with us, across all training grades: foundation core and higher.

The Chief Registrar is a new appointment in the Trust, and is a leadership role for a higher level trainee. The Junior Doctor Body (JDB) is a committee of junior doctors, with a membership drawn from across the CSUs that links directly to the corporate medical directorate. The JDB's aim is to improve communication and engagement between the Trust and trainee doctors.

Simulation and Technology Enhanced Learning

We have a number of clinical skills and simulation centres.

The Leeds Children's Hospital at the LGI manages its own facility delivering multi-professional paediatric training.

Medical Education Leeds operates three education centres at the St James's site and one at the LGI. The Clinical Practice Centre (CPC) at St James's provides medium and high fidelity simulation over two teaching floors, with a meeting space and refreshment area on the ground floor. Each room is set up to emulate clinical areas and there are two simulation wards to deliver a wide range of clinical education and adult resuscitation services. Recent investment in new video recording technology has vastly increased the scope of the training that can be delivered in the CPC.

The Leeds Institute for Minimally Invasive Therapy (LIMIT) is an internationally renowned high-fidelity facility providing specialist surgical simulation. It has a simulation theatre, wet lab and an array of surgical simulators.

A new Technology Enhanced Learning team is in place, creating new learning modules using the latest web technologies and delivering online courses and training programmes on the purpose-built Virtual Learning Environment. In addition, the team collaborates with colleagues across the Trust in the development of packages enabling better learning from incidents. The department has been actively developing social media to engage trainers, trainees and students.

Working with Health Education England across Yorkshire and the Humber (HEEYH)

Each year, HEEYH conducts a quality management visit to the Trust to assess the quality of postgraduate medical education. This visit, combined with the General Medical Council's annual National Training Survey and HEEYH's own survey, help to generate a number of educational 'conditions'. These conditions help us to improve the quality of postgraduate medical education centres in Leeds and a considerable amount of work has gone into reducing the number of conditions registered against the Trust so that we can be sure we're providing high quality education programmes.

The Trust continues to collaborate with HEEYH on a number of initiatives, including:

- Simulation and clinical skills: there is greater alignment between the Trust's and HEEYH's simulation strategies. LTHT delivers a significant proportion of regional teaching in our facilities.
- Regional induction: a clinical e-induction package that was originally developed in LTHT is being rolled out across Yorkshire and the Humber in collaboration with HEEYH and other Trusts.

NHS staff libraries

We continue to operate library facilities in three of our hospitals; LGI, St James's and at Wharfedale.

The main St James's library is located in the Clinical Sciences Building and is run in partnership with the University of Leeds, with whom we also have an agreement giving all staff access to University library services. The Cookridge library is located in Bexley Wing. A new undergraduate library was refurbished this year and opened in J34 in April 2016.

The main Trust library and evidence centre is located in the Gilbert Scott Building at LGI. The team provides an excellent service which is available to all Trust staff, both in the libraries and through on-line tools such as 'Athens' and 'Up to Date'.

Nursing and Allied Health Professional Education

The Trust is committed to supporting all nursing and midwifery staff to achieve their potential through education and development. We want to ensure that every patient receives high-quality, timely care from highly trained staff.

We offer clinical placements in a wide range of settings for 900 nursing and Allied Health Practitioner (AHP) students from most of the universities in the Yorkshire and Humber region. Their learning is supported by over 1500 mentors and practice supervisors, including 190 new mentors who completed the Support for Learning in Practice programme in 2015/16.

We encourage staff in our hospitals to be lifelong learners. All new starters to the Trust take part in our unique Introduction to Professional Practice programme during their first week, which prepares them for working in our clinical areas. From there, registered professionals are supported to further develop their learning through appraisal with the aim of enhancing, improving and innovating patient care.

In 2015/16 the Trust supported 542 applications in nursing and midwifery for higher education programmes, ranging from single modules to doctoral study. By working in close partnership with HEEYH, as well as local and national education providers, we have helped staff to develop and deliver new roles. This includes 46 full-time training posts for advanced practitioners and a new academic route for Assistant Practitioners to Foundation Degree level.

Our Organisational Learning team, in partnership with Learn Direct, have increased the intakes of our successful healthcare apprenticeship programme and offer training opportunities for up to 250 candidates a year. For our unregistered care staff already in post we are looking to support the first cohort of a higher apprenticeship programme in 2016.

All of this work is designed to develop the leadership potential of our nursing and midwifery staff though programmes from the Leadership Academy, local university providers and in-house developments.

Organisational Learning

This year, Organisational Learning (OL) merged with the Estates and Facilities Training and IT Training teams to provide high quality education, training and organisational development across the Trust.

Access to informal development, in particular coaching, has expanded following an increase in our internal coaching team. We also continue to provide workplace mediation in partnership with our health and social care providers.

Mentoring for new consultants

To ensure our new consultants have access to quality mentoring, 30 were given training in a series of workshops, designed and facilitated by Edgecumbe Health.

Interviews have begun for a clinician to undertake a 12-month secondment to champion mentoring within the CSUs, revise the current handbook, develop a training and support plan and properly embed mentoring across LTHT over the next year.

Inductions

Our Corporate Induction programme has been refreshed and our joining processes streamlined with 99% of new starters completing Corporate Induction on their first day of employment as of May 2016, compared with 97.5% in May 2015. Our Chief Executive welcomes all new starters to the organisation on their first day of employment and our feedback shows that this is appreciated and provides valuable context of their role within the organisation.

Agenda for Change (AfC) Appraisal

Having an appraisal is a key opportunity for staff and managers to have a meaningful two way conversation about performance, behaviours and objectives as well as an opportunity for staff members to agree a personal development plan.

In 2015/16, 95% of AfC staff had an appraisal. This means that we are the highest performer nationally for ensuring staff have an appraisal.

Mandatory training

The mandatory training framework is made up of 11 overarching topics which ensure that all staff receive the training and updates they need. This includes around 70,000 training sessions on an annual basis.

Overall Mandatory Training performance within the Trust has improved from 89% as of May 2015 to 92% in May 2016. The Trust Training Interface supports staff to view and complete their Mandatory Training and currently has over 13,000 users across the Trust. All new starters to the organisation are encouraged to register on the Trust Training Interface as part of the induction process. In addition, OL has made use of the work done by Estates and Facilities to provide access to IT systems for their staff who do not usually have it.

Talent and leadership update

Over the past 12 months, 648 staff members took part in our leadership development plans, following the launch of the 'Leaders in Leeds' programme.

Programmes Apr 2015 - Mar 2016	Target Audience	Number of participants
CMI - Level 2 Team Leading	Team leaders, supervisors	35
CMI - Level 3 First Line Management	First line managers	48
CMI - Level 5 Management & Leadership	Middle managers	27
CMI - Level 7 Strategic Management & Leadership	Senior managers	4
New Consultants Development programme	New consultants	49
Lead Clinicians Development programme	Existing and aspirant lead clinicians	59
Post Graduate Certificate in Healthcare Management	8a and above	30
Introduction to Management	Bands 3 - 7	145
Leading for Patients - B5	Nurses, healthcare scientists, allied health professionals	105
Leading for Patients - B6		39
Leading for Patients - B7		42
Business Partnering programme	Senior leaders & leaders (corporate)	57
Talent @ Leeds	All levels	8

Sage and Thyme programme

This is a foundation level communication skills training programme suitable for any member of staff. The programme trains staff to deliver timely interventions to support patients, families and visitors who may be upset or distressed. To date there are 622 staff who have been trained, of which 339 have been trained during 2015/16.

Work experience and schools engagement

In 2015 LTHT made a Health Education England partnership pledge, committing to working with partner organisations to deliver a number of key strategic intentions linked to the national framework, The Talent for Care.

We have been focussing on improving links with local schools, colleges and communities in a number of ways. This year we have:

- Recruited a member of staff to develop links between schools and LTHT, capture activity and support evaluation to identify which engagement activities provide most benefit for all parties
- Signed up to Inspiring the Future, a national charity that connects local schools and employers
- Recruited and developed over 151 LTHT staff as volunteer Healthcare Career Ambassadors to promote NHS careers and jobs
- Instigated partnership agreements with two local schools
- Provided more than 80 LTHT staff to attend 35 school or career related events in Leeds
- Provided four week internship placements to local schools, and mentoring students through the Career Ready programme
- Worked with schools and relevant partners to develop appropriate resources and work-related engagement activities

Apprentices

In 2015/16, 234 apprentices have started at LTHT in a wide range of areas including:

Clinical Support Workers	169
Business Administration Assistants	49
Pharmacy	5
Medical Engineering	4
Medical Physics	4
Mechanical & Engineering	2
Gardening	1

Learning bursts

Learning bursts are a condensed training session designed to equip leaders in the Trust with vital skills that are key to their work. They offer an alternative to traditional training, allowing participants to attend shorter 90-minute group sessions rather than full day workshops.

1,071 members of staff attended these sessions during 2015/16 and we will work to increase this over the next year.

Sector-based work academy

In partnership with Leeds City Council and Jobcentre Plus, we operate a sector-based work academy which aims to bring unemployed people back into the work place by offering them a role as an Apprentice Clinical Support Worker (CSW).

In 2015, 25 people began and successfully completed this programme and were offered substantive employment as CSWs.

Supporting our diverse workforce

The annual NHS staff survey tells us that our staff with a protected characteristic including disability, race, gender or ethnic background are more positive about their working experiences than they were in 2015. As part of the 'Our people (staff and volunteers) are supported and engaged' workstream the Trust has set three targeted ambitions to improve the experiences of these staff. By 2020 we will:

- Reduce the discrimination faced by Black Asian and Minority Ethnic staff by 50%.
- Improve the number of Black Asian and Minority Ethnic (BAME) staff who say that the Trust provides equal opportunities by 50%.
- Take positive steps to increase the staff engagement score for our disabled staff by at least 50%.

The 2015 staff survey data shows that we are making good progress in relation to all these ambitions.

In October 2015, the Trust was re-assessed for its eligibility to use the Two Ticks symbol and we were re-accredited as being 'positive about disabled people' in our employment activities. One of the requirements of this commitment is that disabled applicants meeting the essential criteria for a role are automatically guaranteed an interview.

In addition to the 'positive about disabled people' accreditation, the Trust has also signed up to the Mindful Employer Charter. This is a voluntary commitment to work towards removing barriers in the recruitment and retention of staff with mental health problems.

	2014			2015		
	White	BAME	% Gap	White	BAME	% Gap
% Experiencing discrimination at work in last 12 months	12%	25%	17%	8%	21%	13%
% believing the organisation provides equal opportunities for career progression / promotion	86%	70%	16%	88%	77%	11%
	Disabled	Not disabled	% Gap	Disabled	Not disabled	% Gap
Overall staff engagement	3.45	3.71	7%	3.59	3.79	5.2%

Occupational Health Service

The Occupational Health department provides health screening for prospective employees and staff and undertakes health surveillance and immunisation programmes such as the annual Flu Campaign, where 75% of staff were vaccinated last year. A multidisciplinary team provides expert clinical advice to staff and managers to prevent ill-health caused or exacerbated by work and to promote health and well-being, helping to keep staff in work.

The service is registered to the national accreditation scheme for Occupational Health providers, Safe Effective Quality Occupational Health Service (SEQOHS - www.seqohs.org).

Health and safety

Health and Safety in the Trust is overseen by the Risk Management Committee (Board Sub Committee) with supporting assurance groups. Staff involvement and consultation is strongly encouraged, and information from regular meetings of the Health and Safety Consultation Committee is posted on the Trust intranet.

In 2015 the Trust was awarded the prestigious ROSPA Silver Award for it Health and Safety arrangements, The highest possible Award ROSPA Gold was achieved in 2016. Leeds Teaching Hospitals NHS Trust is one of a very small number of NHS Trust to receive this international recognition.

In March 2016 the Trust Board approved a revised Health and Safety Policy, which explicitly details roles, responsibilities, arrangement and integration with the Trust corporate governance processes.

Minimum performance standards have been created for all health and safety risks and wards and departments are audited annually to ensure they comply. An annual Health and Safety Report publishes the results of this auditing process.

RIDDOR (staff) - significant work-related injuries and diseases

Year	2010	2011	2012	2013	2014	2015
RIDDOR's	117	105	93	68	74	61
All reported incidents	20678	21425	24212	25218	26278	28428

What did our staff tell us in the staff survey?

The NHS Staff Survey took place between October and November 2015 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:

- This year we undertook a full census survey for the first time. Significantly more LTHT employees shared their experiences than any other Trust in the country, with 3026 more responses than the second placed Trust. Our response rate was 50.1%, which compares to a national average return of 41% and shows that LTHT staff want to share their experiences.

- We were keen to maximise our response rate to build engagement and help analyse the results by work area. We provided paper surveys for those members of staff without access to computers. We also ran a comprehensive communication campaign with regular reminders and ensured protected time for staff to complete the survey. This means that we not only had a high response rate but heard from a good spread of staff throughout the Trust.

- Overall, LTHT has improved in most areas and has improved at a faster rate than the rest of the NHS. The Trust has moved from a position where we were lagging behind the national average to one where we are now roughly in line with the national average. The Trust is moving in the right direction, however there are still opportunities for improvement.

- LTHT is the most improved NHS Trust nationally for the 2015 Staff survey, improving on 13 of the 32 key findings.

- LTHT staff are reporting that their experiences around treatment of patients and of the Trust as a place to work are improving year on year.

- LTHT scored highest nationally for the percentage of staff appraised in the last 12 months - 95% compared to the national average for acute trusts of 86%.

Recognising and celebrating the achievements of our staff, teams and services

LTHT is incredibly proud of the successes our people continue to achieve in their areas of work and we are committed to celebrating these.

In November 2015 we held our first Trust-wide awards, Time to Shine, which celebrated the work of our people across all areas of the Trust. Awards were presented in 11 categories; all closely linked to The Leeds Way and three Unsung Heroes were named. This event was a great opportunity for teams to showcase the projects they had been working on across the year and encouraged people to share their learning and experience.

We have also made a commitment to recognise the long service of our people. This year we have held two long service events where we celebrate the dedication of colleagues who have 20, 30 or 40 years' service at the Trust with a commemorative certificate and badge. This event is a great opportunity to acknowledge the contribution our people bring to the Trust over a long period of time and for them to share their experiences of working in our hospitals.

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 high-quality care and accessible services. This year, we have continued to listen to our patients and have learnt from their feedback to improve the care we deliver.

3.1 Involving patients and the public

Patient Care and Public Involvement (PCPI) panel

Throughout 2015/16, the Trust brought together a group of people representing a wide range of different local communities to make sure that the views, needs and priorities of patients, carers and the public are properly taken into account. This work centres around the Trust's PCPI Framework toolkit, which makes sure those who use the services of our Trust are involved in how they are provided.

A number of services within the Trust participated by carrying out a self-assessment on the PCPI activity within their area. Including:

- Elderly Medicine
- Infectious Diseases
- Cystic Fibrosis
- Metastatic breast disease

These teams planned and carried out some new engagement and involvement activity before presenting their evidence to the PCPI panel for independent assessment.

Following completion of the four pilots, a workshop took place in September 2015 with wider involvement from departments across the Trust and the local community. The outcome was that the PCPI framework would be made available for wider use across the Trust along with a package of other support tools. This helps more staff in the Trust understand how to better involve patients and the public when making improvements to services in the future.

Building on the success of the PCPI panel, the team are also introducing a patient reference group and a patient leaders programme to further involve patients, carers and the public in the work of the Trust.

Maternity experience workshop

As part of ongoing work on the Maternity Strategy for Leeds 2015-2020 and in response to the 2015 Maternity Survey, the Trust hosted a workshop for mums (and their babies) alongside those delivering maternity care, both in our hospitals and in the community. The workshop was well attended and there were some really interesting discussions with a graphic illustrator on hand to capture what was being said in an easy to understand format.

The event centred on the 'Whose Shoes?' toolkit, which presents participants with scenarios from different points of view - mums, clinical staff, managers and commissioners - in order to generate discussion. The session concluded with participants making pledges about what they are going to do to improve our maternity service at LTHT. Further workshops will be organised to keep an eye on progress.

Section 3
Patient Care and Experience

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 services to friends and family if they needed similar treatment. Patients can choose from six options, ranging from 'extremely likely' to 'extremely unlikely'.

The test has now been successfully rolled out across all Trust inpatient wards, emergency departments, maternity services, children's services, day case units and outpatients. During 2015/16, the Trust gathered 96,279 views and comments from patients about its services via the FFT.

The chart below shows the proportion of patients during that period who recommended Trust services to their friends and family, based on their experience of care. Overall, 93% of patients who completed the FFT test said they would recommend the Trust to friends and family.

Percentage of patients who would recommend Leeds Teaching Hospitals NHS Trust to friends and family

Bar chart showing percentage of patients who would recommend by department:
- Trust overall: 93
- Inpatients: 94.2
- Emergency dept: 85.7
- Maternity: 96
- Outpatients: 95
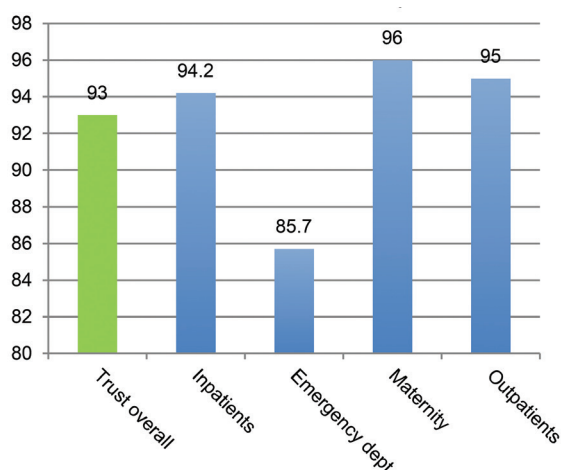
Patients are asked to provide FFT feedback by completing a paper form in most parts of the Trust. However, text messaging (SMS) and Interactive Voice Messaging Services

(IVM) are used in our emergency, maternity and radiotherapy departments. The Patient Experience team continue to look at ways to make completing the test as easy as possible for all our patients. In the coming year, this will include introducing an online version of the feedback form that can be completed electronically.

During 2015/16, feedback gathered from the FFT has been used to make positive changes to patient experience. Examples include:

- Moving smoking shelters further away from Gledhow Wing entrance as patients reported that smoke was drifting into wards through open windows
- Extending visiting times on wards to improve flexibility for visiting friends and family
- Making specialist cooling systems available for side rooms on a ward when patients reported that these become uncomfortably warm
- Improving information provided to patients pre-operatively by displaying posters in waiting areas
- Installation of TVs in clinic waiting areas

Within the Theatres and Anaesthesia CSU, the team is publicly displaying actions that they have taken as a direct result of patient feedback.

YOU SAID
WE DID

You said 'what is Pre-assessment and what does it involve'
We devised a patient illustration poster to explain the role of Pre-assessment prior to your operation

You said there was nothing to do to pass the time whilst waiting to be seen.
We ordered two new flat screen televisions.

You said our waiting room chairs were too small and uncomfortable.
We ordered 20 new chairs in brighter colours for each waiting area.

Example of patient feedback via the FFT:

"Very efficient, waiting time in clinic was a bare minimum. Staff all extremely friendly and polite. Best run NHS clinic I've attended in years".

"Very friendly staff, and kept me fully informed. Were happy to help and answer questions."

"Food was good and staff friendly and helpful. Everyone most helpful at a stressful time."

The word cloud below demonstrates the words that are most commonly captured in comments provided by patients completing the FFT. The bigger the word, the more often our patients have mentioned it in their feedback.

National patient surveys

We believe it is important that we listen and respond to the feedback we receive from patients. Alongside the FFT, the Trust takes part in a number of other national patient surveys coordinated by Picker Institute Europe. Some of these are mandatory but some we undertake voluntarily so that we can check what patients think about their experiences of our hospitals. These surveys also allow us to see whether actions we have put in place in response to previous feedback are having the desired effect and improving our services.

National Inpatient Survey 2015

We take part in the National Inpatient Survey every year. It asks patients specific questions about their admission to hospital, what to expect after procedures and their experience of discharge. The results of the 2015 survey were published in March 2016 and, compared to our previous inpatient survey results, we did significantly better in some areas. However, there are still challenges for us to address elsewhere (see table below). Some patients commented that they feel we do not seek their views on the care we provide and that they are not informed about how to complain and we will be making this a key focus during 2016/17.

There has been a significant decrease in the number of respondents reporting that their discharge was delayed. This is really positive for the Trust as a great deal of work has been done on improving our discharge processes over the last year.

Inpatient Survey: significant changes since last year's survey (lower scores are better)

Areas in which we have got significantly better since last year (survey question)	2014	2015	National Trust Average
Hospital: did not always get enough help from staff to eat meals	41%	30%	34%
Surgery: risks and benefits not fully explained	21%	13%	17%
Surgery: questions beforehand not fully answered	24%	16%	21%
Surgery: anaesthetist / other member of staff did not fully explain how would be put to sleep or control pain	17%	11%	14%
Discharge: was delayed	50%	39%	41%
Area in which we face challenges (survey question)			
Hospital: patients using bath or shower area who shared it with opposite sex	9%	13%	12%
Hospital: toilets not very or not at all clean	4%	7%	5%
Overall: not asked to give views on quality of care	64%	71%	69%
Overall: did not receive any information explaining how to complain	55%	61%	59%

National Maternity Survey 2015

The 2015 National Maternity Survey was published in October. This survey demonstrated significant improvements in performance since the previous survey in 2013. LTHT was ranked nationally as the fifteenth most improved Trust out of the 62 Trusts who conduct their surveys with Picker Institute Europe.

Compared to our previous maternity survey results, we showed significant improvements in some areas, but we know there are still challenges to be addressed. (see table below).

Maternity Survey: significant changes since 2012 survey (lower scores are better)

Areas in which we have significantly improved since last survey (survey question)	2013	2015	National Trust Average
Labour and birth: not all staff introduced themselves	19%	12%	16%
Labour and birth: not involved enough in decisions about care	28%	20%	25%
Postnatal hospital care: not given information or explanations needed	48%	35%	39%
Postnatal hospital care: not treated with kindness and understanding	39%	28%	31%
Postnatal hospital care: hospital room or ward not clean	7%	3%	3%
Postnatal Hospital care: toilets and bathroom not clean	13%	7%	9%
Feeding: did not receive consistent advice	47%	38%	45%
Postnatal care at home: did not have confidence and trust in visiting midwives	35%	24%	29%
Postnatal care at home: did not receive enough help / advice about feeding baby	36%	27%	36%

Areas in which we face challenges (survey question)			
Antenatal check-ups: Did not see same midwife most of the time	51%	60%	65%
During pregnancy: Midwife did not always give the help needed	21%	32%	26%

Whilst we are pleased with our improved performance and with our results compared to other Trusts, we recognise that there are still areas in which we could do better.

As a result of the survey we will be continuing our focus on antenatal care, as this is an area where some scores were lower than in previous years. This work is closely aligned to our Maternity Strategy for Leeds, which has been developed with the Maternity Services Liaison Committee and focuses on greater personalisation and continuity of maternity care.

Patient stories

One of the best ways for us to improve the care we provide is by listening to the stories of our patients and their families. We continue to have been helped this year by the 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 by producing video stories.

Our video stories this year covered a range of topics. One patient, who spent a long period in critical care talked about the positive difference that our Allied Health Professionals (AHPs) had made to her rehabilitation. Other video stories have featured the benefits of spiritual care for patients who have no religion but who are facing difficult times and the problems encountered by parents and their children with complex needs during hospital admission. All of the videos produced by the Patient Experience team are shared with relevant departments to encourage improvement and each month a video story is selected to be shown at the Trust Board meeting.

Some examples of improvement from patient feedback:

The Trust continues to support the Blind and Partially Sighted Patient Advisory Group and the Deaf and Hard of Hearing Patient Advisory Group. Throughout 2015, both groups carried out access audits to help us ensure that we meet the sensory access needs of patients and their carers in individual departments and areas of the Trust. Their partnership working with the Trust helps us meet the NHS Accessible Information Standard for recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability.

One significant development as a result of their involvement has been at the Eye Clinic at Seacroft Hospital. The feedback of the group led to the creation of a new pavement and resetting of tactile surfaces, repainting of handrails and doors and the introduction of 'meet and greet' volunteers to help guide patients.

A new group was established in 2015 by the Catering and Patient Experience teams to look at hospital food provided to patients to make sure it meets their cultural and religious needs. The group includes representatives from the diverse communities across Leeds who have taken part in a food tasting session of around 20 dishes and been part of detailed discussions on the handling, preparation and serving of food. This ensures the values of The Leeds Way continue to be at the centre of the services we provide to our patients.

3.3 Improving information for patients and carers

Providing good quality information for patients and carers is an essential part of the high standards of care we aim for across the Trust. During 2015/16, we developed a Patient Information Forum with representation from CSUs, Patient Experience, Communications and Medical Illustration teams.

The purpose of the group is to develop improved processes to make sure that the information provided to patients and carers is accurate, up to date, relevant, useful and easy to read. Part of the work that the group has been doing is to review the Trust's recently updated patient information procedure and to develop a new website.

The Trust now provides some of its patient information through a system called EIDO. EIDO Healthcare specialise in providing high-quality leaflets that give patients the right information for them to be able to safely consent to procedures. Using EIDO has increased the number of patients who have access to consistent information about their condition.

3.4 Resolving complaints

We value all feedback from patients, relatives and carers. We recognise that this is an important way of helping us to improve both the treatment and care we provide and the environment for our patients across the Trust.

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

In 2015/16 we refreshed our Complaints Policy to better embed learning and we have continued to improve the experience for those who make a complaint on behalf of themselves or someone they know. We have improved how we handle and respond to the complaints we receive, particularly reducing the length of time it takes us to respond and the language we use in our letters.

All complainants are now contacted by telephone as soon we receive their correspondence so we ensure that we fully understand their experience and how they believe we can respond to their concerns. This call is also an opportunity to explain the complaints process and how to access additional support if it is needed. Each complainant is allocated a named member of the Complaints

Team as a single point of contact to make it easier for people to know who they should talk to if they have any questions.

Every CSU has an identified lead for complaints, usually the Head of Nursing. Clinical teams are encouraged to meet with all complainants face to face to resolve concerns if they wish. These meetings can now be audio recorded giving complainants an accurate permanent record of discussions that took place. It also reduces the length of time it takes for us to provide a response.

All complaints are assessed when received by the Trust and go through a quality assurance process. In the first instance this is undertaken by the Complaints Manager or their deputy.

All of our most serious complaints are reviewed weekly by the Chief Nurse, Chief Medical Officer and the Director of Quality. This year we have continued to see a reduction in the volume of this type of complaint with 13% fewer complaints being referred to the Quality Team (from 22 to 19).

An initiative called 'Speak to Sister, Message to Matron' was launched in December 2015. This involves posters being displayed in public areas to inform patients and relatives that speaking with departmental managers can often result in effective and fast resolution of their concerns.

The Complaints team has developed and introduced child-friendly literature that supports and informs younger people about how they can raise a concern. This was presented at a national children's conference hosted by LTHT and was met with much praise.

To ensure we continue to improve the experience of people who complain we have asked NHS Benchmarking to undertake a survey to measure how satisfied people are with the complaints process. This survey started in February 2016 and will run until January 2017. We will use the feedback from this survey to make further improvements to our complaints processes.

This year, we have also increased the number of complaints that were responded to within 40 working days.

Percentage of complaints responded to within 40 working days
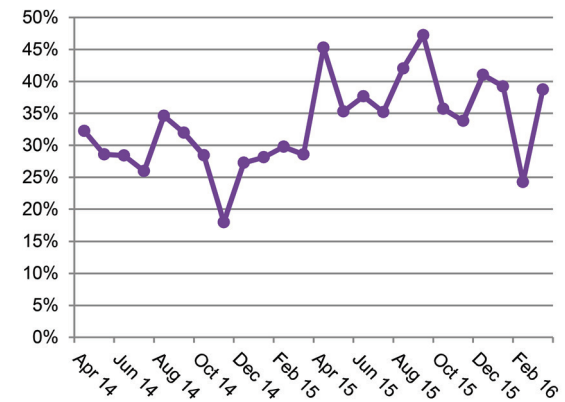
During 2015/16, we received 720 complaints, 16% fewer than the number received during 2014/15 (856).

Cumulative complaints received in 2015-16 compared with 2014-15
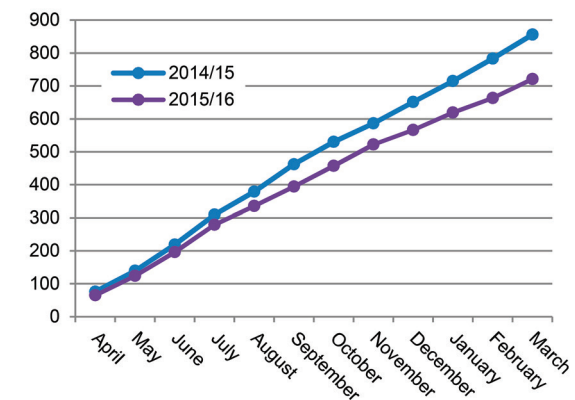
Cumulative serious complaints received in 2014/15
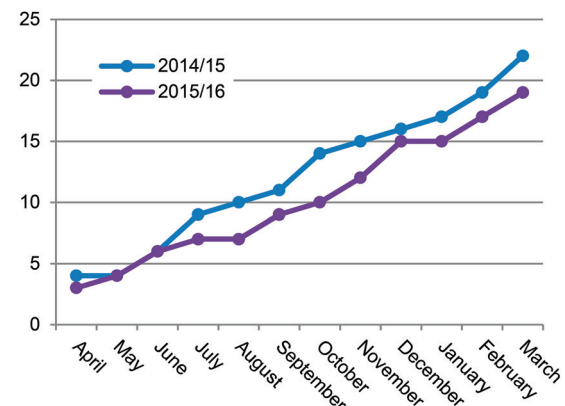
Each complaint may contain a number of themes. The main themes of complaints received during 2015/16 are shown below:

Most common themes raised in complaints received by the Trust in 2015/15

Theme	Count
Communication with patient	409
Communication with relatives/carers	217
Delay/failure in treatment/procedure	124
Delay/failure to diagnose	109
Attitude of medical staff	108
Attitude of nursing staff	89
Inadequate pain management	84
Failure/delay to undertake test	72
Injury sustained during treatment/operation	68
Communication failure between departments	61
Waiting list time (outpatient)	60
Delay/failure to follow up	56
Lack of clinical assessment	55
Not fit for discharge	52
Failure to follow up on observations/recognise deteriorating patient	47
Delay in giving information/results	44
Communication between medical teams	42
Communication failure within department	38
Inadequate discharge planning	36
Delay in medicaton (inpatient)	35

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.

Re-Opened Complaints

We have produced an infographic to show the Complaints team's journey towards improving our complaints process.

The Complaints Team Journey

The Leeds Teaching Hospitals **NHS**
NHS Trust

Open, closed, reopened and new complaints

— Total open on 1st day of month
— Total closed in month
— Total reopened in month
— Total received in month

Staffing

- November 2014 - Appointment of two Band 5 Case Managers and investment in staff in Patient Experience.
- Jan 2015 - Appointment of four Patient Safety and Quality Managers.
- March 2015 - Recruitment of Head of Patient Experience.
- April 2015- Restructure of team to case management.
- 2015 - Recruitment of an additional Lead Nurse in Patient Experience.

Developments

- March 2015- March Challenge - achieved our aim for CSUs to close the longest running open complaints.
- May 2015- Case Managers met with all CSUs to describe the new structure, process changes and vision for complaint handling. Staff, patient and family feedback was used to guide the improvements and changes.
- June 2015- Complaints masterclasses commenced across the Trust to educate staff on complaints and PALS services.
- December 2015- Message to Matron introduced encouraging patients/carers to "Speak to Sister", or send a "Message to Matron" aiming to resolve concerns locally and prevent escalation.
- January 2016- PALS extended to reception areas in our hospitals providing people with the opportunity to discuss their concerns.

Success!
Improving complainant experience!

Process Changes

- April 2015- Dedicated support to CSUs provided by allocated Complaints Handler.
- April 2015- Complaint Handlers calling complainants. Aim to establish all concerns to be investigated and offer a local resolution meeting.
- June 2015- Worked collaboratively with Risk Management through weekly forums, to link incidents with complaints to support learning.
- August 2015- Complaints Team send medical records to lead CSU reducing the time taken to investigate. The aim to reduce the time taken for medical notes to become available for complaint management.
- September 2015- Implementation of Datixweb which enables the team to produce detailed reports.
- December 2015- Implemented a process for recording complaint resolution meetings to improve timeliness and experience for complainants.

Overall successes

- Reduction in the number of complaints received in 2015/16 by 32% compared to 2013/14.
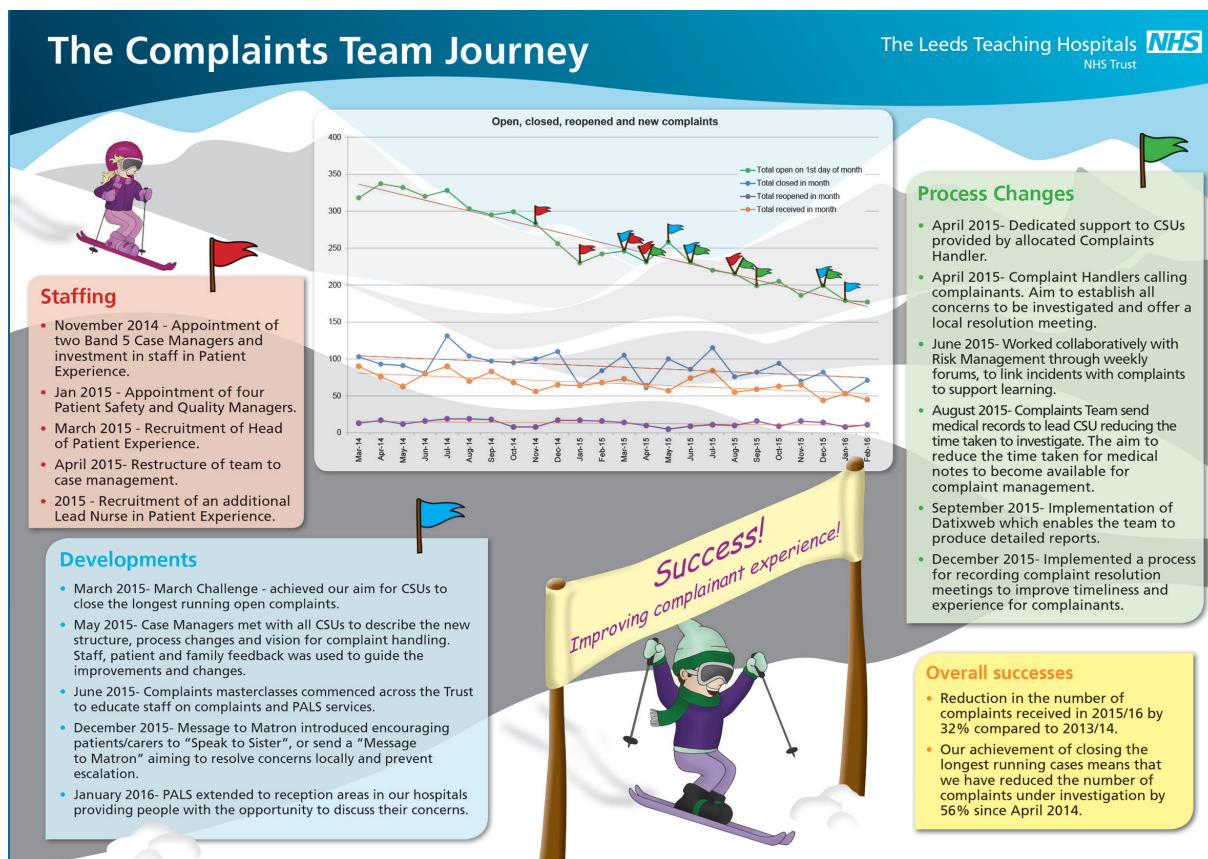- Our achievement of closing the longest running cases means that we have reduced the number of complaints under investigation by 56% since April 2014.

3.5 Working with partners

We continue to develop relationships with local stakeholders such as advocacy groups, community forums and involvement groups. This year, a joint training session was held between the Trust and Advonet, an organisation which supports and promotes independent advocacy in Leeds and the surrounding area, to identify opportunities for learning and ways in which experience can be improved for people who wish to raise a concern.

A number of recent Trust initiatives have been developed with the support of our partners. These include the development of a Trust Trans Policy and the associated staff training that has evolved through collaboration with Trans+ve. The Deaf and Hard of Hearing Advisory

Group and the Blind and Partially Sighted Advisory Group worked with us to develop our Interpreting and Translation Policy. We have also been working with charities Mesmac and Leeds Gate to revise our equality and diversity training plan.

We have continued to support Healthwatch Leeds in making visits to our hospitals. During these visits, the Healthwatch team independently survey patients, families and carers and provide us with feedback on their experience of care in our hospitals. This feedback helps us to identify ways that we can improve the care we offer.

In 2015/16 Healthwatch visited our Acute Medicine department and obtained the views of patients using our transport services.

We have welcomed this support from Healthwatch Leeds and will continue to work with them in 2016/17 when they will be gathering feedback from people who visit our Outpatient departments.

The Trust is additionally involved in working with partners across Leeds through a complaints group, supported by Healthwatch. This group enables organisations across the city to work together to find ways we can improve our complaints processes and has already identified a number of opportunities where joint working could better support this.

The Trust's Head of Patient Experience continues to attend the Patient Voices Group that was established by Healthwatch Leeds in 2014/15. This forum generates further opportunities for working with our partners and, as a result, we are improving the support that is offered to patients and members of the public who wish to become involved in the work we do.

Carers

Here at LTHT we recognise the great contribution that carers make to the lives of our patients. We also acknowledge that some of our inpatient areas have not always been as welcoming to carers as we would like.

As a response to carer and patient feedback, we have made some changes within our hospitals and have signed up to 'John's Campaign'; a national initiative which encourages hospital staff to work in partnership with carers to ensure that patients receive the care that works best for them.

We have simplified visiting times for our general wards and have introduced a standard of Midday to 8pm visiting on most of our wards (some specialist, high dependency areas are exempt). As part of John's Campaign, we also support carers to stay with a relative or friend outside of these hours if they would like to.

We have distributed posters and leaflets to all our inpatient areas to provide more information for patients and carers about how John's Campaign can support them.

Our carers leaflet contains information about a new Carers' Charter that has been developed to support the John's Campaign principles. The Charter shows how we have pledged to improve the care we provide for carers and to work alongside them to improve the care for our patients.

Our Carers Charter

We will do our best to...

- Learn from you how best to support the person you care for.
- Welcome you to be present on our wards as long as you would like to be.
- Ask how we can create a better environment for the person you care for.
- Ask how we can create a better environment for you.
- Welcome you to be present during protected mealtimes if you would like to be.
- Explain how you can support other patients to maintain their dignity while you are staying with us.
- Let you know in good time when we need your support to leave the ward area so we can provide clinical care.
- Ask you what you might need help with.

We would be glad if you could...

- Help us to understand how to make care more personal.
- Help us to get to know the person we are caring for better.
- Talk to us about any concerns you have with the care and treatment we are providing.
- Suggest improvements to make the experience of the person you are caring for better.
- Tell us how to make your experience better.
- Recognise there are occasions when we may need to ask you to leave the ward area so that we can provide care.
- Recognise the need to ensure the privacy and dignity of all patients on the ward.
- Look after yourself - your support is appreciated, but no way expected.

Volunteers

Volunteers are vital in helping us deliver the best possible care and experience for patients. We have over 400 volunteers working in a wide variety of roles across the Trust and their work not only enhances patients' well-being during their stay, but can also directly support their recovery and rehabilitation.

This includes providing therapeutic or social activities for patients, helping out on wards at mealtimes, working with chaplaincy, supporting our Haamla service, or simply being a friendly face to help make sure patients and visitors find their way around the hospital and get to appointments on time. This is just a small example of the roles our volunteers perform and there are many other ways in which they help out. We're also always happy to listen to ideas people may have about putting their particular skills or talents to use in the hospital.

Volunteering creates an important link between the Trust and the local community, allowing people to contribute their time, energy and enthusiasm to a worthwhile cause. Volunteering can also be a great way for people to put their skills and life experience to good use, helping them to develop new skills and build self-esteem and confidence in preparation for paid employment.

We are committed to increasing the number of volunteers at LTHTand we are looking at ways we can improve the experience of volunteering and make the recruitment process as smooth as possible whilst ensuring all safeguarding requirements are met. Part of this new approach involves making better use of technology, and those interested in volunteering can now register their interest on our award-winning careers website at **https:// jobs.leedsth.nhs.uk/volunteers**. In addition, volunteering opportunities are advertised on the NHS Jobs website, **www.jobs.nhs.uk**.

We have also been forging links with local schools and colleges to provide volunteering opportunities to Year 12 students and above who may be thinking about working towards a career in healthcare.

Our volunteers come from all age groups, abilities and communities, the common denominator being enthusiasm and a passion for helping others. We will be hosting a celebration event for our current volunteers on 7 June 2016 as part of National Volunteering Week.

We would also like to take this opportunity to publicly thank and recognise the continued, significant contribution each one of our volunteers makes to our patients.

Involving our members

Over the last year, the Trust continued to grow its membership, which has grown to just over 25,000 members compared to 22,811 last year. The mix of gender, ethnicity and age is monitored to ensure our membership continues to be representative of the wider Leeds population, as well as Yorkshire and the Humber and the rest of England. Our data is checked on a monthly basis against national death records and the NHS Spine to ensure that we only hold current information on our members.

Constituency	Membership as at 31st March	
	2015	2016
Leeds	18,277	19,881
Yorkshire & Humber	4074	4614
Rest of England	460	548
Total	22,811	25,043

In 2015 our membership magazine, Connect, was relaunched. The twice-yearly magazine features informative articles on the fantastic work which takes place within our hospitals and also provides details of our Medicine for Members' programme of talks held exclusively for Trust members.

These sessions are chaired by members of the Trust Board or the senior management team. This year, we hosted almost 30 sessions for members across the Trust sites and at different times of day to enable members to attend at a time suitable for them. Topics have included robotic surgery, rheumatology, brain aneurysms and strokes. This has been our most extensive programme to date and saw over 600 attendances.

Previous and current topics can be viewed on the members section of the website: **www.leedsth.nhs.uk/members.**

Chaplaincy

LTHT's chaplaincy service now includes an Honorary Humanist Chaplain, responding to new national guidelines for chaplaincy that were issued in 2015. In addition to the broad range of faith groups represented in chaplaincy, this development has enabled chaplaincy to respond to the needs of a wider group of patients, staff and carers. In 2015/16 this has included providing support to non-religious parents at the time of losing a baby.

During the year approximately 1,000 patients were interviewed by volunteers using an assessment designed to identify spiritual needs. These included both religious and non-religious elements and saw a significant rise in the number of patients being referred for chaplaincy support.

Chaplaincy staff participated in a "Schwarz Round", an event open to all disciplines and grades of hospital staff, where episodes of patient care are shared with a particular emphasis on the emotional impact. 36 staff members attended and excellent feedback was received, including that it was 'brilliant and thought-provoking' and 'reassuring to hear familiar themes from other professionals'.

It is now part of the tradition at St James's and the LGI that during each carol service we include an act of remembrance for colleagues who have died during the year. A Trust director lays a wreath and the names of staff are read out. Colleagues from the departments concerned are also invited to attend. This is part of chaplaincy's work to support staff so that they can provide excellent care for others.

Raising funds

The Leeds Teaching Hospitals Charitable Foundation is responsible for the administration of the Trust's charitable funds. It is independent of the Leeds Teaching Hospitals 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

We are fortunate to have a substantial number of donors and individuals who contribute time and funds. This support enables the charitable foundation to provide LTHT with additional funds to develop the highest quality treatment and services, improve the hospital environment and promote the wellbeing of our patients.

Throughout 2015/16, Mr Edward Ziff, Chair of the Charitable Foundation, has overseen the work of the Charity. The Board of the Charitable Foundation consists of six lay trustees and one NHS link trustee, all appointed via the NHS TDA using powers delegated by the Secretary of State for Health.

During this financial year around £5million 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 to ensure strategic alignment. Patient, Staff and Support Services' two special advisory groups identify projects that enhance the hospital environment for patients and provide additional equipment over and above that funded by the NHS.

This year we continued to support Dr Kate Granger MBE's #Hellomynameis campaign at the Trust, reinforcing the importance of compassionate patient-centred care.

In September, Simon and Vicky Johnson and their daughter, Becky, who run the Lee's Smile charity visited the Trust to donate £60,000 towards video telemetry equipment at the LGI.

The family unveiled plaques in both the paediatric and adult epilepsy suites in memory of their son, Lee, who died from Sudden Unexpected Death from Epilepsy (SUDEP) in December 2010. The epilepsy suite was re-named the Lee Johnson suite.

The Trustees are also committed to encouraging high quality, ethical research and development. During 2015/16, the Foundation once again gave support to fund Honorary Clinical Associate Professors. This involved 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 also gone from strength to strength raising money to enhance and provide a child-friendly environment and fund additional state-of-the-art medical equipment keeping the Trust at the forefront of technology. In 2015/16, the appeal has funded numerous projects to enrich children's experience when they attend hospital.

All of this is made possible by our generous donors and the Charitable Foundation Board of Trustees are extremely thankful to them all.

3.6 Emergency preparedness

Continuing to improve our emergency preparedness, resilience and response to protect the care and safety of staff and patients during a major incident or significant demand on services is at the heart of what the Emergency Preparedness team do here at LTHT.

We must ensure that robust arrangements are in place to continue to deliver care to patients when unexpected incidents occur or at times of severe pressure. Our response to emergency situations has been thoroughly tested this year. We have held a live exercise, experienced a loss of electrical supply and seen periods of industrial action by our junior doctor workforce. These have required the implementation of special measures across the Trust to keep our patients safe and maintain our critical and essential services.

The Emergency Preparedness team engages closely with colleagues across the Trust and partner agencies to develop contingency arrangements to manage foreseeable risks from the effects of extreme weather and infectious diseases to the impact of a mass casualty incident involving terrorism.

Operation Molly

To ensure that we have robust arrangements in place to deliver care to patients affected by a major contamination incident a live exercise took place on 19 September 2015 at St James's. Named 'Operation Molly', this was the Trust's third live decontamination exercise undertaken in close collaboration with the blue light emergency services and with the help of a number of excellent volunteers who pretended to be contaminated casualties.

This was a successful and worthwhile exercise with some excellent learning for our hospitals and partner agencies, which will help to improve and enhance our response to a major contamination incident.

Planning is underway to test the LGI's response to a major contamination incident during summer 2016.

LGI power disruption

Our hospitals have business continuity plans in place to maintain key services in the event of unexpected disruption. In October 2015, some parts of Clarendon Wing at the LGI experienced a break in the electrical supply where some non-essential equipment was affected by the temporary power failure. Our essential equipment was protected by backup systems including reserve generators and battery packs. The electrical infrastructure did not run as expected so contingency plans were implemented. Regrettably it was necessary to postpone a small number of non-urgent planned operations, but the Trust continued to carry out emergency operations and procedures. Other hospital services were unaffected and continued to operate normally.

In February 2016, a water leak meant that some parts of Clarendon Wing again experienced a temporary break in the electrical power supply. Until the Trust was assured that the electrical supply was stable, contingency plans were put in place to ensure the highest possible patient safety. This involved a number of inpatients being transferred to other areas of the hospital and postponing some non-urgent planned operations. We worked with our partners and stakeholders, including clinical networks, referring hospitals and the ambulance service to mitigate risk and maintain patient safety during both incidents. There was a great deal of commitment and cooperation from all staff involved. It was a testament to our teamwork and the robust systems that we have in place to ensure patient safety was not compromised and our usual services resumed promptly.

3.7 Equality and diversity

We are 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 created the Equality and Diversity Strategic Group in November 2013, led by the Chief Nurse to deliver on the equality and diversity agenda.

For day-to-day delivery of the equality and diversity agenda, the Trust has an Equality and Diversity Manager who works closely with the Head of Human Resources for Policy and Performance.

Our Equality and Diversity Strategy 2015 - 2020

The five year Equality and Diversity Strategy was developed in 2015 to clearly show the Trust's commitment to the equality agenda by identifying targeted ambitions and key priorities.These ambitions and priorities help deliver on the Trust's overarching equality objectives, which are in line with the key goals of the NHS Equality and Diversity Delivery System in 2015.

Setting and publishing of equality objectives

The organisational equality objectives of the Trust are set against each protected characteristic.

Objective 1   Better health outcomes
Objective 2   Improved patient access and experience
Objective 3   A representative and supported workforce
Objective 4   Inclusive leadership

Throughout 2014-15 the following actions were achieved:

Equality Objective	Equality & Diversity Strategy Targeted Ambitions	Action Achieved 2014 to 2015
1	We will ensure the rate of outpatient DNAs, readmissions, RTT breaches and A&E breaches are broadly representative of the patients we serve in relation to Black, Asian and Minority Ethnic (BAME) groups, Age and Religion or Belief	CSU equality data on patients collated in relation to complaints, FFT and patient activity
		CSU E&D Checklist introduced to CSUs for completion alongside business planning
		Plans in place for new fields and categories in respect of sexual orientation and disability
		Revised Equality Impact Assessment (EIA) template produced for organisational/service changes
		EIA on all policies signed off by the Equality and Diversity Team
2	We will ensure ready access to hospital services and information	Translation and Interpretation Policy and accompanying guidance produced
	We will improve patient survey results of older inpatients, young patients accessing Maternity Services, LGB accessing A&E and BAME outpatients	Review of Interpreting Services completed and new arrangements implemented
		Collaborative working between Equality and Diversity, Patient Services, Informatics and Patient Advisory Groups to improve patient access by implementing the requirements of the NHS Accessible Information Standard
	We will improve the experience of Trans staff, patients and carers	Trans policy and accompanying guidance produced
	We will improve the experience of LGB patients and carers	Tried and tested "learning bursts" and package of information inclusive of explicit consideration of protected characteristics developed
	We will improve the experience of patients that do not have a religion or belief	Collaborative working with Leeds West CCG in the development of a Patient Reference Group and Patient Leaders Programme reflective of the local population
		Proposal developed with local NHS organisations, Healthwatch, Leeds Involving People and Voluntary Action Leeds on inclusive, third sector engagement on organisational delivery against the NHS Equality Delivery System
		Development against three of four objectives of Trans Index
		Development against two of three key actions for delivery against Stonewall Healthcare Equality Index
		Collaborative agreement between Equality and Diversity and Chaplaincy to deliver non religion/belief training

3	We will ensure we have a broadly representative workforce We will review our recruitment and selection processes We will review approaches to talent management for Bands 6/7 We will increase representation of BAME staff at Band 8b We will improve results of staff survey key findings for BAME staff Reduce over representation of BAME staff and men in conduct procedures Increase engagement with disabled staff We will improve the experience of staff, patients and carers with mental health problems	Increased improvement in equality data on staff
		Further analysis of outcomes from the PSED data with a focus on recruitment and selection, disciplinary and grievance cases, dismissals and pay audit
		Information reviewed and published in respect of the NHS Workforce Race Equality Standard
		Audit of recruitment and selection process completed including revision of job description paperwork and action plan agreed
		Opportunities identified with Talent Management for coaching/mentoring/shadowing reviewed with the launch of Talent@Leeds
		Data quality process on volunteers inclusive of demographic details agreed and underway
		Staff feedback monitored and reviewed in respect of experience at work (against protected characteristics) including staff survey feedback
		Completion of first of three steps of NHS Learning Disability Employment Pledge
		Two Ticks Disability Symbol award achieved
		Launch of Mentally Healthy Workplace
4	All	Developed and launched "Our Equality and Diversity Strategy"
		Developed comprehensive training plan, including Unconscious Bias Training and awareness raising training around protected groups
		Launch of CSU Equality & Diversity Checklist
		Demographic profile of Foundation Trust Membership captured and monitored and set against FT members interested in involvement and engagement activity for the raising of the profile of issues affecting protected groups
		Development of monthly Diversity Matters providing information on cultural and religious events, including local events and local intelligence

Publishing of Equality Information

LTHT publishes information in January each year to show the extent at which equality is placed at the heart of everything it does. The key headline actions that emerge from the analysis of the equality information are subsequently incorporated into the annual review of the Equality and Diversity Strategy to ensure seamless delivery on the equality agenda.

The following key findings and actions were identified in January 2016:

	Key Headline Findings for 2015 to 2016	Key Actions for 2016 to 2017
All people can access the Trusts services and when received experience the best possible clinical outcomes every time	BAME 50% more likely than White to not attend an outpatient appointment and twice as likely than White to not recommend the service to a family member or friend. White 50% more likely than BAME to not be treated within 4 hours within ED, but BAME twice as likely than White to not recommend the service to a family member or friend. Muslims and individuals with no religion were more likely than those of other religions to not attend an outpatient appointment and be treated outside an 18 week period from the point of referral The younger the patient the more likely an appointment is not attended and they are not treated within an 18-week period from the point of referral. The older the patient the more likely they are to be readmitted as an inpatient and the more likely they are not to be treated within 4 hours within ED.	Continue to implement the NHS Accessible Information Standard that ensures practical steps are put in place to ensure ready access to hospital services and information from the first point of contact for patients and carers in 2016. Continue to work towards providing targeted support to Clinical Support Units, including the provision of bespoke equality data where possible, for the identification of specific equality actions in 2016. Continue to improve the experience of patients that do not have a religion or belief in the delivery of our care by the Equality and Diversity and Chaplaincy Departments working collaboratively together to produce a range of information and training opportunities for Clinical Support Units in 2016.
All employees are supported, representative of the local community and led to deliver on equality.	Significant underrepresentation of Black Asian and Minority Ethnic (BAME) staff in the senior Agenda for Change grades. BAME staff significantly less likely than White staff to believe that the Trust provides equal opportunities for promotion. Generally average female pay is less than average male pay, but for the majority of bands / grades it is within the 5% tolerance expected by the Equality and Human Rights Commission.	Review of our HR and recruitment processes and procedures to ensure they are being applied fairly across all roles. Continue our Talent Management programme and encourage participation in leadership development programmes. Our Female Leaders programme will continue into 2016. A review of pay by bands / grades, where there is a pay differential of more than 5% will take place to ensure that our systems are fair. In 2016 we will work to improve the information we hold about our staff through the roll out of ESR self-service which will enable staff to update their own information.

Section 4

Quality Account
2015-16

Chief Executive's Statement from the Board

1.1 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.

1.2 Development of the Quality Account

Our Quality Account for 2015/16 has been developed with our staff, 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.

1.3 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 2015/16.

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.

We had much to be proud of in our quality achievements through 2015/16.

We have consistently delivered on our 62 day cancer waiting times, have almost halved the number of cancelled operations not rebooked within 28 days from 132 to 83 and we are meeting the Referral to Treatment incomplete

standard, providing faster, more efficient and better care for our patients. We have continued to make improvements in quality and safety whilst facing a significant financial challenge which is shared with all NHS trusts and we are proud of our achievements.

The quality of our care continues to be our main priority. We have attracted national interest in our new patient safety huddles. These ward-based, short meetings identify patients at risk of deterioration and the appropriate actions to take. Other initiatives have resulted in a 30% reduction in 2222 calls for urgent medical assistance on pilot wards, and again on pilot wards, a 20% decrease in falls. Our ward healthcheck has gone from strength to strength, achieving significant improvements in how we care for patients at ward level.

The NHS Trust Development Authority chose LTHT to be one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known at the Trust as the Leeds Improvement Method. Launched in elective orthopaedics in Chapel Allerton, it has brought together staff with a range of skills and experience to review and adjust how they work to increase their efficiency and improve patients' experience of our care. It is already paying huge dividends, reducing waiting and theatre turnaround times. As we begin 2016, we will introduce new workstreams in abdominal medicine and surgery, critical care and outpatient services. Complementing this, we are one of the founding Trusts to be working with Lord Carter of Coles as part of his review of NHS productivity to spread the learning from this work.

It is rewarding to see the impact of our improvements becoming embedded in patient care, and the difference this is making to their perception of our service. The 2015/16 NHS Friends and Family Test gathered 87,500 views from patients, and of these 93% said they would recommend the Trust to their friends and family, an increase of 1.67% from the year before. The impact of our work to improve discharge processes has also started to make a difference and has resulted in a

significant decrease in the numbers of patients reporting delays. This is really important as our inpatient survey results that were reported in 2015 showed that patients felt we could improve their discharge experience. We have also responded to patient feedback that told us access to wi-fi was really important to keep them connected with their families by introducing this throughout our hospitals. In addition in 2015/16, new complaints have gone down by 16%.

We are also delighted that we are the most improved Trust in the UK in the 2015 NHS Staff Survey. Findings have significantly improved in 13 key areas, including motivation at work, support from line managers and the number who feel able to contribute to improvements at work. We know how important this is so that staff can deliver better care for patients.

We have worked with our clinicians, managers and local partners at Leeds West Clinical Commissioning Group and Healthwatch Leeds to identify the following priorities set out in our Quality Account, among others, for 2016/17.

Signed

Date: **28th June 2016**

Julian Hartley, Chief Executive
Signed for, and on behalf of the Trust Board

Improving our Quality of Service

2.1 Our Priority Improvement Areas for 2016/17

The following improvement priorities for the Trust have been identified for particular focus in 2016/17. The overarching principle for all these work streams is their importance for patient experience: they have been grouped under the section headings below for the purpose of this Quality Account document.

Patient Safety

- Improvement in the care of patients with acute kidney injury (see section 3.2.1)

- Improvement in the care of patients with sepsis (see section 3.2.2)

- Reduction in number of hospital acquired pressure ulcers and the incidence of category 3 and category 4 pressure ulcers (see section 3.2.5)

- Best use of antibiotic medicines (antimicrobial stewardship) (see section 3.2.11)

Clinical Effectiveness

Leeds Improvement Method Value Streams (see sections 2.1.3 and 3.4):

- Chapel Allerton Orthopedic Centre - total hip and knee replacement patients

- Discharge - Abdominal medicine and surgery specifically focusing on prostrate surgery patients

- Critical Care Step Down - starting summer 2016

- Outpatient Services - starting autumn 2016

Patient Experience

- Making it easier to hear the patient voice - establishing a Patient Reference Group and Patient Leader Programme (see section 3.1.6)

- Improving understanding of our feedback - Improving monitoring of Friends and Family Test (FFT) % recommended, by ward area (see section 3.1.2)

- Learning and Improving from what patients and families tell us

- Implementing method of capturing actions arising from FFT data and Patient Advice and Liaison Service (PALS) concerns (see sections 3.1.2 & 3.1.9)

  – Responding to patient feedback in Outpatients through delivery of programmes to address concerns (see sections 3.1.9)

2.1.1 Summary of 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.

The Strategy set out programmes of improvement work focussing on four main areas:

- **Harm Free Care:** Developing a world-class culture of 'first do no harm' to deliver the safest healthcare in the UK. This will focus on harm free care in our wards.

- **Patient Experience:** Improving the experience for patients and carers whilst in our care.

- **Avoidable Mortality:** Reducing avoidable mortality and improving our national mortality rate to be one of the best in the UK.

- **Integrated Care with Partners:** Working with LIQH to develop improvements in care for the whole of the pathway of care for patients with specific conditions.

LTHT Quality Improvement Programmes 2016/17
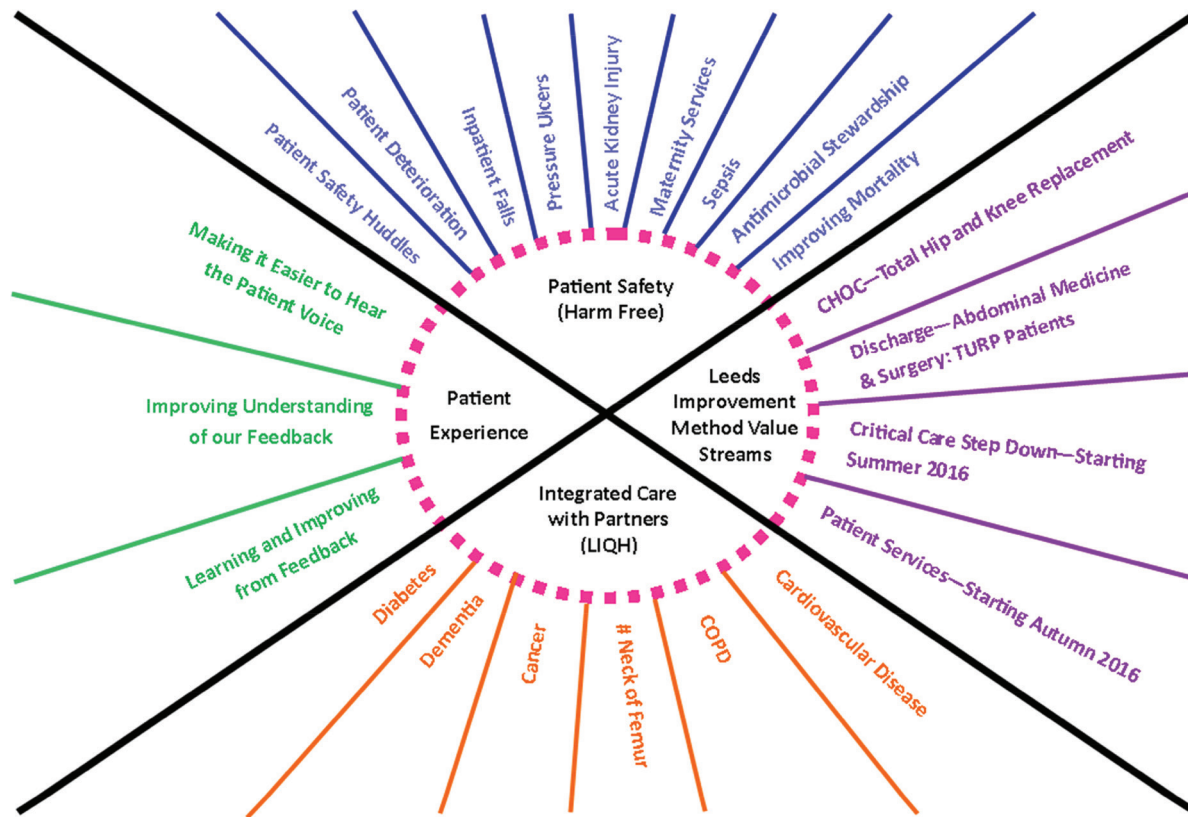
2.1.2 Sign up to Safety Campaign, and the Trust Safety Improvement Plan

In 2014 a national campaign was launched by the Secretary of State for Health called the Sign up to Safety Campaign, with a three year objective 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 focusing on putting safety first, continually learning, honesty, collaboration, and support.

The Trust's Safety Improvement Plan sets out

the organisation's 3-5 year plans 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 continue to be a priority for 2016/17: they are set out in the Patient Safety (Harm Free) section of our Quality Improvement Programme in Table 1 above, and are described in more detail in section 3.2 below.

We were pleased to be awarded £750K by the NHSLA to support improvements in our maternity services in 2015/16 following submission of a bid alongside our Safety Improvement Plan.

2.1.3 Summary of Leeds Improvement Method

LTHT is one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known at the Trust as the Leeds Improvement Method.

The partnership was announced in July 2015 against the backdrop of a system refocusing on quality improvement within tighter financial constraints in healthcare. This is a five year partnership to support an accelerated transformation in quality.

The programme involves formal training and certification in lean methodology and access to licensed materials that will provide the Trust with the opportunity to bring about sustainable and lasting culture change. Over the next two years it includes intensive support through coaching and mentoring for our Leeds Improvement Method Team, leaders and staff across the Trust, in how Virginia Mason have applied lean management successfully in a healthcare setting.

Launched in elective orthopaedics in Chapel Allerton, it has brought together staff with a range of skills and experience to review and adjust how they work to increase their efficiency and improve patients' experience of our care. It has already helped to reduce waiting and theatre turnaround times. In 2016, we will begin new work streams in Abdominal Medicine and Surgery, Critical Care and outpatients services. Complementing this, we are one of the founding Trusts to be working with Lord Carter of Coles as part of his review of NHS productivity to spread the learning from this work.

In summary, the Leeds Improvement Method:
- Is patient focused
- Is the application of observation and data analysis tools, to describe how patients experience our services
- Supports staff to systematically remove waste
- Promotes zero defects and zero harm for patients
- Uses a disciplined time frame
- Encourages participation and respect for each other as equals

At the core of the method are local leadership, forensic analysis of our processes focussing on the patients' experience of our care, and a team approach to improvement directly where the work is done. This, in turn, encourages participation and respect for each other as equals for the work we do.

A video to describe this national work in more detail can be found here on YouTube:

2.2 Progress against our Quality Goals 2015/16

The following improvement priorities for the Trust were 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.

These remain part of our overall Quality Improvement Programme and span more than one year. Progress on each of these can be seen in Sections 3.1 to 3.3.

Review of Quality Programme

3.1 Patient Experience

We have outlined below some of the great initiatives we have been working on to improve the care provided to our patients and their families. Amongst these are a number of examples which show how we have listened to our patients this year and improved their experience of our hospitals.

We know we have much work to do to get better at hearing what patients have to say, and demonstrating that we respond in a way that makes a real difference to them. Consequently our key work streams for 2016-17 are concentrating on:

- Making it easier for people to give us feedback and for them to help us get better at what we do

- Making sure we get smarter at responding to the feedback we are given, and

- Showing our patients and their families that real change has happened from the contribution they have taken time to make.

These principles will build on the work we have undertaken this year and that is demonstrated below.

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

Leeds Teaching Hospitals NHS Trust has been on a successful journey over the last 2 years with regards to formal complaints. This is demonstrated by:

- A 16% reduction in new complaints received in 2015/16 when compared with 2014/15.

- A 50% reduction in open complaints when comparing data from March 2014 (318) to March 2016 (159).

- During 2015/16 the number of re-opened complaints has dropped to an average of 11 per month from 15 in 2014/15.

Cumulative complaints received in 2015/16 compared to 2014/15
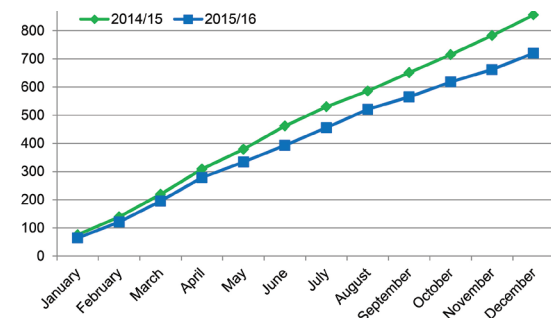
Number of complaints re-opened (cumulative)
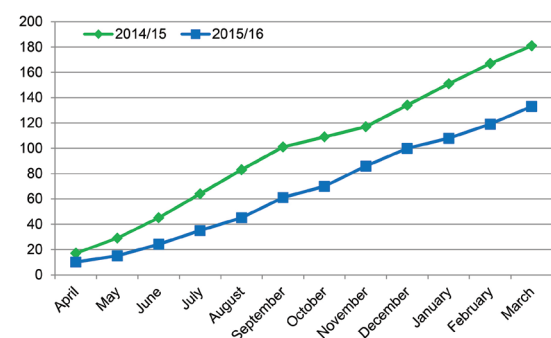
These results demonstrate that as a Trust, we are getting better at making sure we address the concerns people raise in a way that satisfies them, and reflects the success of the process we have put in place (quality check) for all complaint responses to be reviewed by a senior member of the team, before they are reviewed and signed by the Chief Nurse or Chief Medical Officer.

In 2015/16 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 our letters. We have implemented a number of new initiatives which we are confident will continue to help us improve in this area.

Progress in 2015/16

In 2015/16 the Complaints Team have fully implemented changes that resulted from a department restructure in 2014/15. These include:

- 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.

In addition to the changes above, the Complaints Team also implemented a number of other initiatives to improve the complainant experience and to support CSU's with the complaints process; these include:

- The introduction of audio recording of complaint resolution meetings. This gives complainants an accurate permanent record of discussions that took place and assists in reducing the delays in response letters being sent.

- The Complaints Team now requests medical records, on behalf of the clinical teams, as soon as the complaint is received. This is to improve timeliness of complaint responses.

- An initiative called 'Speak to Sister, Message to Matron' was launched in December 2015 (see below). This initiative involves posters being displayed in public areas to inform patients/relatives that speaking with departmental managers can often result in effective and speedy resolution of their concerns. It also gives departments the opportunity to apply local resolution - e.g. to manage a concern outside a formal process which is often much quicker and provides a better experience.

- The Complaints Team has developed and introduced child 'friendly' literature that supports and informs younger people about how to raise a concern. This was presented at a National Children's conference (hosted by Leeds Teaching Hospitals NHS Trust) and was met with much praise - including a tweet from the Head of Patient Experience - NHS England.

Joanne Bickers and Abigail Garrod from the Complaints Team presenting the Child Friendly Literature at the National Children's conference - hosted by Leeds Teaching Hospitals NHS Trust, November 2015.

Learning from Complaints

Over the last year we have concentrated on developing a process which allows the learning that takes place from answering complaints to be shared more widely with staff in the Trust. Posters have been designed for our Clinical Support Units (CSUs) to display in areas frequently used by staff members and to support discussion at their Clinical Governance Forums. These posters contain information relating to a number of different areas of patient feedback, including PALS and Complaints and encourage the leaders of the CSUs to describe learning and actions that have taken place as a result of feedback received.

Some examples of this learning are:

- Following a complaint about a lack of stimulation on one Acute Medicine ward, the area now has a 50" TV with DVD and all side rooms have a TV. The ward has also ordered a CD player along with increasing the number of volunteers and introducing Pet Therapy as other options to increase stimulation.

- As a result of a complaint that described a diabetic patient being given insulin but no food, staff now ensure that meals are available outside normal mealtimes for diabetic patients.

- Information given to patients attending for an ECG has been improved. Patients are given an information sheet to read whilst they are waiting. In addition there are information sheets displayed in the department waiting area to fully explain what an ECG is and what will be required along with a photograph. These guide patients to staff who can ensure they have a chaperone if they wish.

- In addition, the Lessons Learnt Forum in the Trust now includes a story demonstrating learning from a complaint in their regular Trust bulletins to ensure learning is shared as widely as possible to improve experience for patients.

Aim for 2016/17

We have set out the way in which we intend to improve the complaints process in our Complaints Improvement Plan for 2015-17. This is based upon guidance in the Parliamentary and Health Service Ombudsman (PHSO) report "My Expectations" and the recommendations contained within the CQC and Patient Association report following their joint inspection in April 2014.

To ensure we keep improving the experience of people who complain we have asked NHS Benchmarking to undertake a survey to measure how satisfied people are with the complaints process. This survey will run from February 2016 to January 2017. We will use the information on an ongoing basis to make further improvements to our processes as a direct result of what this tells us about how we need to improve.

An internal audit highlighted that we could improve on capturing lessons learnt as a result of complaints. We included this in our complaint policy review and will work on implementing processes this year to ensure that the feedback received from patients supports improved learning across the Trust.

How will this be Monitored?

The Patient Experience Sub Group receives regular reports setting out our performance on complaint handling against a range of indicators. They also receive information from our satisfaction survey and approve the actions we take as a result of the feedback. Themes and trends of subjects raised in complaints and the numbers of complaints clinical areas receive are monitored through the Safety and Outcomes Sub Group. The Trust Board also receive twice yearly reports about our complaints process and the experience we are providing to complainants.

3.1.2 Friends and Family Test (FFT)

The NHS Friends and Family Test (FFT) is a national initiative to help us understand how patients feel about their experience in our Trust. The survey asks people if they would recommend the services they have used. Results can be acted upon quickly which can be used to identify areas where more can be done to improve the patient experience.

- FFT was initially applicable only to patients on Inpatient wards, A & E and Maternity services. It was rolled out to provide all patients with an opportunity to give feedback in April 2015. The additional services that were implemented in April 2015 included Paediatrics, Day Case areas and Outpatient Services. Between April and November 2015, FFT was implemented in a further 225 areas across the Trust as follows:
- 25 Day Case areas
- 16 Paediatric wards and Paediatric Day Case areas
- 1 extra Adult Inpatient ward
- 183 Outpatient services

As of December 2015, the Trust provided the opportunity for patients to give feedback via FFT in 290 areas. This means 78% more areas now offer the chance to complete FFT than in April 2015.

Patients are being surveyed using a combination of methods including forms, text messaging, interactive voice messaging, electronic tablets, and through an on-line App. Children and those with learning disabilities are supported through the use of specially adapted response forms that include pictures and colour.

The team is exploring the possibility of using volunteers to help with capturing feedback in the future. This would be particularly useful for patient groups that have difficulties in filling in forms and will make sure as many patients as possible are listened to.

In 2015/16 the Trust collected 96,279 responses from patients completing the FFT. The average response rate across Inpatient services, A&E and Maternity Services in 2015/16 was 29.46%.

Between 2015 and 2016 the percentage of patients recommending Trust services increased by 3%, whilst those who did not recommend Trust services decreased by 23%.

Inpatient Friends and Family Test Results

	2014/14*	2015/16
% who would recommend the Trust to friends and family if they needed similar care or treatment	90.83%	92.39% ⬆
% who would not recommend the Trust to friends and family if they needed similar care or treatment	3.75%	2.9% ⬇
% 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	5.42% *	4.71% ⬇

Clinical teams have access to all patient feedback via an internal dashboard (database) and regularly use this information to see how patients are feeling about the care being given in the area they are responsible for. The database helps identify areas in which patients have reported positive experiences and also where experiences have been less positive.

Examples of comments received and actions that have been undertaken during 2015/16 include:

Feedback received via FFT	Action the Trust took in response
Chairs in waiting room are too small and dingy	New chairs have been purchased for the waiting area in Surgical Pre-Assessment
Sat bored in waiting room	Installation of a television in Endoscopy
Unsure of procedure	New patient information leaflet sent out to all patients attending Surgical Pre-assessment
Visiting times too restrictive	Visiting times extended on Cardiac Surgery / Vascular ward
Coat hooks and shelves required	Coat hooks and shelves installed on Cardiac Surgery / Vascular ward

Examples of comments where individuals or teams are mentioned

"The ambulance staff were professional and courteous ensuring I was handed over to hospital staff efficiently. The doctor was professional, caring and knowledgeable. I think his name was Andrew."

"Staff were brilliant from start to finish. They were friendly and polite and listened to my disabled elderly father which many don't. They saw to him quickly and were very efficient.

"Excellent communication nursing staff kept me up to date with what was happening. Friendly and approachable staff."

Examples of comments relating to concerns that were quickly fixed

"I was seen fairly quickly as I had chest pains but the waiting area was uncomfortable and I was extremely cold due to the door opening and closing frequently…….."

"The receptionist and doctor I had were absolutely brilliant, so helpful and friendly, felt very reassured. However the nurse and HCA I had didn't even introduce themselves, stuck a thermometer in my ear without telling me what was going on and then left me in a room on my own for three hours without telling me what was going on…"

During 2016/17, the Friends and Family Test Team will continue to work closely with clinical services to ensure the Trust demonstrates quick responses to the patient feedback. This year we would like to get better at sharing information about what has changed as a result of feedback to demonstrate that we do listen and that we appreciate patients taking time to share their thoughts with us. We will also focus more on recognizing and acting quickly where feedback consistently tells us something needs to change.

3.1.3 Staff Friends and Family Test (Staff FFT)

Following the successful introduction of the Friends and Family Test (FFT), the facility was extended to staff for the first time from April 2014, to provide on-going feedback about the Trust.

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 results of Staff FFT for 14/15 and 15/16 are presented below. Overall the FFT results have improved since implementation in 2014.

	Response Quarter 1 (May 2014)	Response Quarter 2 (Sept 2014)	Response Quarter 4 (Mar 2015)	Response Quarter 1 (June 2015)	Response Quarter 2 (Sep 2015)	Response Quarter 4 (Feb 2016)
Response Rate (numbers of staff, students and volunteers)	750	1507	1514	1644	1671	1540
How likely are you to recommend LTHT to Family and Friends if they needed care or treatment?	72.7%	81%	84%	86%	84%	83%
How likely are you to recommend LTHT to Family and Friends as a place to work?	56.9%	65%	68%	68%	67%	66%

N.B - as the same questions are included within the National Staff Survey which is conducted annually in Quarter 3, the trust did not complete the separate Friends and Family Test for Staff during this period.

The results from the National Staff Survey in 2015 are shown in the table below.

Indicator	Reporting period	Trust performance	National average
Percentage of staff who would recommend the Trust as a provider of care to their family or friends	2015	69%	70%
	2014	63%	65%
	2013	58%	64%
	2012	47%	62%

Equal opportunities for career progression or promotion	LTHT score 2014	LTHT score 2015	National Average for acute trusts
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	86%	87%	87%

The score for this key finding shows us both in line with the national average and improving year on year. Work to create an inclusive work force is supported by a refreshed Equality and Diversity Strategy which focuses on three key work areas of:

- Inclusive leadership
- Our people are representative of the communities we serve
- Our people are supported and engaged

Harassment, bullying or abuse	LTHT score 2014	LTHT score 2015	National Average for acute trusts
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	26%	26%	26%

We continue to perform in line with the national average for this key finding: the trust wide team of dignity at work advisors, alongside Human Resources and line managers, work to create a culture where bullying and harassment is promptly addressed and acknowledged. The Leeds Way values and behaviours set out how we expect staff to behave, clearly signposting that bullying and harassment is unacceptable.

3.1.4 National Patient Surveys

We take part in the National Inpatient Survey annually and the results of the 2015 survey were published in March 2016. 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 most recent survey are below:

Inpatient Survey: significant changes since last year's survey (lower scores are better)

	2014	2015	National Trust Average
Areas in which we have got significantly better since last year (survey question)			
Hospital: did not always get enough help from staff to eat meals	41%	30%	34%
Surgery: risks and benefits not fully explained	21%	13%	17%
Surgery: questions beforehand not fully answered	24%	16%	21%
Surgery: anaesthetist / other member of staff did not fully explain how would be put to sleep or control pain	17%	11%	14%
Discharge: was delayed	50%	39%	41%
Areas in which we have got significantly worse since last year (survey question)			
Hospital: patients using bath or shower area who shared it with opposite sex	9%	13%	12%
Hospital: toilets not very or not at all clean	4%	7%	5%
Overall: not asked to give views on quality of care	64%	71%	69%
Overall: did not receive any information explaining how to complain	55%	61%	59%

We are working with CSUs and corporate teams to address these areas. Additionally, an ambition has been set within our Nursing, Midwifery and Allied Health Professionals Strategy, for all Clinical Service Units to undertake a new initiative which directly addresses findings from the inpatient survey.

Maternity Survey 2014

The 2015 National Maternity survey was published in October 2015. This survey demonstrated significant improvements in performance since the 2013 survey.

Maternity Survey: significant changes since 2012 survey (lower scores are better).

	2013	2015	National Trust Average
Areas in which we have got significantly better since last year (survey question)			
Labour and birth: not all staff introduced themselves	19%	12%	16%
Labour and birth: not involved enough in decisions about care	28%	20%	25%
Postnatal hospital care: not given information or explanations needed	48%	35%	39%
Postnatal hospital care: not treated with kindness and understanding	39%	28%	31%
Postnatal hospital care: hospital room or ward not clean	7%	3%	3%
Postnatal Hospital care: toilets and bathroom not clean	13%	7%	9%
Feeding: did not receive consistent advice	47%	38%	45%
Postnatal care at home: did not have confidence and trust in visiting midwives	35%	24%	29%
Postnatal care at home: did not receive enough help / advice about feeding baby	36%	27%	36%
Areas in which we have got significantly worse since last year (survey question)			
Antenatal check-ups: Did not see same midwife most of the time	51%	60%	65%
During pregnancy: Midwife did not always give the help needed	21%	32%	26%

As a result of the survey there are still areas to improve and we will be continuing our focus on antenatal care. This work is closely aligned to our Maternity Strategy which has been developed with the Maternity Services Liaison Committee and which focuses on greater personalisation and continuity of Maternity care.

3.1.5 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, who take time to tell us about their experiences in a variety of ways, including through video stories.

We have filmed a range of video stories this year including a patient who had spent a long period in critical care talking about the positive difference that our Allied Health Professionals (Physiotherapists, Occupational Therapists, Speech and Language Therapists, Dieticians and Orthotics) had made to her rehabilitation. Other films included the benefits of 'spiritual' care for patients who have no religion but who are facing difficult times, and the problems encountered by parents and their children with complex needs during hospital admission.

People with Sensory and Physical Disabilities

The Trust continues to support the Blind and Partially Sighted Patient Advisory Group and Deaf and Hard of Hearing Patient Advisory Group, which throughout 2015 has resulted in both groups contributing to making sure the sensory access needs of patients and their carers are met by individual departments and areas of the Trust.

One significant development as a result of their involvement has been changes introduced to Seacroft Hospital, including the creation of a new pavement and resetting of tactile surfaces, repainting of handrails and doors and the introduction of 'meet and greet' volunteers to help guide individuals.

For wheelchair users and those with prosthetic limbs who visit our Specialist Rehabilitation Centre based at Seacroft Hospital, a new entrance canopy has been completed and all the doors have been fitted with sensors so that they will automatically open and close as people approach.
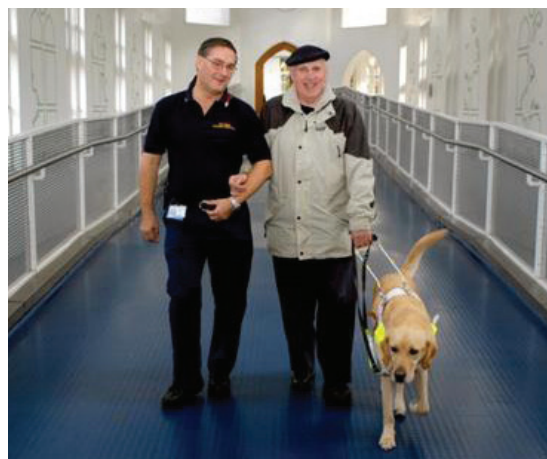
Alan, a long-standing member of our Blind and Partially-sighted advisory group

Working with our local communities

A new group was established in 2015 by Facilities (Catering) and the Patient Experience Team to look at hospital food provided to patients to make sure they meet patients' cultural and religious needs. The group includes representatives from the diverse communities across Leeds who have taken part in a food tasting session of around 20 dishes and been part of detailed discussions on the handling, preparation and serving of food. The work of the group continues to widen further the involvement of different local communities, ensuring cultural and religious needs are met by the Trust.

Members of the Hospital Food Group at a tasting session

We also work with our local communities to provide culturally appropriate maternity services with assistance from Doula volunteers. The

Haamla project has offered a Doula service since 2011 and to date they have attended 78 births, with a further 38 ladies offered post-natal support. Eight doulas who completed the training have gone onto midwifery training. We currently have 15 active doulas and recruitment occurs yearly. We have already had 40 expressions of interest for our recruitment event in May 2016.

You said….We did

Examples of other actions that have been taken by the Trust this year in response to feedback from patients can be seen below:

- Moving smoking shelters further away from Gledhow Wing entrance as smoke was reported by patients to be drifting into wards through open windows.

- Extending visiting times on a ward to improve flexibility for visiting friends and family.

- Making specialist cooling systems available for side rooms on a ward when patients reported that these become uncomfortably warm.

- Improving information provided to patients pre-operatively by displaying posters in waiting areas.

- Installation of TV's in clinic waiting areas.

- In response to concerns raised via many different routes, the Trust has now made all patient areas Wi-Fi enabled, from April 2016.

Discharge

Improving the quality of discharge of patients and their families remains a key priority for the trust. In 2014, the main concerns highlighted by patients through the patient survey were: delays in discharge, the provision of medication, and how much information and involvement patients had in the discharge process.

The Trust has worked hard in 2015/16 to address these key themes. To begin with, a dedicated discharge coordinator has been introduced to help inform and involve patients with their discharge process, while also supporting communication with external care providers such as social workers. In addition,

by working together with Leeds Community Health through the Local Quality Incentive Scheme (LQIS) for Discharge, the number of discharge incidents has been reduced by over 60% compared with 2014/15. Work is now in progress to further address the delays in discharges, with a bundle of improvements - including a new fully electronic referral process - now in place to streamline and strengthen both the discharge planning process and the subsequent referral to aftercare services.

Care of Patients with Parkinson's Disease

In response to feedback from carers, in 2016/17 we will be developing a plan to improve the care of patients with Parkinson's disease across our hospitals. Our intention is to focus particularly on the timeliness of administration of medications.

3.1.6 Patient and Public Involvement (PPI)

Working with People with Learning Disabilities

2015/16 was an exciting year for our engagement with people with Learning Disabilities. In March 2015 we held a Men's Health day for people with Learning Disabilities which was shortlisted for a Nursing Times award. The awards ceremony was held at the Grosvenor House Hotel, London, and this was a great opportunity for letting others know about what we have done and meeting other nurses and people with Learning Disabilities from around the country.

Not to be outdone, the Women's Health Day was held in March 2016 and was opened by Christine Talbot, from ITV's Calendar, and also featured on the programme.

To celebrate Learning Disability Week in June 2015, LTHT held a fashion show which was attended by Leep 1 and other NHS and Third Sector organisations across Leeds. Hospital uniforms were imaginatively transformed and modelled by people with Learning Disabilities and staff members who walked the catwalk to loud applause. The video can be found on YouTube: **https://www.youtube.com/watch?v=NN2J8jM-_RM**

We continue to actively seek the views of people with Learning Disabilities who stay in hospital, surveying all people with Learning Disabilities who are inpatients during the months of May and November. We achieved a very respectable response rate of 60% for our November 2015 survey and our Learning Disabilities team and strategy group are using the findings to improve the service we deliver.

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.

Alun Pymer and Angela Longbottom from the Trust Bereavement Team visiting the local Sikh Community

Alun Pymer from the Trust Bereavement Team meeting Ramesh, a member of the local Sikh Community

We also extended the opening hours in the Bereavement office so we can respond to all families in a timely manner and reduce unnecessary waiting for paperwork.

Working with partners

Relationships with local stakeholders such as Advocacy Groups, Community Forums, and involvement groups, continue to develop. A joint training session was held between Advonet and the Trust this year to identify opportunities for learning and ways in which experience can be improved for people who wish to raise a concern.

A number of recent Trust initiatives have been supported through working with partners:

these include the development of a Trust Trans policy and associated staff training that has evolved through collaboration with Trans+ve. The Deaf and Hard of Hearing Forum and the Blind and Partially Sighted Forum worked with us to develop an Interpreting and Translation Policy. Additionally, Mesmac and Leeds Gate are currently assisting us to develop our revised Equality and Diversity training plan.

We have continued to support Healthwatch Leeds in making visits to our hospitals to independently survey patients, families and carers and provide us with feedback on their experience of care in our hospitals. This feedback assists in helping us to identify important actions that can be taken to improve the care we offer. We have welcomed this support from Healthwatch Leeds and will continue to work with them in 2016/17 when they will be gathering feedback from people who visit our outpatient departments.

The Trust is also involved in working with organisations across Leeds through a Healthwatch supported Complaints Group to find ways to improve the complainants' experience through improved joint working.

The Trust Head of Patient Experience continues to attend the Patient Voices Group (PVG) that was established by Healthwatch Leeds in 2014/15. Through this forum, further opportunities for working with partners are identified. As a result the Trust is taking steps to improve the support that is offered to patients and members of the public who wish to take a lead in becoming involved in some of the work of the Trust.

Finally, the Trust has undertaken important work this year with local Councillors, funeral directors and representatives of the Muslim faith community. Through a working group that has been established by Councillors, the Trust has gained a better understanding of how it can improve support to families who experience a bereavement. Learning and making changes as a result of this feedback will build on the good work that the Trust has started through the development of the Care after Death and Bereavement policy and we look forward to continuing this work in the coming year.

Maternity Experience Workshop

As part of ongoing work on the Maternity Strategy 2015-20 and in response to the 2015 Maternity Survey, the Trust hosted a workshop for mums (and their babies) and those delivering maternity care, both in our hospitals and in the community. The workshop was extremely well attended and a graphic illustrator was on hand to capture what was being said.

The event centred on a game called 'Whose Shoes' in which participants are provided with scenarios presented from a variety of points of view - mums, clinical staff, managers and commissioners - in order to generate discussion. The event ended with participants making pledges about what they are going to do to improve our Maternity Service.

Participants at the 'Whose Shoes' Workshop

Patient Care and Public Involvement (PCPI) panel

Throughout 2015, a group of people representing a wide range of different local communities worked together with the Trust to make sure the views, needs and priorities of patients, carers and the public were being taken into account. The work centred around the testing of a toolkit known as the Patient Carer and Public Involvement (PCPI) Framework.

A variety of services within the Trust participated by carrying out a self-assessment on the PCPI activity within their area. Following this they planned and carried out some new engagement and involvement activity and presented evidence to the PCPI panel for independent assessment.

Activities Room and Drop in Café: Part of Elderly Medicine's submission to the PCPI panel

Following completion of the four pilots, a workshop took place in September with wider involvement from departments across the Trust and the local community. The PCPI Framework will now be made available for wider use across the Trust along with a package of other support tools. This will help more staff understand how to involve patients and the public in making improvements to services in the future.

Patient Reference Group and Patient Leaders Programme

Building on the success of the PCPI panel the Trust PCPI Team are beginning two larger-scale and long-term projects, one to develop a Patient Reference Group and one to support patients who are interested in working with the Trust to access a Patient Leaders programme.

The Patient Reference Group will be established in 2016 and is expected to be a pool of individuals with an interest in involvement and working with the Trust either as a patient, carer or member of the public.

Patient Leaders (from the Leeds West CCG)

3.1.7 Carers

At LTHT we recognise the great contribution that carers make to the lives of our patients. In response to both carer and patient feedback we have made some changes within our hospitals and have signed up to 'John's Campaign'; a national initiative which encourages hospital staff to work in partnership with carers to ensure that patients receive the care that works best for them.

We have simplified visiting times for our general wards and have introduced standard visiting hours (midday - 8pm) on most of our wards (some specialist, high dependency areas are exempt). 'John's Campaign' supports carers to discuss with staff, staying with a relative or friend outside of those hours if they would like to.

In 2016/17 we will be distributing posters and leaflets to all our inpatient areas to provide more information for patients and carers about how 'John's Campaign' can support them. Our carers leaflet contains information about a new Carers Charter that has been developed to support the John's campaign principles. The Charter shows how we have pledged to improve the care we provide for carers and to work alongside them to improve the care for our patients.

Our Carers Charter

We will do our best to...

- Learn from you how best to support the person you care for.

- Welcome you to be present on our wards as long as you would like to be.

- Ask how we can create a better environment for the person you care for.

- Ask how we can create a better environment for you.

- Welcome you to be present during protected mealtimes if you would like to be.

- Explain how you can support other patients to maintain their dignity while you are staying with us.

- Let you know in good time when we need your support to leave the ward area so we can provide clinical care.

- Ask you what you might need help with

We would be glad if you could...

- Help us to understand how to make care more personal.

- Help us to get to know the person we are caring for better.

- Talk to us about any concerns you have with the care and treatment we are providing.

- Suggest improvements to make the experience of the person you are caring for better.

- Tell us how to make your experience better.

- Recognise there are occasions when we may need to ask you to leave the ward area so that we can provide care.

- Recognise the need to ensure the privacy and dignity of all patients on the ward.

- Look after yourself - your support is appreciated, but no way expected

3.1.8 Volunteers

"Leeds Teaching Hospitals - a great place to volunteer"

Volunteering creates an important link between Leeds Teaching Hospitals and the local community, allowing people to contribute their time, energy and enthusiasm to a worthwhile cause while delivering the best possible care and experience for patients. Working in partnership with paid staff, the activities of our volunteers not only enhance patients' well-being during their stay, but can directly support their recovery and rehabilitation.

Our volunteers come from all age groups, abilities and communities, the common denominator being enthusiasm and a passion for helping others.

Bexley Wing Trolley Volunteers, Gerald Thornton (left) and Peter Jefferson, after a successful morning taking a trolley round our wards

We are hosting a celebration event for our current volunteers on 7th June 2016 as part of National Volunteering Week.

We currently have a volunteer workforce of over 400, engaged in a wide variety of roles, which include providing therapeutic or social activities for patients, helping out on wards at mealtimes, working with chaplaincy, supporting our Haamla service, or simply being a friendly face to help make sure patients and visitors find their way around the hospital and get to appointments on time.

We are committed to increasing the number of volunteers to support this objective and we're looking at ways we can improve the experience of those interested in volunteering. We are making the recruitment process as smooth as possible, whilst of course ensuring all safeguarding requirements are met. People interested in volunteering can now register their interest on our Careers Website at https://jobs.leedsth.nhs.uk/volunteers or on the NHS Jobs website www.jobs.nhs.uk.

We have also been forging links with local schools and colleges in providing volunteering opportunities to Year 12 students and above, who may be thinking about working towards a career in healthcare. We will continue to do this going forward in 2016/17.

3.1.9 Raising Concerns - Patient Advice and Liaison Service (PALS)

During 2015/16 we have continued to make improvements to our PALS service and the way we deal with our patients' concerns. The PALS service is the first port of call for patients with concerns, queries or complaints.

Number of PALS enquiries received (by month) in 2015/16 compared to 2014/15
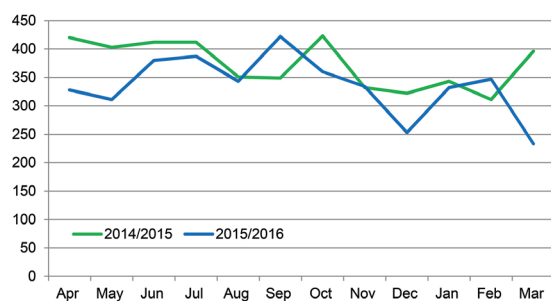
In 2015/16 we have received 4622 PALs concerns, enquiries or complaints.

The 5 top themes identified were:
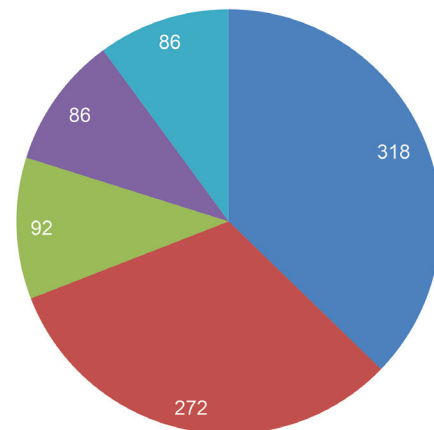
- CM006 Communication with patient — 318
- AD38 Waiting list time OP — 272
- AD004 Cancelled/rescheduled clinic/appt — 92
- CM007 Communication with relatives/carers — 86
- CM018 Difficulty contacting dept — 86

It is clear that a number of these themes relate to the way in which our patients access our services and the difficulties they encounter with our systems and processes. For this reason we have identified as one of our key priorities for 2016/17 the need to improve experience for our outpatients. This work will be supported through the Leeds Improvement Method value stream and through work the Trust is taking forward with Healthwatch.

The PALS team continues to look at new ways in which they can improve the support they offer to patients and members of the public. They are now providing a 'Front of House' service each weekday at Chancellor Wing Reception (SJUH) and Brotherton Wing Reception (LGI) and during the next year the PALS team intend to provide a regular 'Front of House' service at Chapel Allerton Hospital.

The PALS team continues to publicise their services to local groups who represent the diverse community we serve. We have worked

with the 'Get Me Better Champions' and Learning Disability groups to increase awareness of what PALs is and how we can help people with learning disabilities and hearing impairments.

The PALS team is also working with the Trust Bereavement team to produce a leaflet giving advice on how to raise concerns, tailored to meet the specific needs of those who have lost family members or friends. This is because we recognise that people who are recently bereaved may find it particularly difficult to access the help they are looking for and would benefit from having additional support available to them.

During 2016/17 we will get better at ensuring the actions resulting from our PALs concerns are captured in a way that can be shared across our hospitals for the benefit of all our patients.

3.1.10 Improvements in patient and carer information

Providing quality information for patients and carers is an essential part of the high standards of care we expect to provide in the Trust.

During 2015/16, a Patient Information Forum was developed to make sure that the information provided to patients and carers is accurate, up to date, relevant, useful and easy to read. Part of the work that the group has been doing is to review the Trust 'Patient Information Procedure' to ensure that all leaflets are reviewed at least once every 3 years so patients can be confident that the information they are being provided with is up to date and accurate.

An important initiative that took place in February 2016 was the implementation of a new interpretation / translation service, following a review which took place earlier in 2015/16. During the review it was identified that the Trust had challenges meeting the needs of patients, where English was not the first language spoken. This was because, on average, only 85% of interpreter bookings were successfully filled, meaning that around 15% of patients were not being appropriately

supported to understand and take part in their hospital consultations. Additionally, written translation could take up to two weeks to be delivered. Since February 2016 the Trust has been working with Peal Linguistics Ltd to improve the care that is provided. It is still early days, however the change has already resulted in great improvements, with figures for March 2016 showing that 97% of interpreting requests were filled. Pearl are additionally able to support written translation of information in between 1-3 days, meaning that the Trust now has access to better support to enable improved responsiveness and patient care.

Work is being taken forward to ensure there is information available in all our clinical areas that can assist patients to tell us when they feel they need additional support in either translation or interpretation. We are also working on making some of our more commonly used patient information leaflets available in the top languages used by our patients.

3.1.11 Engaging with our Members

In 2015/16 we engaged with our Members; these are public and patient representatives from the communities we serve, who provide support to the Trust.

Early in 2015 our refreshed Public and Patient Involvement (PPI) Questionnaire was circulated to over 24,000 of our members to capture feedback from our members on the services provided by the Trust. To date, over 7,000 of our members have now completed a PPI Questionnaire and work is ongoing with Patient Experience, Research & Innovation and Outpatients services to invite members who have expressed an interest to take a more active role in providing feedback to specific engagement activities.

In 2015 we provided an extensive series of free sessions for our members under our Medicine for Members programme on a wide range of topics, including public health strategy, cancer and radiotherapy treatment, bowel

screening, helping people to stop smoking. The programme included almost 30 events held at venues across the Trust sites with over 600 attendances. Each session was chaired by a member of the Trust Board or a senior manager. This is an important forum for us to engage with the public, including people who use our services, and we will continue this into 2016/17.

3.2 Patient Safety

3.2.1 Improvement in the care of patients with acute kidney injury (AKI)

Background

From over 100 applications, LTHT was successful in being awarded a Health Foundation 'Scaling up Improvement Programme' grant worth £500,000 (approximately £70,000 for LTHT). The project aims to assess whether the introduction of the following interventions can result in an improvement in the quality of care and outcomes for patients with AKI:

a) Acute kidney injury (AKI) electronic alert notifying clinicians of patients with AKI (stage 1, 2 or 3)

b) AKI education package for staff, and

c) AKI management plan linked to a patient care pathway.

In light of the national AKI CQUIN, the AKI project within LTHT will also include a fourth intervention of;

d) additional information on the Electronic Discharge and Advise Notice (EDAN), to improve the safe discharge, follow-up and rehabilitation of patients with AKI.

The Health Foundation AKI project involves four NHS Trusts that will roll out the project in a stepped wedge approach. The timeframe for this in LTHT is as follows:

- Mar-May 2016 LGI, pilot wards
- June-Aug 2016 SJUH, pilot wards

At LGI the ward areas selected for the pilot are; L15 Vascular, L18 Cardiology, L35 Orthopaedics/37 Orthopaedics/39 HDU and at SJUH the pilot wards selected are; J17 Elderly, J28 AMU and J42 Urology.

Aim

The overarching aim of the LTHT AKI project is to apply evidence based interventions to improve the; prevention, detection, management, safe discharge, follow-up and rehabilitation of patients with AKI.

Achievements to date

In light of the Health Foundation Project, AKI NICE guidance, National Patient Safety Alert (June 2014) and the AKI CQUIN, a multidisciplinary LTHT AKI project group was established in July 2015. The group includes wide representation from medical (including paediatrics), nursing, pathology, pharmacy, IT, outreach, communications, patient safety and quality. A GP and a patient representative have also been recruited to the group. Two Project Managers from the Bradford Improvement Academy have also been appointed to lead the project implementation.

A variety of activities have been undertaken including the development of a project plan, driver diagram, risk register, measurement and communications plan.

Audits of randomly selected patients with AKI on the pilot wards (30 LGI patients and 30 SJUH patients) have been conducted every quarter since March 2015 to assess the quality of care of patients who have been diagnosed with AKI. In order to incorporate the requirements of the AKI CQUIN the audit has also been extended to capture the information that is currently sent to GPs on the EDANs. The EDAN audit aims to review the information sent to GP's to help with the follow-up and rehabilitation of patients that have had AKI during their hospital admission.

Other activities achieved to date include;

- The development of the 'STOP AKI' acronym, logo and management plan

- The implementation of the AKI warning algorithm which now generates an electronic alert to notify pilot ward staff of patients' AKI status, as it displayed on the electronic white boards. This alert contains an eForm of the STOP AKI management plan which allows the user to respond to the prompts and provides a robust auditable system to help to demonstrate the effectiveness of the project

- A Project Nurse/Educator was appointed in March 2016 and visits the pilot wards most days raising awareness of the project and educating staff. Together with the clinical lead they have been testing education packages on ward multi-disciplinary teams and once agreed it is envisaged that these will be developed into an e-learning package

- A formal launch event was held on 11 April 2016 and was attended by over 70 representatives from the pilot wards/CSU's, primary care, the Improvement Academy, University of Leeds and representation from the Leeds North CCG

- A patient information leaflet has been developed, tested and implemented on the pilot wards at LGI

- A wide range of 'STOP AKI' branded promotional materials have also been developed and are being used on the pilot wards to raise awareness of the project (e.g. pens, pens, posters, post-it notes, badges, water bottles). Other resources such as doctors and nurses information cards and posters have also been developed as they aim to educate and guide staff around the actions they should take in relation to patients with AKI. Magnets have also been developed to be used at the end of patient beds to indicate to ward teams which patients have AKI.

Aim for 2016/17

The CQUIN target for 2016/17 will be agreed with our commissioners over the forthcoming months.

3.2.2 Improvement in the care of patients with Sepsis

Background

The 2015/16 Local Quality Incentive Scheme for Sepsis agreed with commissioners from NHS West Leeds CCG, required LTHT to:

i) develop and implement protocols for screening for sepsis within the Emergency Department (ED) and in the Medical and Surgical Admissions wards where patients are directly admitted, and

ii) ensure that intravenous antibiotics are initiated within one hour of presentation for those with suspected severe sepsis, red flag sepsis, or septic shock.

The sepsis steering group chaired by Dr Stuart Nuttall (Consultant in Emergency Medicine, LTHT) meets monthly and oversees this work to standardise and improve sepsis care across the Trust.

The overall aim is to reduce mortality through improving the identification and management of red flag sepsis and septic shock in acute adult patients.

Progress in 2015/16

The screening tool (BUFALO) and the sepsis guidelines were approved in July 2015 and subsequently made available for use across the organisation.

BUFALO – Sepsis Intervention Tool

B	• **B**lood Cultures + septic screen, U&E's
U	• **U**rine Output - monitor hourly
F	• **F**luid Resuscitation
A	• **A**ntibiotics IV - see microbiology guidelines
L	• **L**actate measurement
O	• **O**xygen - to correct hypoxia

The use of the sepsis screening tool and care bundle are now embedded within The Emergency Departments (ED).

Acute admission areas are supported in providing reliable and effective sepsis bundle care via the implementation and embedding of the screening tool (BUFALO). The assessment areas are engaged in the implementation phase of the plan which includes education, introducing BUFALO tool and ensuring systems and process are developed to support staff to comply with best practice for adult patients admitted acutely with red flag sepsis.

Simulation work to test processes including BUFALO screening is regularly performed to compliment ongoing education and awareness. During the sepsis awareness week in September 2015 there was a programme of simulation using sepsis scenarios across the organisation for different clinical teams to learn from. Sepsis continues to be included as part of induction and education packages for both nursing and medical staff. Sepsis has also been incorporated in an e learning package as part of the Acute Kidney Injury programme. Learning is shared via the sepsis steering group through operational leads.

Aims for 2016/17

The work plan for 2016/17 will extend to include both adult and paediatric patients presenting as emergency admissions or inpatient admissions to ensure there is systematic screening for sepsis and where sepsis is identified, provide timely and appropriate treatment and review. The sepsis protocols and BUFALO tools will be embedded in a reliable way across identified wards.

There will be focused work to look at antimicrobial review for those patients with red flag sepsis or septic shock where a decision was made to treat with intravenous antibiotics.

The Sepsis programme of work is closely aligned to the wider Trust patient safety programme regarding care of the deteriorating patient. Support for the introduction of the BUFALO tool and compliance with the care bundle continues to be assisted by the work of the deteriorating patient programme.

The targets for 2016/17 are based upon the CQUIN requirements for % of eligible direct emergency admissions screened and treated,

and day 3 antimicrobial review, for both adults and paediatrics.

For acute inpatients the milestones are based on establishing the baseline on the use of the tool, day 3 antimicrobial administration and day 3 review, and incremental improvement targets from the baseline.

3.2.3 Deteriorating Patients - Improvement in the care of patients when their condition deteriorates on our wards

The Deteriorating Patients Collaborative commenced in July 2014. We asked the collaborative teams, "How can we reduce avoidable deterioration on our wards?"

Progress to date

The sixteen collaborative wards have been utilising the Model for Improvement as a framework for testing new interventions and making changes in their areas. Ward teams identified small tests of change that they believed would lead to improvement. Following a period of developing and testing interventions and identifying those interventions having an impact on reducing harm, the "Deteriorating Patient Intervention Bundle" was launched in June 2015. This outlined the most successful interventions for testing at scale across all of the Collaborative wards.

The Intervention Bundle includes;

- **Safety Huddles** - Team members meet daily to identify patients they are worried about deteriorating today, and, as a team, decide what actions to take. Local data regarding their last 2222 call* is shared.

> **Number of days without a 2222 call**
>
> Ward name

*A 2222 call is a crash call to summon an emergency care team to a patient suffering a cardiac arrest

- **1:1 NEWS Training and Observations Made Easy** - The **"Observations made easy"** tool is given to any bank/agency nurse, CSW or anyone unfamiliar with the ward environment, when they arrive at the start of the shift to ensure they are familiar with our way of performing observations, and give them opportunity to ask questions about anything they are unsure of. One to one ward NEWS training led by a senior nurse is also be given to all new regular members of ward staff to deliver personalised training to the individual based on their own knowledge level and the specifics of their ward patients and environment.

- **NEWS Sticker** - To prompt the timely and appropriate graded response to an elevated NEWS and consideration of an individualised escalation plan.

- **Escalation of Care Sticker** - To prompt decision making by the senior clinician responsible for the patient and promotes individualised care decisions and discussions with the patient.

- **Post 2222 Call Review** - Carried out by the ward team after any 2222 calls (including cardiac/ respiratory arrests and medical emergencies), using a simple template; the lessons can be shared and incorporated into the safety huddle.

Impact - Collaborative Outcome Data

Our ambition was to reduce avoidable deterioration by 50% by October 2015 across our Collaborative wards, and we are proud that significant progress has been achieved. Analysis has shown a 30% reduction in 2222 calls for urgent medical assistance on these wards so far, with an earlier response to deterioration and earlier identification of patients approaching end of life. We know with continued commitment to learning and improvement we can get further. The Statistical Process Chart (SPC) below shows the number of 2222 calls for urgent Medical Assistance on pilot wards before and during the Collaborative for all 2222 calls.

2222 calls for urgent Medical Assistance
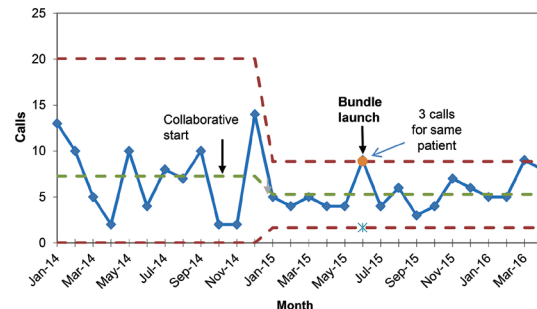
Example of Ward Level Impact

The following were highlights of what wards have achieved, and there are many more examples.

- L37 (Trauma and Orthopaedics) achieved over one year between 2222 calls in Dec 2015, previously averaging 29 days between calls

- J96 (Oncology) went 84 days between calls March 2016 (average 23 days)

- L19 (Cardiology) went 86 days between calls in Jan 2016 (average 17 days)

- L35 (Trauma and Orthopaedics) went 166 days between calls in December 2015 (from an average of 52 days)

- J89 (Haematology) went 194 days without a call in Dec 2015 (average 53 days).

- J10 went 151 days between calls in April 2015 (average 22 days)

Ward L37
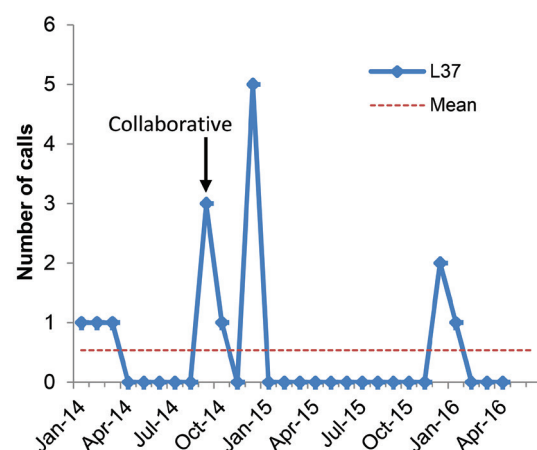
Ward L19
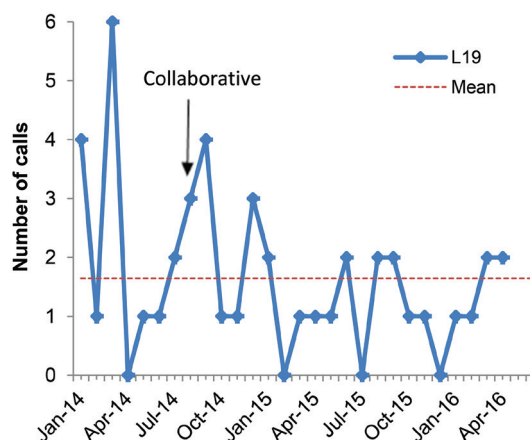
Next Steps

The intervention bundle is to be scaled up across all wards in the Trust. The scale up plan commenced in Abdominal Medicine and Surgery and CSU in April 2016, the early learning of this scale up model will be identified informing the wider spread across CSUs in 2016-17.

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

Background

In July 2014, as part of our Quality Improvement Programme, we launched a collaborative programme for 14 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). Throughout 2015/16 we finalised the intervention bundle and have continued to work with our pilot wards embedding all five interventions.

The initiatives in the Intervention Bundle are; Safety Huddles, Toileting, Footwear, Post Fall Reviews, and Cohorting.

Key Achievements

In 2015/16, all of the pilot wards have achieved at least 18 days without a fall, with 10 wards achieving over 25 days, and 4 achieving over 45 days without a fall.

Incidence of Falls per 1,000 bed days on Pilot Wards
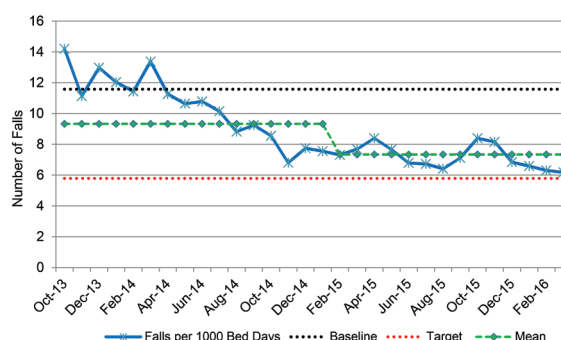
Towards the latter part of 2015/16 we have started to identify and work with other clinical teams to spread the intervention bundle to other wards. Our plan in 2016-17 is to have a planned scale up to all inpatient areas.

We know that based on the Safety Thermometer data the national median values for all falls prevalence across the Trust is 1.9%, and 0.72% for falls with harm (February 2016). Across Leeds Teaching Hospitals we are already below the national median with a prevalence rate of 1.19%, and 0.52% for falls with harm.

Alongside the Falls Improvement Programme, in 2015-16 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.

Aim for 2016/17

The challenge for us in 2016/17 is to spread the learning from the collaborative improvement programme across the Trust to deliver the same improvements in all of our clinical areas.

We will work with CSUs to plan a roll out of the intervention bundle to their ward areas, utilising the skills of the Falls Faculty to build a body of improvement knowledge in each CSU so that they can confidently undertake and consistently implement quality improvement initiatives.

We will develop the measurement framework to enable ward and CSU teams to see how the intervention bundle is being implemented and the impact on falls it is having. Our aim is to reduce the number of falls in our hospitals by 50% compared to our initial baseline: this has almost been achieved in the pilot wards, however, we recognise that this will be challenging in wards where the falls are already very low or have already made a reduction.

The prevalence of falls will continue to be monitored through the monthly Safety Thermometer return. At ward level we will monitor the actual number of falls as this is a more meaningful measure of the ward teams. 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.

3.2.5 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 as 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. They are categorised from one to four according to the level of severity.

Progress in 2015/16

In 2015/16 we embedded the use of a revised risk assessment tool and throughout the year we have had no category 4 pressure ulcers develop in comparison to 5 in 2014/15. We have also seen a reduction in category 3 and category 2 pressure ulcers.

We have been working to develop a set of interventions with a group of wards to test, using a similar methodology as the falls improvement work and this work is progressing well.

The initial pilot; wards in the Trauma Related Services CSU are the initial pilot wards and have reduced their pressure ulcers from 77 in the first half of the year to 40 in the second half of the year. We are now in the process of completing an intervention bundle to enable scale up and spread with other CSUs.

Incidence of developed pressure ulcers and rate per 1,000 bed days, by month in Trauma Related Services CSU
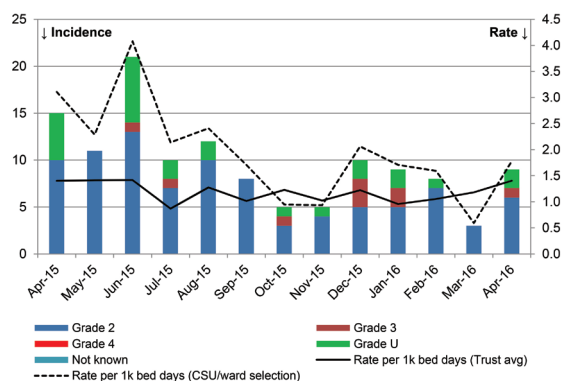
Incidence of developed pressure ulcers and rate per 1,000 bed days, by month
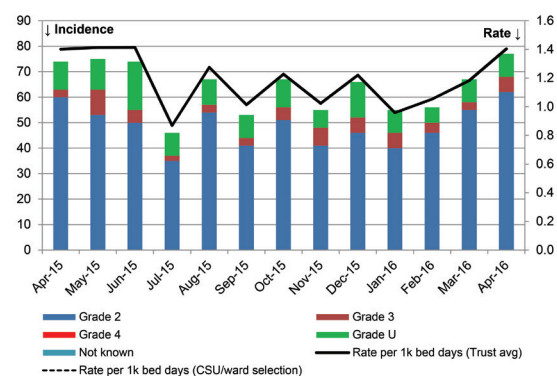
We have also been working closely with our colleagues across Leeds to reduce pressure damage in all settings, including the patient's home and care homes. We have a city wide work plan and have had a number of forums where teams have come together to discuss where the risks are and plan how to reduce them.

Prevalence of pressure damage prior to coming into hospital (old) and developed in hospital (new)

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Presure Ulcers - Old	2.95	2.84	2.66	3.7	2.65	2.74	3.4	2.59	3.47	2.89	2.42	2.9	3.89
Presure Ulcers - New	1.44	1.58	1.62	1.36	1.58	1.34	1.31	0.91	1.77	1.32	0.83	0.88	1.02
Patients	1528	1586	1544	1541	1519	1497	1530	1543	1584	1591	1573	1588	1570
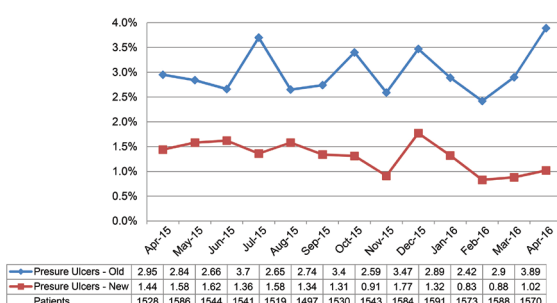
Aim

In 2016/17, reduction of pressure damage will be one of our main Quality Improvement areas. We will work closely with clinical teams to ensure that the interventions in the change bundle that have been identified to reduce risk and incidence of pressure damage are tested and shared across the organisation. Our aim will be to achieve zero avoidable category 3 or 4 pressure ulcers developed in our hospitals by the end of 2016/17.

How will this be monitored?

We will continue to monitor the prevalence of pressure ulcers through the monthly Safety Thermometer return. Progress 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 also be provided to the Trust Board and commissioners at Leeds West CCG.

3.2.6 Scaling up Improvement: Reducing Harm and Improving Patient Safety Culture by Integrating Daily Patient Safety Huddles on Wards

Background

LTHT was successful in being awarded a Health Foundation 'Scaling up Improvement Programme' grant worth £500,000 to lead with the Yorkshire and Humber Improvement Academy the implementation of ward level safety huddles across four acute hospitals in three NHS Trusts- Leeds Teaching Hospitals, Barnsley Foundation Trust, and Scarborough Hospital over 2015-17. The work aims to:

i)   Implement huddles in 129 hospital wards

ii) Deliver demonstrable improvements in ward-level patient safety culture

iii) Deliver a significant reduction in patient harm

iv) Generate and disseminate learning about the implementation of safety huddles that is valuable across the NHS

Safety Huddles

Safety Huddles are a ward patient safety meeting, focused on one or more agreed patient harms (identified by the team) such as falls, pressure ulcers, or avoidable deterioration. The huddle is a short meeting (5-10 minutes) that takes place daily on the ward at an agreed time, involving all members of the team. It follows some general principles: staff review how many days it is since the last fall, cardiac arrest (or other agreed harm); look at who may be at risk of the harm today; and what actions need to be implemented by the team to reduce the risk. The meetings are non-hierarchical and everyone is encouraged to raise concerns or make suggestions.

Safety huddles were first tested at LTHT in 2013. They were adapted and embedded successfully to eight LTHT wards in 2014. This has been associated with reductions in harm including: falls; pressure ulcers; medication delays; and improvements in safety culture. This led to the successful grant from the Health Foundation to determine how to implement huddles at scale, without losing the local ward ownership.

Wards choose how they want to introduce safety huddles and which harm(s) they want to focus on. They receive coaching support from the Project team, testing and adapting huddles to their local needs, with the aim of embedding them into the ward routine. They display the "days since the last harm event" and run charts, so progress can be monitored and discussed. Certificates are provided for wards when significant milestones are reached e.g. days between targets. There is also funding to support a ward member (of band 5 level) ½ day per week during the implementation phase.
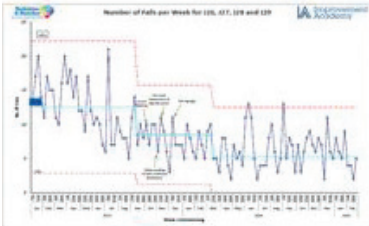
Project Progress to Date

The Implementation phase commenced in August 2015, each month 4-10 LTHT wards are approached as a new cohort. The first four weeks are for engaging the ward teams, identifying the harm the team wish to focus on and undertaking baseline data collection and culture surveys. There is then a 3 month period of testing huddles in their local context with coaching support, followed by a post implementation phase with light touch support when huddles should be embedded (occurring at least five days/week) and surveys are repeated. Each ward receives Statistical Process Charts for their focus of harm.
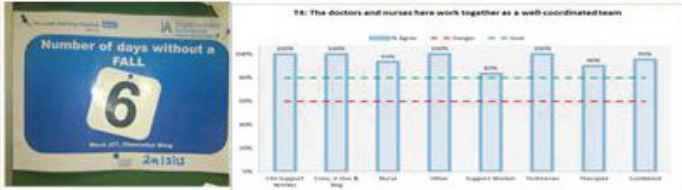
To date 38 wards now have huddles embedded at LTHT, and a further 24 wards are continuing to test and adapt huddles to their context. Early results show positive impact on teamwork and culture, alongside reductions in harm. The work is being formally evaluated by the University of Bradford.

The Safety Huddle ... ignites a spirit of learning

"We are achieving results now, that none of us thought were possible 12 months ago"
Consultant Medicine for Older People, LTHT

Safetly Huddle on Ward J17

Safety Huddle in action

Example of a Statistical Process Control chart for Impact on falls
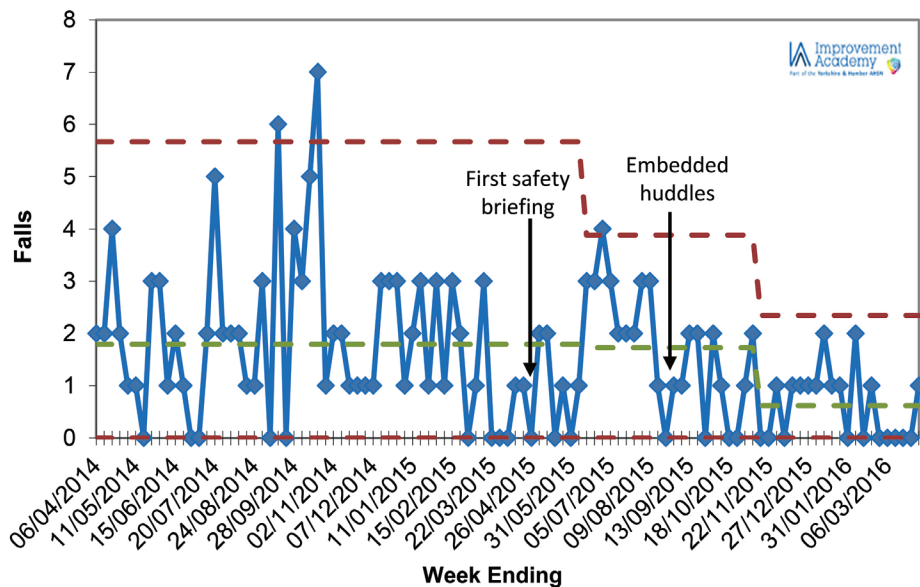
Examples of impact at March 2016:

- By January 2016 Ward J21 (General Medicine) had gone over 150 days since an acquired pressure ulcer, 104 days between 2222 calls and seen over a 50% reduction in their falls.

- J17 became the first medical ward to achieve 50 days without a fall in December 2015 and went over 150 days without an acquired pressure ulcer in January 2016.

- Wards J27 (Acute Medical Admissions) and L24 (Neurosurgical) reached significant milestones of over 30 days without a fall in March 2016 and L50 (Trauma and Orthopaedics) went over 40 days without a fall in January 2016.

Patient and Public Involvement (PPI) in Safety Huddles

In the safety huddles team the value of stakeholder engagement is highly prioritised. Consequently, there is an individual in the project team with the specific role of 'Lead for PPI'.

Patient and public engagement events have been held where safety huddles are demonstrated and suggestions from attendees as to how patients and families can contribute to huddles are being tested, e.g. discussing in the huddle if family members had any concerns.

Team members and coaches are invited to attend the workshops to share ideas; for those unable to attend the PPI lead provides regular updates to the group.

Further PPI events are planned to continue to update stakeholders with developments as the project progresses.

3.2.7 Patient Safety - Reduction in harm - maternity care

Background

Following a review of claims received over a five year period (2009-2014) the Maternity Sign up to Safety bid (further details in 2.1.2) focused on three key areas in which it was decided that the CSU could make the most impact. These were wrongful birth (failed screening standard resulting in a poor outcome), loss of a baby and care delivery events. The trust was awarded £750K to support these improvements in maternity services following a successful bid to the NHSLA when our Safety Improvement Plan was submitted.

Within each key area three main drivers were identified common to each theme - namely Training, Resources and Leadership.

Aim

Our aim is to achieve a 50% reduction in wrongful birth, loss of a baby, and care delivery events by March 2018.

Training

To reduce care delivery events, and those involving loss of a baby, the focus is on developing and implementing a new fetal heart rate monitoring training package encompassing human factors and situational awareness which are areas found lacking in existing training packages. The outline of the training and the development of the content have been completed, in partnership with other organisations and stakeholders. Dissemination of the training started in January 2016.

Further training support to enable core staff on the delivery suite to access advanced neonatal life support training has also been identified.

In relation to reducing wrongful birth incidents, the focus has been on the provision of additional training for midwifery staff in relation to mid trimester scanning. An additional work stream to support smoking cessation has resulted in a midwife being seconded to implement Carbon Monoxide (CO) monitoring across the antenatal and inpatient postnatal service. This has been completed and testing introduced incrementally from January 2016.

Resources

Three new ultrasound machines have been purchased and this additional screening equipment will ensure adequate capacity of screening services to support effective detection, contributing to a reduction in wrongful birth and loss of a baby. To support smoking cessation and thus improve birth outcomes, 30 "CO" smoke analysers have also been procured with an additional 15 on order.

In order to contribute to the reduction in care delivery events, we have agreed to purchase additional equipment to provide wireless fetal heart rate monitoring in labour. Twenty six additional CTG machines have now been purchased.

To increase the quality of information from antenatal records, and therefore contribute to a reduction in wrongful births, a new IT system has been agreed. The project team has been working with the supplier of the intrapartum

IT system to define the scope of work, with system development taking place currently.

Leadership

Audit capacity and project management resource has been identified from within the current structure, in order to ensure that the project work streams progress to timescale, and meet their objectives. Further, identified leads are progressing work in relation to the best start strategy which focuses on public health, and the national and regional still birth care bundle.

Outcome Measures

Key outcome measures have been agreed and will be monitored via the Women's CSU Clinical Governance and Risk Management Forum. The areas to be monitored will include:

- Reduction in maternity related claims relating to wrongful birth
- Reduction in perinatal morbidity and mortality rates
- Reduction in babies diagnosed with Hypoxic Ischaemic Encephalopathy
- Reduction in incidents involving the misinterpretation of CTGs

3.2.8 Staffing

We know that great care is dependent on great staff. Our ambition is to make LTHT one of the best places to work. We have been growing our workforce, from 15,200 in March 2014 to 16,500 in March 2016 including 850 additional nurses, over 500 of these RN's. Whilst much of the national focus has been on Nurse recruitment, it's clear that great care needs team work, as we treat people with evermore complex needs, we are proud of the contribution our Allied Health Professional staff add to the patient experience and the speed of their recovery.

The right number of staff is an essential precondition to great care but not enough. We

have highlighted the importance of training and development, significantly increasing our mandatory training and appraisal rates and have overhauled our leadership programmes. We are also embedding our values through The Leeds Way to drive staff engagement. In 2015 we were the most improved trust on the national staff survey, improving our results in 17 key result areas. In 2016 we won an award as the best employers for apprenticeships and we have around 240 apprentices, helping to secure our pipeline for the future.

Sickness Absence

The overall sickness absence rate for Leeds Teaching Hospitals has improved significantly during 2015-16 as can be seen here:

12 Month Sickness Trend, March 15 - February 16
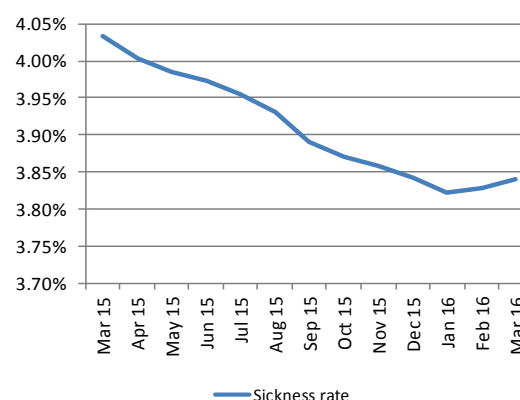
We continue to be committed to reducing sickness rates across the Trust, and the attendance management team set up in April 2013 work with managers across the Trust to support staff in managing levels of absence from work through sickness. This work will continue 2016 - 17, helping to ensure we have the numbers of staff we need at work to bring real benefits to patients.

Nurse Staffing

In 2014 there was an investment of £14 million into additional nurse staffing at the Trust. In 2015-16 we continued to drive our recruitment to make the best use of the investment to increase the total number of registered

and unregistered staff with the outcome of improving care for our patients.

Ward staffing levels are constantly reviewed and adjusted responsively according to:

- Daily clinical activity and service need
- Patient acuity and dependency, measured biannually using evidence based tools
- National guidance on staffing in specialist services
- Professional oversight, led by the CSUs.

The generation of off duty rosters is now fully electronic to reduce variability and improve transparency with on-going adaptations to respond to changes and escalation.

Recruitment: Registered Staff - Nurses, Midwives and Operating Department Practitioners (ODP)

The clinical and corporate teams attended four RCN recruitment fairs and the RCN Congress this year, and hosted regular local open days in our continued pursuance of showing Leeds as a first class place to start and develop a career in nursing and caring.

We continue to work closely with our local universities to attract and recruit the graduating nursing, midwifery and ODP students. This year we have worked collaboratively with Leeds Community Health to recruit jointly in a strategy to keep the Leeds students as part of the healthcare workforce in Leeds.

We completed the recruitment of 30 Italian nurses jointly with our colleagues in NHS Professionals and the final cohort of 8 nurses has arrived in Leeds and is due to start on our wards in June 2016.

Applications for the Return to Practice programme have slowed down somewhat from the initial intake of 9 candidates in January 2015, and we now draw between 9 and 12 nurses per year back to professional practice.

As a result of this drive on recruitment in 2015-16, 523 new Band 5 registered staff started in post within the Trust, of which 429 of were external recruits.

Recruitment: Advanced Practitioners

The Trust benefited from additional funds from Health Education England in the Yorkshire and Humber Region to support advanced practitioner (AdP) training. In 2015-16 we were able to recruit 25 new AdP trainees across our clinical services to commence on one- or two-year training programmes leading to substantive AdP roles on completion. The culmination of the training investment over the last two years will be 45 new AdPs working in the Trust by 2018.

Recruitment: Support Workers

Our recruitment and training of apprentice support workers continues to grow, with 10 cohorts per year and the number of places increased from 20 to 22 per cohort in 2015, and planned to expand further to 30 from July 2016. When combined with the recruitment of 176 trained Band 2 and Band 3 clinical support workers, this is starting to have a positive effect on unregistered vacancy levels in the trust, though there is still a considerable way to go to achieve full establishment.

Our 17 trainee Assistant Practitioners (TAPS) completed their studies in July 2015 and are now fully immersed in substantive posts, with really positive feedback from clinical areas on the impact the Assistant Practitioners (APs) are having on the delivery of care. The next

cohort of 25 TAPS commenced a new two-year programme in September 2015 leading to a foundation degree, and with links to be able to join registered nurse training on completion.

There is a need for more APs across the Trust, and particularly in clinical areas with high patient dependency. However a question has arisen over the future of the AP training programme due to funding changes. We are in discussion with Health Education England based in Yorkshire & the Humber (HEEYH) to identify potential solutions.

Flexible Workers

In November 2015 NHS Improvement published caps on rates of pay for agency staff with the aim of reducing expenditure on agency staffing, to be implemented in three stages. From December 2015 to March 31st 2016 the Trust has implemented the new agency rates. We have worked with our own staff to promote the uptake of additional shifts including local incentive and overtime payments.

We have worked in collaboration with our nurse bank supplier, NHS Professionals, to increase recruitment to the bank and the uptake of vacant shifts through incentive schemes and long-term placements.

The workforce team will continue this work as further rate restrictions arise.

3.2.9 Ward Healthcheck

The Ward Healthcheck was launched in January 2013 and has continued to develop. 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 and outpatient areas. The programme audits the assessment, identification of risks, delivery and evaluation of care against agreed standards for each patient. We have modified the standards and their content to reflect changing practice and recommendations.

Ward Metric results by CSU and Standard (information for March 2015 and March 2016)

Mar 15 Question Group	Abdominal Medicine and Surgery	Acute Medicine	Adult Critical Care	Cardio-Respiratory	Centre for Neurosciences	Chapel Allerton Hospital	Childrens	Head & Neck	Institute of Oncology	Trauma and Related Services	Urgent Care	Womens
Medicines Management	88.2%	85.4%	87.0%	91.5%	91.5%	95.7%	90.4%	100.0%	90.6%	83.7%	100.0%	96.2%
Patient Observations	90.9%	90.8%	97.1%	85.0%	88.9%	97.5%	89.9%	97.0%	84.3%	91.6%	97.4%	94.2%
Falls Assessment	86.0%	95.2%	91.3%	92.1%	89.2%	94.7%	89.4%	90.0%	94.5%	89.2%	93.9%	-
Infection Prevention	78.8%	92.9%	93.3%	83.0%	91.5%	100.0%	83.9%	92.3%	87.8%	81.4%	100.0%	95.7%
Pressure Area Care	82.3%	88.3%	95.2%	92.8%	91.8%	100.0%	92.6%	100.0%	82.2%	79.1%	85.3%	83.5%
Continence	89.7%	95.0%	95.7%	94.6%	96.9%	100.0%	94.9%	100.0%	95.0%	91.6%	100.0%	93.2%
Nutrition Assessment	83.5%	91.2%	96.1%	91.2%	97.1%	100.0%	94.7%	92.3%	84.8%	84.2%	100.0%	-
Pain Management	83.0%	92.7%	98.6%	90.0%	87.8%	100.0%	95.4%	91.3%	81.5%	82.2%	100.0%	100.0%
Patient Dignity	95.1%	98.1%	100.0%	95.3%	96.8%	100.0%	95.5%	80.0%	90.5%	94.3%	100.0%	100.0%
Discharge	73.6%	83.9%	100.0%	77.4%	76.9%	73.7%	83.0%	88.9%	67.4%	63.1%	100.0%	83.8%
Resuscitation Equipment	91.7%	92.9%	100.0%	70.0%	100.0%	100.0%	82.4%	100.0%	88.9%	100.0%	100.0%	50.0%

Mar 16 Question Group	Abdominal Medicine and Surgery	Acute Medicine	Adult Critical Care	Cardio-Respiratory	Centre for Neurosciences	Chapel Allerton Hospital	Childrens	Head & Neck	Institute of Oncology	Trauma and Related Services	Urgent Care	Womens
Medicines Management	90.5%	89.0%	93.8%	95.0%	88.6%	89.5%	95.6%	100.0%	89.5%	85.6%	94.7%	96.4%
Patient Observations	91.4%	90.7%	95.7%	90.6%	89.9%	92.7%	90.2%	100.0%	93.1%	84.0%	96.4%	97.3%
Falls Assessment	97.2%	92.9%	96.7%	98.6%	96.9%	97.5%	97.9%	100.0%	95.9%	83.9%	93.3%	0.0%
Infection Prevention	81.3%	86.5%	93.2%	86.8%	78.8%	100.0%	88.2%	100.0%	86.1%	78.3%	63.6%	95.2%
Pressure Area Care	91.2%	88.0%	96.0%	97.2%	89.8%	94.3%	90.7%	77.3%	86.7%	91.6%	91.7%	82.9%
Continence	93.6%	95.6%	98.2%	96.8%	97.5%	100.0%	97.4%	100.0%	92.7%	94.2%	100.0%	96.1%
Nutrition Assessment	93.4%	88.3%	94.5%	96.0%	93.3%	100.0%	96.5%	100.0%	90.0%	89.0%	93.3%	-
Pain Management	95.6%	96.8%	98.3%	97.5%	98.1%	100.0%	97.5%	85.0%	98.8%	90.3%	90.9%	100.0%
Patient Dignity	97.4%	97.9%	94.7%	96.0%	99.1%	97.4%	97.0%	89.5%	100.0%	97.3%	92.3%	99.0%
Discharge	84.0%	85.5%	100.0%	86.4%	90.4%	100.0%	88.1%	83.3%	95.6%	75.2%	-	-
Resuscitation Equipment	91.7%	93.3%	60.0%	87.5%	83.3%	50.0%	93.8%	100.0%	77.8%	87.5%	100.0%	100.0%

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)

Welcome to Ward L90
Patient Safety Board

The Leeds Teaching Hospitals NHS — NHS Trust

Aim for 2016/17

In 2016/17 we will use the information from the ward metrics, healthcheck and a range of other quality markers as the foundation for a ward accreditation programme. The work on developing this programme has already started with our senior clinical teams we plan to start to test with our high achieving wards as a means to recognise their success.

3.2.10 NHS Safety Thermometer

The NHS Safety Thermometer provides a 'temperature check' on harms associated with falls, pressure ulcer, catheter associated urine infections (CAUTI's) and venous thrombo-embolism (VTE). Data is collected nationally on one Wednesday every month.

When comparing March 2016 to March 2015, harm free care has decreased from 94.5% in 2015 to 93.76% in 2016 although there are fluctuations throughout the 12 months.

Safety Thermometer performance is tracked on the Ward Healthcheck which updates monthly, and a summary is circulated to CSUs identifying areas for improvement.

Harm free care performance for LTHT can be seen in the graph below

Percentage of patients free from new harm and harm free, April 2015 - March 2016
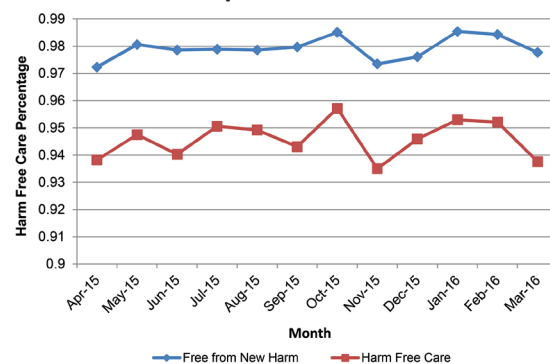
3.2.11 Reducing rates of Healthcare Associated Infections (HCAI)

Our aim is to eliminate all avoidable hospital associated infections, such as those due to Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (CDI). This has remained challenging in 2015/16, although we have continued to make good progress with on-going reductions in the number of patients who developed infections whilst in our care.

The key objectives achieved in 2015/16 included:

- Changing the choice of our routine first line CDI treatment for high risk patients

- Optimising treatment pathways for patients who develop CDI by centralising their care where clinically appropriate

- Following the National guidance on how to screen patients to see if they have the MRSA bacteria on their skin or in their nose already - as some people do.

- Evaluating how well the targeted MSSA screening in high risk patient populations works

- Developing a Trust-wide approach to reduce the risk of infections that can sometimes occur when a cannula is used to gain access to a patients veins. A cannula, also called a venflon, is a small flexible tube inserted into a vein to give a patient medication or fluids that they are unable to take by mouth or that need to enter your blood stream directly

- Enhancing roles and responsibilities in Clinical Service Units to strengthen antimicrobial stewardship - making best use of antibiotic medicines for the care of patients

- Making sure that standard precautions are always routinely used when we are caring for patients with new emerging infections

- Making publically available the planning, application and measurement of cleanliness

- Using the hydrogen peroxide vaporisation programme when needed to clean areas in the Hospital

- Sharing information by developing an HCAI dashboard

- Making sure we are making changes to implementing the new national guidance on Antimicrobial Stewardship

MRSA

MRSA is a type of bacteria that is resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

In 2015/16, 6 patients developed an MRSA bacteraemia whilst in our care, plus one where the MRSA isolate was a sample contaminant. This total is over 10% less than last year's; however it is recognised nationally that each NHS Acute Trust continues to have an MRSA bacteraemia annual target set at zero, and it is of note that a handful of our peers have achieved this. At the start of 2015/16 we had gone 114 days since our last MRSA bacteraemia and proceeded to increase that to a local record of 162 days before the next case.

Progress against the MRSA target (cumulative)
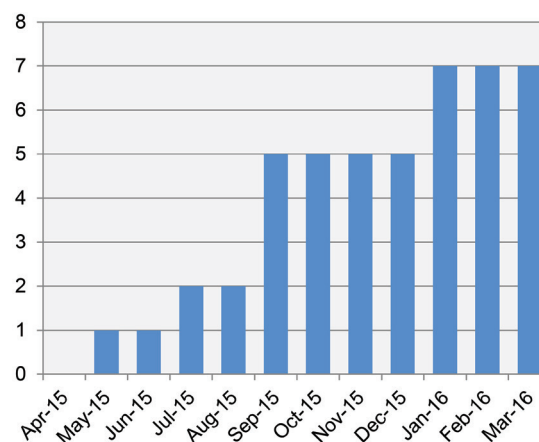
The days between cases continue to lengthen which shows that we can achieve our aim of zero avoidable MRSA bacteraemias, and match the top-performing Trusts.

CDI

Clostridium difficile is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but the condition can usually be treated with another course of different antibiotics.

In 2015/16 139 patients developed CDI in our hospitals against a trajectory of 119. Of these 139, at least 29 have been agreed as having no significant lapses in patient care by the Trust, which would have contributed to the development of the infection.   These cases were decided following detailed review of the individual circumstances of each case in conjunction with our commissioners.

Number of CDI Cases Attributed to the Trust
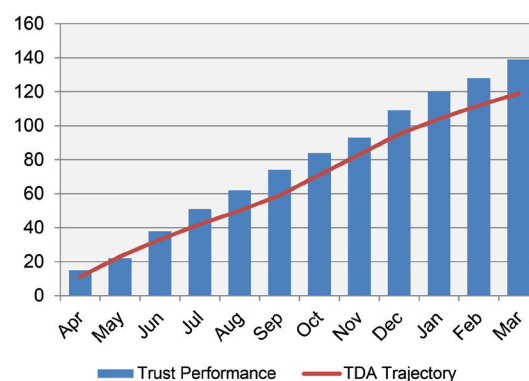
CDI rate per 100,000 bed days

Indicator	Reporting Period	Trust Performance	National Average	National Range
CDI Rate per 100,000 bed days (Patients 2+)	2015/16	19.7	16.1	0.0 to 69.7
	2014/15	21.6	15.1	0.0 to 62.2
	2013/14	25.6	14.7	0.0 to 37.1
	2012/13	26.1	17.3	0.0 to 30.8

Antimicrobial Stewardship

Antimicrobial Stewardship is a phrase that describes our work to improve the selection and use of antimicrobial medicines to treat a patient's condition so their use does not contribute to the problem of developing resistance to our current antimicrobial medicines.

The Trust Antimicrobial Stewardship (AMS) Committee reviewed its membership and terms of reference in April 2015. As part of this new integrated process and in order to facilitate greater engagement with the CSUs, the chairmanship and format of the meetings were reviewed and changed. This has allowed greater ownership of antimicrobial stewardship locally and provided greater opportunities for the AMS team to support the CSUs.

We have reviewed our AMS systems against the updated guidance for hospitals and made a change to the monthly audit programme to include day 3 review of treatment regimens, adherence to antibiotic guidelines and completion of allergy boxes. A multi-specialty project group has been set up to further improve compliance against day 3 review.

The Health Education England framework on AMS education and training is still in progress, however Level 1 training on antimicrobial resistance has been released for all staff. This will be used as part of the Trust's 2016-17 training programme.

Objectives for 2016/17

In terms of infection prevention and control, we plan to be one of the top performing health organisations in the country.

The targets we have been set for 2016/17 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:

- Provide a robust approach to MRSA screening to ensure all high risk patients receive the appropriate antibiotic treatment prior to surgery

- All patients with CDI are reviewed daily by a designated individual/s to provide specialist advice and optimise treatment

- All staff will complete antimicrobial training at the level that is appropriate for their role.

- Promote antimicrobial ward rounds in all in-patient areas and support best practice with respect to initiating and reviewing all antimicrobials

- Review our current antimicrobial guidelines, to encourage the use of antibiotics which have been shown to be less likely to cause CDI, and to reduce the use of very broad-spectrum antimicrobials, where clinically appropriate

- Integrate lessons learnt from inoculation injuries throughout the Trust and further promote the use of safe working practices for all our staff

- Introduce a vessel health and preservation programme

- Complete the 2016 national point prevalence survey on HCAI and antimicrobial usage

- Ensure compliance with the publicly available specification for the planning, application and measurement of cleanliness (PAS 5748:2014)

- Recruit a Trust Decontamination Manager to implement appropriate, effective decontamination of patient shared equipment

- Develop a process so that targeted CSUs can collect data on catheter related bloodstream infections electronically at source

- Develop an electronic flagging system to ensure the early recognition of patients identified with multi-antibiotic resistant organisms and thereby facilitate the early adoption of appropriate IPC practices

- Implement a daily side room report to allow safe placement of patients.

3.2.12 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 benefits of using the electronic form are:

- Improved patient safety due to easy recognition of those patients requiring risk assessment or requiring re-risk assessment.

- Improved efficiency and reduction of duplication

- The form will be instantly available for clinical staff to view

- Data capture will be accurate and timely with increased efficiency and reduced costs

The table below shows the percentage of patients who have had a VTE risk assessment in 2015/16, (Quarter 4 may improve as we are still awaiting some results from coding for March).

Percentage of admitted patients risk-assessed for VTE

Indicator	Reporting Period	Trust Performance	National Acute Average	National Acute Range
Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)1	Q4 2015/16	95.75%	95.45%	78.1%-100%
	Q3 2015/16	96.56%	95.50%	78.5% - 100%
	Q2 2015/16	96.00%	95.90%	75% -100%
	Q1 2015/16	95.9%	96.04%	88% - 100%

[1]Excludes independent sector providers

Comparative figures from 2014/15

Indicator	Reporting Period	Trust Performance	National Acute Average	National Acute Range
Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)1	Q4 2014/15	95.94%	95.91%	79.23% - 100%
	Q3 2014/15	96.06%	95.92%	81.19% - 100%
	Q2 2014/15	96.56%	96.24%	90.48% - 100%
	Q1 2014/15	95.75%	96.08%	87.25% - 100%

Since April 2013 we have completed a Root Cause Analysis (RCA) when a patient develops a VTE during or within 90 days of their hospital admission. From 2015 the target completion rate is 100%, we achieved this in quarter 1 Completion rates are described below.

We have been incorporating the learning from these events into health care professionals training on VTE and we are aiming to ensure regular learning from these events is shared across the Trust.

VTE Incidence

		Q1	Q2	Q3	Q4
No. of Hospital Admissions	Contextual Metrics	54,076	56,064	56,961	57,115
No.of VTE identified cases		117	133	144	231
No. of New HAT (Hospital Associated Thrombosis)		36	52	69	82
No. of HAT as % of Admissions		0.07	0.09	0.12	0.14
No. of HAT as % of VTE identified cases		30.77	39.10	47.92	35.50

	% RCA Target	Q1	Q2	Q3	Q4
No. of HAT requiring RCA (Root Cause Analyses)	Q2 ≥ 60% Q4 ≥ 80%	36	52	69	82
No. of RCA completed		36	48	60	31
% of RCA completed		100	92.31	86.95	37.8
No. of HAT considered preventable		1	2	3	0

3.2.13 Preventing harm from misplaced nasogastric tubes

Feeding through a misplaced nasogastric (NG) feeding tube is defined by the Department of Health as a Never Event. 2015/16 has seen improvements within our hospitals to improve standards and safety for those who require nasogastric tubes for feeding (NGTs). These include;

- Appointment of an extra Enteral Feeding CNS

- Radiographers empowered to highlight any problems they observe, allowing focused training/feedback to be given to individuals or clinical areas

- Datix review of any incidents related to NG tubes every 2 months at the Enteral and Parenteral Guidelines group meeting, with actions taken

- Check x-ray interpretation by radiographers, without secondary radiology reporting, enabling early, safe NG tube position change when required

- Improved training including an e-learning package, which was rolled out to all junior doctors and nurses from August 2013 and all senior doctors from October 2013. Practical training for nursing staff, with competency assessment, has been in place since June 2012

In the most recent NG tube audit, there has been an increase in the use of NG tube care plans from 87% to 98%, an increase in recording of tube external length from 76% to 90% and an increase in confirmation of tube position before each use from 86% to 90%. The percentage of patients with acceptable pH sent for an x-ray reduced from 11% to 2%.

NG tube bedside care plans have been updated to include a risk assessment for patients being fed overnight (to reduce the risk of aspiration), in addition to changes in response to feed back. Proofs are currently awaiting their final check before re-launch of the updated care plan. This will enhance the safety of patients receiving NG feeding and will aid full completion of the documents.

3.2.14 Safeguarding vulnerable people

During 2015-16 the Trust has continued to strengthen and improve the arrangements in place 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 including representation from Leeds South and East Clinical Commissioning Group (CCG) and Adult Social Care lead against the delivery of a clear work plan seeking evidence and assurance with regard to the safeguarding arrangements within the Trust.

The Deputy Chief Nurse and Head of Safeguarding represent the Trust at the Local Safeguarding Adults Board (LSAB) and Local Safeguarding Children's Board (LSCB) with members of the Trust Safeguarding Steering Groups being active in the sub-groups of both the LSCB and LSAB.

The Deputy Chief Nurse has presented to both the LSCB and LSAB with regard to learning from the Savile Investigations, following the publication of Kate Lampards report in March 2015.

In June 2015 the LSCB (as part of the Section 11 assurance process) undertook a 'challenge visit' to the Trust. The LSCB provided feedback that the visit provided the panel with the opportunity to be assured that safeguarding measures were implemented at all levels within the organisation, that the Trust understands our responsibilities with regard to Safeguarding Children and that good progress had been made overall.

In May 2015 the Trust presented its Annual Safeguarding Assurance Statement to the Leeds West CCG. 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.

2015-16 has seen a number of changes on a national and local level with regard to safeguarding. The Trust has refreshed

and updated its Safeguarding Policies and Procedures to ensure they are reflective of required changes including the implementation of the Care Act (2014) which came into effect on 1st April 2015 and requirements for the mandatory reporting of Female Genital Mutilation.

The Trust has responded well to these changes whilst continuing to focus on areas of practice where we recognise the need for continued improvement. The Trust has:

- as part of our work to improve the voice of the child improved the complaints process for children and young people introduced a complaints leaflet developed with the Trust Youth Forum;

- introduced electronic referrals to Children's Social care Services in the Leeds Local Authority in July 2015;

- as part of our focus on staff education and training sustained improvement in the proportion of staff who have received safeguarding training with compliance for Level 1 training, reaching 94% for safeguarding adults and 94.2% for safeguarding children training;

- in January 2016, commenced using the Datix system to improve the recording of safeguarding concerns and the Trusts ability to report safeguarding activity; and

- in October 2015, participated in the National Safeguarding Week with members of the LSCB, LSAB and CCG attending the launch in the Trust - the week included poster presentations, public facing information stands and light touch training events for staff.

3.2.15 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 and weekly meetings are held within the Trust to ensure these conversations take place.

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. The Quality Assurance Committee provides assurance on the follow up of incidents and the implementation of learning, including undertaking more detailed reviews of any areas of concern identified.

This year has seen a slight reduction in the total number of serious incidents reported. This has been primarily due to the change of reporting in relation to Category 3 pressure ulcers.

Following the revised serious incident framework by NHS England in April 2015 a recommendation was made that the process for reporting category 3 pressure ulcers should be reviewed locally to identify the most serious pressure ulcers that were considered to be avoidable and led to longer-term or permanent harm.

Number of serious incidents reported (by year)
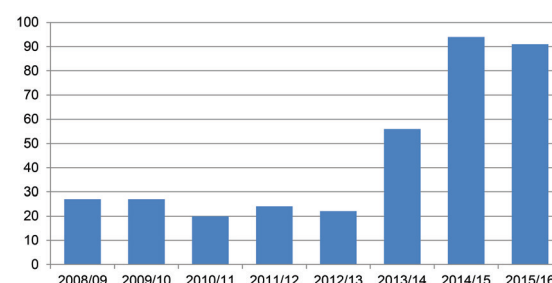
The Trust agreed with commissioners that a category 3 pressure ulcer would be reported as a serious incident to the CCG where the Root Cause Analysis investigation concludes it could have been prevented and led to longer-term or permanent harm.

The increase in reporting since 2012/2013 is a positive sign that previously unrecognised learning opportunities are being maximised.

Patient safety Incidents (NRLS) October 2014 - March 2015

Indicator	Trust Performance	Average all Acute Performance	All Acute Hospital Range
Rate of patient safety incidents (per 1000 bed days)	37.05	35.34	3.57-82.21
Number of patient safety incidents that resulted in severe harm	14	Not specified	2-128
Number of patient safety incidents that resulted in death	6	Not specified	0-24
Percentage of patient safety incidents that resulted in severe harm	0.1%	0.4%	0.1%-5%
Percentage of patient safety incidents that resulted in death	0.1%	0.1%	0%-1.1%

We have introduced a process where we undertake a detailed review of all incidents that are reported in the category moderate, serious harm or death with our clinical teams to ensure these incidents are both reported and managed appropriately.

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

Quality and Safety Matters topics

Nutrition and Hydration	Duty of Candour	Positive Identification of Patients
Mouth Care	Looking After Your Skin	Nasogastric Tube Feeding
Insulin	Falls	Tracking Health Records
Deteriorating Patients	Violence and Aggression	Sepsis
Paracetamol	VTE Prevention	Informed Consent
Alcohol Screening	Stop the Pressure	Discharge Planning
Preventing Needlestick Injuries	Using IV Vancomycin	Safe Prescribing and Administration of Oxygen

The Trust also publishes a Learning Points Bulletin, including specific case studies and summaries of incidents to identify the important learning points and actions to be taken. The Bulletin was published which identified links to the Lessons Learned You Tube channel and the Lessons Learned page on the Trust intranet. A link was placed on the front page of the intranet in a prominent position to encourage staff to visit the lessons learned page.

In February the Lessons Learned Group was launched across the Trust and an action from this group was that a screen saver was placed on every Trust computer advertising the group and contacts. A year on the group is now established and more practitioners have joined the group from a variety of specialties to enable Lessons Learned to be disseminated more widely. It is anticipated over the following months that an electronic 'blog' will be established allowing Lessons Learned to be published daily across the Trust.

The Lessons Learned group

Never Events

NHS England revised the list of Never Events in 2015/2016. There were 25 Never Events in total on the list in 2014/2015, however this list has been reduced to 14 Never Events.

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 common reported Never Events relate to retained surgical items, wrong site surgery and wrong implants.

We have reported five Never Events during 2015/2016 under the following categories

- Retained surgical item x 2
- Wrong site surgery x 2
- Wrong implant x 1

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.

Duty of Candour

The statutory Duty of Candour Regulation came into force on 27 November 2014. The Duty of Candour applies to all cases of 'significant harm'. This covers the National Reporting and Learning System (NRLS) categories of 'moderate', 'severe' and 'death', and also includes 'prolonged psychological harm'.

The Duty of Candour is a CQC regulation covering all providers of health or social care in England. The regulation states that where the 'harm' threshold has been reached, specific reporting requirements are to be initiated.

LTHT has worked hard to ensure the Duty of Candour is complied with. Since the introduction, two Quality & Safety matters bulletins have been published and disseminated across the Trust. The bulletins have been displayed in clinical areas for staff to gain a clear understanding of the regulation.

The Risk Management department have designed an electronic learning tool which is accessed via the risk management site on the Trust intranet. All members of staff can obtain access to the learning tool and representatives from Risk Management have presented this learning tool to CSU Governance meetings.

Every week the Risk Management department monitors the Datix web incident recording system to ensure evidence has been provided against incidents of moderate, severe harm or death and the Duty of Candour regulation has been complied with; this is supported by the Patient Safety & Quality Managers who work closely with the CSUs to ensure staff are aware of the requirements and Duty of Candour is followed.

3.2.16 Scan 4 Safety

The Government has announced £12 million investment across six pilot sites to accelerate the implementation of electronic procurement systems that will help deliver efficiency savings. Leeds is one of the six demonstrator sites selected to take part in the trial which will see every product given a barcode, from medical items such as pacemakers to day-to-day items such as stationary: this will mean supply chains for hospitals are made simpler, reducing the estimated £150m the NHS wastes each year on products which have been either oversupplied or perished.

The project will enable products to be tracked to patient and location level using barcodes and unique location identification.

In addition to savings from pay and non-pay efficiencies there will be a considerable benefits in terms of patient care and safety through:

- release of clinical time to patient care
- opportunity to manage down risks
- patient tracking to enable more efficient rounds by our clinical staff
- more efficient use of our diagnostic and interventional environments
- virtually live tracking of our in-patients, and their investigation and specialised equipment requirements

3.3 Clinical Effectiveness

3.3.1 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.
  - The SHMI is expressed as rate where 1 is the national average; the HSMR is expressed as a rate where 100 is the national average.

The table below shows the Trust's latest published SHMI, for the period July 2014 to June 2015, also shown is the HSMR for the same period. The Trust continues to fall within the 'as expected' banding for both measures.

Trust SHMI & HSMR Jul-14 to Jun-15

Trust level mortality, Oct 14 - Sept 15	Spells	Value	Observed deaths	Expected deaths	95% Confidence Interval
SHMI	121,812	1.009	4,126	4,089	0.909-1.100
HSMR	59,316	97.35	2,514	2,583	93.58-101.23

Higher than expected	As expected	Lower than expected

SHMI Indicator

Indicator	Reporting Period	Trust Rate	National Average	National Range
SHMI	Oct 14 to Sep 15	1.01	1.00	0.652 - 1.177
	Jul 14 to Jun 15	1.01	1.00	0.661 - 1.209
	Apr 14 to Mar 15	1.02	1.00	0.670 - 1.243
	Jan 14 to Dec 15	1.03	1.00	0.655 - 1.243
	Oct 13 to Sep 14	1.04	1.00	0.597 - 1.120
	Jul 13 to Jun 14	1.04	1.00	0.541 - 1.120
	Apr 13 to Mar 14	1.01	1.00	0.539 - 1.120
	Jan 13 to Dec 13	1.01	1.00	0.624 - 1.118

Trust level SHMI and HSMR (basket of 56 diagnoses) by rolling 12 month period
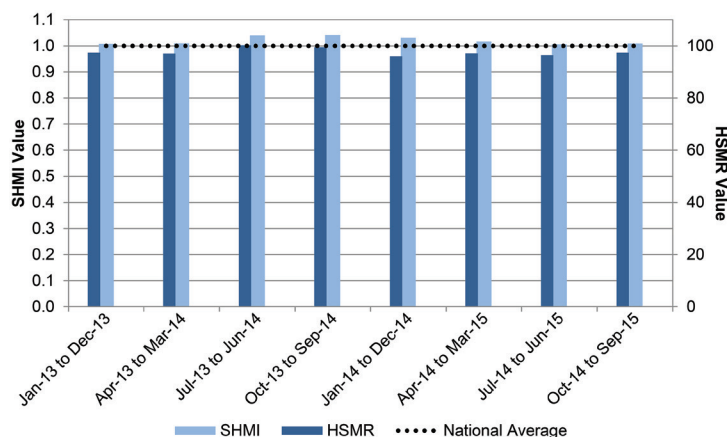
The Trust SHMI and HSMR rates have consistently fallen within the expected range.

The Trust noted a step change in its SHMI in the January 2015 publication (period July 2013 to June 2014) from 1.01 to 1.04, linked to a fall in the calculated expected deaths. Whilst this remained within the expected range, the Trust implemented a detailed investigation including:

- In depth analysis of SHMI data supported by Dr Foster and the HSCIC SHMI Team

- Clinical coding audit of 750 cases across 10 targeted diagnosis groups

- Clinical review of case note recording for 3 largest diagnosis groups

- Establishment of a Comprehensive Mortality Improvement Programme, work streams:

  – Understanding & Visibility of Mortality Reporting

  – Mortality Review & Learning

  – End of Life Care

  – Recording and Clinical Coding

No significant clinical issues were found, the quality of clinically informed coding was found to be high, but these processes have undoubtedly contributed to a heightened awareness of the importance of reviewing mortality to derive learning resulting in a progressively improved SHMI.

The Trust SHMI and HSMR rates continue to be monitored closely by the Trust Mortality Improvement Group, Clinical Directors and Clinical services. Further work includes:

- Participation in the Improvement Academy Avoidable Mortality Project - 75 clinicians trained in structured case note review and 50 cases reviewed.

- Trust wide evaluation of Specialty Mortality Review Processes including pilots of structured review process in specialties.

The Trust uses tools provided by Dr Foster to review more current mortality rates, the SHMI is published 9 months in arrears. The table below shows the Trust's most recent HSMR position which remains within the expected range;

Trust HSMR Dec 14 - Nov 16

December 2014 to November 2015	HSMR (basket of 56 diagnoses)	HSMR (all diagnoses)
Observed deaths	2,524	3,053
Expected Deaths	2,615	3,144
HSMR	96.52	97.12
95% Confidence Interval	92.79 - 100.36	93.71 - 100.63

Improvement Programme Update

In 2015 a Mortality Quality Improvement Group was established to look at ways to improve on mortality rates. An essential part of this will be the introduction of a new case note review process, developed by the Improvement Academy. To complement this work, training sessions are being provided and, to date, 84 Trust staff have been trained. The Trust has taken part in a regional trial of the review tool and contributed anonymised data from 49 case note reviews in September 2015. Learning from these reviews, and the wider pilot, will be shared within the Trust. Use of the case note review tool is currently being piloted in three specialties to inform the development of a consistent specialty mortality review process to be rolled out across the Trust. A survey of existing specialty review processes has also been undertaken.

Weekend Care

Weekday and Weekend HSMR - Emergency Admissions

Trust HSMR - Emergency Admissions Dec 14 - Nov 15	Spells	Value	Observed deaths	Expected deaths	95% Confidence Interval
SHMI	25,727	94.56	1,741	1,841	90.17 - 99.11
HSMR	8,393	100.38	629	627	92.68 - 108.54

Higher than expected	As expected	Lower than expected

The table above shows the Trust HSMR for emergency patients split by weekday and weekend day of admission. The Trust HSMR for emergency admissions on a weekend is within the expected range and for admissions on a weekday is lower than expected. These metrics, along with the Trust level SHMI and HSMR are used by the CQC in their Intelligent Monitoring Tool as measures of the Trusts effectiveness.

3.3.2 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.

Readmissions to the Trust within 30 days of discharge: elective spells

Trust performance ······ Peer performance
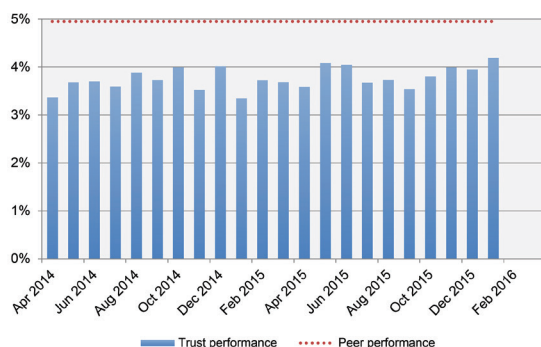
Readmissions to the Trust within 30 days of discharge: non-elective spells

Trust performance ······ Peer performance
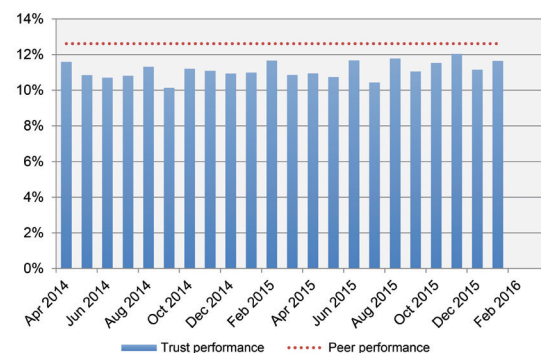
The above show monthly re-admission rates for patients who had originally been in hospital for planned care (elective) and those who had originally been in hospital as an emergency (non-elective). The average performance for our peer hospitals is also shown. It is clear that our rates are consistently lower than other teaching hospitals for both categories of patients.

3.3.3 Patient Reported Outcomes Measures (PROMs)

Patient Reported Outcome Measures (PROMs) aim to measure improvement in health following certain elective (planned) operations. These are: hip replacement, knee replacement, groin hernia and varicose vein. Information is derived from questionnaires completed by patients before and after their operation and the difference in responses is used to calculate the 'health gain'. 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 diagram below (Please note that the 2014/15 and 2015/16 data is still provisional; the final signed-off data will not be available until summer 2016 and summer 2017 respectively). Trust participation rates for hip and knee replacement are in line with the national average and for varicose vein are well above average. Work is on-going to bring groin hernia rates up to a similar level.

PROMs Pre-operative participation rates - all procedures
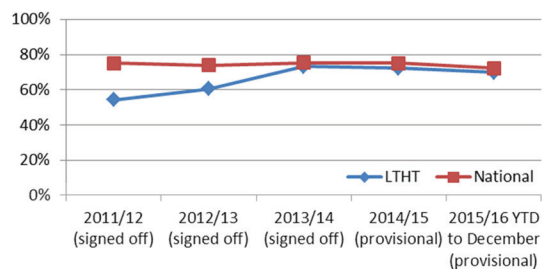
Source: HSCIC; 2015/16 YTD (December) as at January 2015

3.3.4 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 of those affected 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 2015/16

Improving the Identification of People with Dementia and other Memory Problems

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.

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 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.

The Trust has been an active partner in the city wide work being undertaken with the support of the Leeds Institute for Quality Healthcare, improving memory services is one of the identified work streams that the multi-professional teams are working on.

We are working with partners to develop a care plan that will be transferred to the patients' GP on discharge for individuals where a diagnosis is made in hospital; this is to promote seamless care between hospital and community services.

Appointment of Support Worker for Carers

Our Carers tell us through our survey that they do not always feel they are supported to make decisions about the care of their loved ones

and do not understand the range of services available to them. This year, in conjunction with Carers Leeds (a Third Sector agency in Leeds), we have appointed two Carer Support Workers (CSW) who work across sites and proactively link in with carers through referrals from wards or events like coffee mornings scheduled in clinical areas.

Staff Who Are Skilled to Deliver Care

Dementia training is now included in the induction programme for all registered nurses and clinical support workers when they start in the organisation and each ward has been actively encouraged to agree the level of training needed based on their patient population.

Improving Person-Centred Care

To enable carers to provide better background information on patients with dementia, the Trust introduced the 'Know Who I Am' document. The document has been reviewed to include further information for carers and is now being used for patients with dementia throughout the Trust, facilitating staff to provide better person-centred care.

This year we have focussed on introducing the 'Know Who I Am' document to all clinical areas, alongside education packages. We have also introduced a patient name board with small magnets to identify patients that may have a cognitive impairment and therefore may need additional support. We will continue to review this through our nursing audit programme in 2016/17.

Creating Environments which are more Dementia Friendly

There is evidence that making the hospital environment more 'dementia friendly' (DF) improves patient care and both patient / carer satisfaction. We focussed on a number of our elderly care wards to make them more 'dementia friendly' through signage, lighting, colour schemes, environmental decoration, availability of structured activities and reminiscence resources.

The Trust has also introduced 'dementia friendly' blue plastic crockery, which improves patient nutrition as less food is wasted. Also, photo menus (to enable people with dementia to recognise meals better) have been introduced on certain wards and can be downloaded from the Trust Intranet for other wards who wish to use them.

'Dementia friendly' crockery and pictorial menus

3.3.5 Medicines Optimisation

Involving people in decisions about their medicines is important as this means treatments are more likely to be taken and used correctly. Good communication when prescribing and managing medicines can help patients to have a more active role in dealing with their own medicines which can help to reduce problems and errors.

Medicines Optimisation - Information about Medicines

Helping patients and carers ask questions about the safe and effective use of medicines is part of our approach to medicines optimisation. Last year the hospital pharmacy team led the introduction of a tool called MaPPs (Medicines: a patient profile summary) to try to help answer some of our patients questions about their medicines.

This year some of our healthcare teams have started to use this system by asking their patients if they would like to receive one of the individualised printed information sheets specifically about the medicines they use.
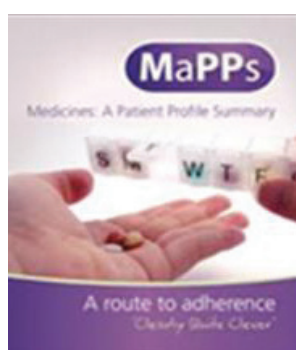
In 2016/17 the Trust is keen to find out why some teams have not used the tool as much as others to see if this is because there are different needs for patients coming into the hospital for diverse types of care with a variety of questions.

We have continued to increase the range of information about medicines used across all healthcare organisations in Leeds in our on-line Leeds formulary (www.leedsformulary.nhs.uk) which is supported by the Pharmacy Medicines Information Service at the hospital.

Last year this on-line resource was accessed over 50,000 times (increased usage from the previous year) and people accessing it includes hospital doctors, General Practitioners and their practice based staff, hospital and community pharmacists and nurses as well as members of the public themselves.

We have received feedback from people caring for patients, and some patients that the Leeds Formulary helps to provide some answers about medicines in addition to resources such as NHS Choices.

Some people find it helpful to have a way to contact a healthcare professional who they can talk to so wards, clinics and services provide specific contact details to patients. The Medicines Information helpline (0113 206 4376) provides a telephone point of contact in the hospital for patients or carers to speak directly to a member of the pharmacy team to ask for advice or information about their medicines. The helpline received and answered 350 questions from patients last year.

Specialist clinics are available across the Trust for patients who need to make decisions about the medicines on offer to them, ensuring that they have the right information regarding their individual needs. Some patients require specific medications for a variety of diseases affecting the heart, lungs, cancer, digestive problems etc. Patients who come to these clinics can now spend time talking to specially trained staff nurses, pharmacists and pharmacy technicians about their choices and medicines specifically for them.

The Drug and Therapeutics group is responsible for making sure that the Trust has the right medicines available and how they can be used cost effectively. Leeds Involving People have been helping the Drug and Therapeutics group throughout 2015/16 to try to find the best way of ensuring the patients views and voice are represented in this area of work.

Medicines Optimisation - Accurately Listing your Medicines

In 2014 we started to develop and promote a city wide campaign, 'Your Medicines, Your Health' to encourage more patients to bring their own medicines into hospital with them as we thought that this would help to reduce waste and to help optimise the use of medicines in Leeds.
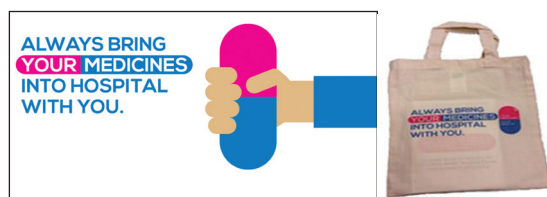
To start the campaign we sought views from patients and carers, from staff across the NHS healthcare community, the Yorkshire Ambulance service and the British Red Cross amongst others.

These views and experiences were really important in helping us to scope and brand the project plan and to help us focus on the issues that patients and carers told us they thought really mattered the most. This helped us develop a campaign logo and gave us ideas as to how to promote the campaign. We used advertisements on local buses and our trust fleet of vehicles, posters in GP surgeries and community pharmacies and banners around our hospital sites. We held promotional "road-shows" within our hospitals using promotional materials which provided the opportunity to have great discussions with patients and visitors as well as staff.

Making best use of a patient's own medicines in hospital

- Ensures that medicines are always available when needed
- Helps hospital staff to know what medicines a patient is taking
- Ensures that patients are using medicines that they are familiar with
- Helps us to introduce any new medicines into a patients treatment clearly, involving the patient or carer and in a way to avoid confusion.
- Reduces delays at discharge because of medicines supply
- Reduces waste across the healthcare economy

A recent audit showed we have also been able to help reduce waste with medicines across our whole healthcare economy. 55% of inpatients surveyed now always bring their medicines into hospital with them and they responded that they were very happy to do so.

Part of what we do in the hospital to optimise medicines use is to make sure that a patient's current prescription reflects what medicines they are taking. As noted in the NICE Guideline on Medicines Optimisation, 'accurately listing your medicines' is key to helping patients make the most of their medical treatment; this is particularly important at the point both when a patient comes into hospital and when they are transferred out again. The 'Your Medicines, Your Health' campaign was thus designed in part to help make sure that healthcare professionals in the hospital always have an up-to-date list of all the medicines each patient is taking.

Further aims of the campaign were to reduce duplication and potential confusion for patients, and to help all the healthcare services in Leeds make better use of our medicines resources. Changes to the way the hospital pharmacy teams worked during 2015/16 have allowed us to support our doctors in the hospital by preparing the list of patient's medicines and entering it onto our electronic discharge information systems (eDAN), and by making more use of other suitably trained healthcare professionals, such as nurses, pharmacists and podiatrists, to prescribe medicines for patients.

As part of helping patients and their family or carers to become involved with the medicines process in the hospital whenever possible, we also make sure that, provided appropriate consent has been given, any changes to the medicines list are shared with the patient, their carer and/or family, and any others who help them manage their medicines supply.

The "Your Medicines, Your Health" project work is now complete but the changes made to the way we use patients medicines continues; it is linked to how we perform medicines reconciliation and still involves many partners working together.

When we started the project planning we asked some of our patients and carers their opinions about our campaign ideas and in February 2016 we asked the same questions again to see if our work had made a difference. We were told 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.

Medicines Optimisation - Sharing Information about Medicines and Electronic Discharge and Prescribing

Whenever a patient is transferred from one place to another it is important that relevant information about a patients medicines is discussed and shared so that everyone involved has the information they need to help prevent mistakes with medicines wherever possible. Patient confidentially should also be respected.

Last year we worked to improve our electronic discharge information system (eDAN), and this continues to be used in most areas of the hospital to provide clear information about medicine changes to patients and their GPs. At the end of 2015/16 85% of our hospital inpatients had their information transferred to their GP within 24 hours of leaving the hospital and 90% of the requests Pharmacy received for a new medicine supply, once a patient was ready to be transferred from the hospital, were made within 2 hours of the order being placed.

During 2015/16 we also successfully implemented the eMEDs electronic system, which now supports the prescribing and administration of medicines across three of our hospital ward areas. Benefits of the new system include both a reduction in prescription errors and a lower likelihood of medicine doses being missed. Feedback from the current users has shown that the new system is easier to use, reduces duplication, and makes up-to-date medicines lists much easier to produce and share when transferring patients out of the Trust.

We have used the system to provide discharge prescription and information to more than 600 patients since it was installed and we hope to have the new system in use across more of the hospital during this coming year.

Medicines Optimisation - Improving Services with Medicines for Hospital Outpatients

In 2014/15 we recognised that a new model of working was required to enable us to provide our hospital inpatients and outpatients with access to services for prescribing / dispensing medicine and advice 24/7.

In 2015 our partnership with Boots Alliance came to fruition with the opening of three new outpatient hospital pharmacies; one on the Leeds General Infirmary and Children's Hospital site and two at the St. James's hospital site in Bexley Wing and Chancellor Wing. This new service has increased seven day access to medicines for patients who attend outpatient or urgent care services. The Boots Hospital Pharmacies dispense around 15,000 medicines each month and provide patient's with onsite access to a pharmacist who can advise on the choice of medicines if purchase is a suitable approach to help manage symptoms or to help direct patients to the most suitable heath care resource for their needs.

Boots Hospital Pharmacies (Dementia Friendly and support the Trust's Public Health agenda on smoking cessation) are now working with the Trust to offer more patients the opportunity to pick up their medicines from a local Boots store rather than wait in the hospital.

3.4 Leeds Improvement Method

LTHT is one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known at the Trust as the Leeds Improvement Method.

In October 2015 four work areas, known as Value Streams, were chosen for developing the Leeds Improvement Method over the next 12 -18 months:

1. Total Hip & Knee Replacement Surgery, Elective Orthopaedics, Chapel Allerton Hospital

2. Transurethral Resection of the Prostate (TURPs), Abdominal Medicine & Surgery, St James's University Hospital

3. Step Down Care, Critical Care, Leeds General Infirmary

4. Outpatient Services, Patient Services, Cross Site

Value Stream 1 - Total Hip and Knee Replacement Surgery Patients

Since December 2015, there have been two week long workshops called Rapid Process Improvement Workshops (RPIWs). These are specifically focused on teams understanding the contribution and impact they have within a single work area and /or process. The first two events have focused on:

RPIW1 Theatre List Order Changes

The theatre list, the agreed and safe order in which patients are planned for their operations on the day of surgery, goes through a variety of changes from the point at which it is first created up to the actual day of surgery. These changes can happen for a variety of reasons and can have a negative impact on the experience of our patients e.g. extended waiting times beyond what was initially expected (hrs/days), recovery time can be affected due to patient dehydration from prolonged periods of no fluids or food if they arrived to be operated first on the list and for agreed reasons are moved to the end of the list. Staff become frustrated from organising and re-organising critical setup for patients in and outside of theatres i.e. appointment rescheduling to on the day theatre equipment re-organisation.

RPIW2 Theatre Inventory

Ensuring that that there is just the right amount of inventory in the right places at the right time underpins a safe and timely patient experience. Storing unnecessary amounts of stock uses valuable space and takes time to find it/retrieve it and in some cases inventory may become out of date. Transporting inventory between locations and preparing equipment for theatre, which is not used, uses additional staff time in processing, sterilising and the important safety checks when counting instrumentation in and out of theatre.

Early Achievements in 2015/16

It is very early days in the development of this method in the Trust and the initial work has already delivered improvements for patients and staff alike. The rigour of the process requires each RPIW team to develop and measure the impact of their improvement work at 30,60 and 90 days and beyond, if required, after the initial generation and testing of an idea.

Theatre List Order Changes following workshop week of the 25 January 2016

Achievements - Theatre List Order Changes	
Before	After
Patients receive a letter 3 weeks prior to surgery	Patients agree a date for surgery in their Outpatient Appointment
Patients re-ordered on the theatre list on the day of surgery	Surgeon and Anaesthetist plan next weeks list one week in advance
Surgeon and Anaesthetist walk around the ward environment to find patients on the day of surgery	Patient for Theatre 1 in Exam Room 1, Patient for Theatre 2 in Exam Room 2 etc.
10% of patients make contact to rearrange surgery date	89 patients agreed date for surgery in clinic - to date no-one has cancelled
In 2014/15 at least 450 patients impacted by a list change	16/89 patients surgery has been completed and no-one has been re-ordered on the day
Surgeon and Anaesthetist walk on average 628 steps on the day of surgery looking for patients	Surgeon and Anaesthetist walk on average 236 steps on the day of surgery

A video to describe this work in more detail by the people who were involved can be found on YouTube.

Theatre Inventory

The second workshop took place during the week of 7th March 2016 to look at theatre inventory for patients having a total hip or knee replacement on the day of surgery.

Having the right amount of inventory in the right places at the right time underpins a safe and timely patient experience. Storing unnecessary amounts of stock uses valuable space and takes time to find it/retrieve it and in some cases inventory may become out of date. Transporting inventory between locations and preparing equipment for theatre, which is not used, uses additional staff time in processing, sterilizing and counting in and out of theatre.

Theatre staff knew that in preparation for a patient's surgery in theatre they count out and then count in again the instrumentation that is not used in theatre which takes a lot of time (picture 1). They also know that they pick common items for all surgeons that could be pre prepared in a single pack (picture 2). The group highlighted the common items across all Orthopaedic surgeons pick lists for a total knee replacement (picture 3).

BEFORE – Total Knee Replacement (picture 1)

Tray Picking: **19** mins **57** secs

Tray Prep: **29** mins

BEFORE – Total Knee Replacement (picture 2)

Contents for a total knee replacement (picture 3)
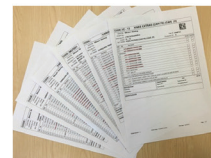
With an Orthopaedic surgeon involved in the work many items were removed from the theatre trays that are not used for this type of surgery (picture 4). The team recommended a new single pre prepared pack which is currently under development (picture 5). The time it now takes to prepare for surgery is reduced significantly in terms of tray picking and tray preparation.

AFTER (picture 4)

Sterilisation Costs ⬇ 40%

AFTER (picture 5)

Tray Picking: **55** secs ⬇ 19 mins 2 secs

Tray Prep: **8** mins **51** Secs ⬇ 20 mins 9 secs

Next Steps

Implementation of the Leeds Improvement Method will continue in Orthopaedics at Chapel Allerton during 2016/17 and work will commence in the other three Value Streams between April and December 2016.

3.5 Integrated Care Improvement Programme

Over the last two years, 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.

Each Professional Leadership & Change Programme is a 13 day educational & change programme with six additional days to support embedding ideas into practice. The programme is designed for health and social care (public & third sector) professionals in Leeds, who wish to actively improve the quality of care provided to those using services by working collaboratively with colleagues across the city on a shared ambition.

The aims and focus of each of the programmes can be seen on the following pages.

Cardiovascular Disease (started in 2014/15, with three work streams)

a) Appropriate diagnosis of chest pain (led by Team Heartache)

Aim/Outcome - The aim is to identify the current status of the pathway, and through improvement techniques, data and the input of service users and professionals from all parts of the pathway we are looking to identify and implement improvements in the pathway

Findings - 50% of those that attended cardiology outpatient appointments with chest pain were found to not have a cardiac related problem.

b) Arrhythmias (led by the Arrhythmia Angels)

Aim/Outcome - To optimise outcomes and quality of care for people requiring interventions/treatment for suspected/confirmed arrhythmia and to prevent inappropriate use of secondary services.

Findings - 27% of those that attended cardiology outpatient appointments for an arrhythmia associated symptom (e.g. palpitations etc.) were found to not have a cardiac related problem.

Update on Progress - A new referral pro-forma has been developed between GP, Cardiology and A & E, and has been widely consulted on at Target meetings. Feedback has been extremely supportive and constructive. Consensus has been achieved regarding implementation of a revised Arrhythmia pathway. There are ongoing discussions within LTHT regarding the resources required to support this, specifically the resource (Nurses and Consultant supervision). A Project Initiation Document (PID) is currently being developed by the Transformation team in conjunction with LTHT. A number of constraints currently exist in relation to resourcing and IT infrastructure, and work is ongoing to address these.

c) People who have the co-morbidity of depression and coronary artery disease, (led by the Happier Hearts Team)

Aim/Outcome - To improve the physical and psychological health of patient's post-**myocardial infarction (heart attack)**, focusing on new or existing anxiety and/or depression

Findings - Under identified depression in M**yocardial Infarction (MI).** Only 3% of patients were able to be identified with anxiety of depression against 30% as indicated in NICE guidance

Update on Progress - The group is exploring communication of diagnosis using ppm+ and to patient, ongoing training of junior doctors and ways to support post -MI patients 6 months after discharge. The group are proposing to develop a multi-speciality MDT clinic.

Chronic Obstructive Pulmonary Disease (started in 2014/15, with three work streams)

a) Self-Care (led by the Bonnie Breathers Team)

Aim/Outcome - To support people with COPD to manage their own condition and to reduce the likelihood and impact of exacerbations.

Findings - Data shows that there is variation in the number of reviews, number of inhaler checks and number of hospital admissions across Primary Care. Initial scoping suggests there is also variation in the number of quality of reviews taking place.

Update on Progress - The project team propose to focus implementation efforts on improving self-management support for patients not able / willing to participate in the full pulmonary rehabilitation programme. This will include development and testing of a decision support tool to help professionals (particularly in primary care) and patients make preference sensitive choices.

b) Crisis (led by the Calming Crisis Team)

Aim/Outcome - Reduction in variation of approach to COPD patients in crisis.

Findings - Anxiety increases the frequency of hospital admissions and readmissions for acute exacerbation of COPD.

Update on Progress - The group began screening for depression and anxiety in early October - every patient from COPD, cardiac and diabetes was screened for depression and anxiety. As a result of the Calming Crisis team a new role has been developed a "Psychological Wellbeing Practitioner" to meet the unmet demand of mild to moderate depression.

The team introduced a Patient Health Questionnaire (PHQ) and a GAD7 assessment. Clear referral criteria were developed. A patient scoring less than 18 on the PHQ or less than 7 on the GAD7, are referred to the "mild to moderate depression" sessions (8 CBT sessions as per the evidence based developed by Manchester). Patients with a PHQ score higher than 18 or a GAD7 score higher than 7 would be classed as "Severe" and referred through the existing pathway. The numbers of "severe" patients has not altered and remains the same as before, but the referrals for the "mild to moderate depression" have increased.

c) Diagnosis (led by the Inspiro Carpets Team)

Aim/Outcome - Improving the early and accurate diagnosis of COPD whilst improving patient experience.

Findings - There is not consistency in spirometry in primary care for various reasons including: inappropriate equipment, staff not feeling confident in carrying it out and the interpretation which can lead to inaccurate diagnosis.

Update on progress - This team is looking at increasing the accuracy of diagnosis of COPD. Majoring on the accuracy both of the interpreting and technique of spirometry. The essential model is around using a mini hub model to increase the volumes for both taking and interpreting spirometry tests. So the volumes would allow clinicians to specialise and build competence. The team feel the current model does not allow clinicians sufficient volumes to do that. With this in mind, the team have been engaging with a not for profit organisation in the north east who have done a similar thing; pooled and thus increased volumes so that clinicians could specialise and build competence. This organisation have been

supplying some guidance on the model and required volumes and the team have met with them a few times.

Fracture Neck of Femur (started in 2014/15, with three work streams)

a) Prevention (led by the Prevention of Falls Team)

Aim/Outcome -

- To reduce the incidence of fractured neck of femur (NOF) in high risk groups in Leeds amonst people living in their own homes.

- To establish over a 12 month period a quality improvement project that provides Comprehensive Geriatric Assessment to moderately frail patients in the community

- Improve detection and management of moderately frail patients in order to reduce falls

Findings -

- In the study cohort of moderately frail patients with an electronic frailty index score of 0.25 (n=97):

- 100% patients were on at least one medication that could contribute to falls.

- The mean number of medications per patient was 10 (range 3-24)

- 65% had fallen or stumbled in the last 12 months

- Only 22 patients had a fall documented in their records (22%).

- 51 patients screened as a 'high falls risk' and were invited to the falls workshop

  – 27% had a significant lying/standing BP drop

  – 90% required implementation of interventions to reduce their falls risk such as: Medication changes (77% cases), referral to memory clinic (9%), secondary care (9%).

Update on progress - The group comprised of multi-disciplinary primary and secondary healthcare professionals. They used a plan, do, study, act approach to test QI ideas and develop

them further. The group focused on patients with an electronic frailty index score of 0.25 (moderately frail) and telephoned this cohort of patients to ask them four questions which allowed an assessment of falls risk.

Additionally, a case notes review of comorbidities in this cohort was completed. All of the patients deemed to be of a high falls risk were invited to a falls prevention workshop where they received a pharmacy led medications review, a series of investigations such and lying and standing blood pressure, pulse, alcohol intake etc. Each patient was then invited to have a discussion about the findings and to create an individualized plan for the patient based on the data collected.

This work is currently being scaled up in Leeds South and East CCG across 9 GP practices with a footprint of 70,000 patients. It is anticipated that with greater number of patients being involved then further impact of this work can be reliably established.

This project won a prize at the British Geriatrics Society International Falls and Postural Stability Conference 2015 when presented as a poster.

Patient Involvement in LIQH Frailty and prevention of falls work -

- A method of co-production was used to gain stakeholders views regarding falls and frailty.

- Video interviews of a number of patients and their families were performed and used to shape the project and clinic.

- Additionally, patient feedback was also collected from clinic attendees and used to improve future clinics.

- 100% patients attending said the falls prevention clinic was useful; with 92% stating it was very useful.

b) Post-operative care and the hospital journey (led by In Hospital Team Group)

Aim/Outcome - To understand and improve the quality of care for patients with fractured neck of femur (NOF).

Progress - Work of the group ceased because a private company were already doing a piece of work to baseline the system and there was a big system change in the launch of a new hip unit.

c) Post Discharge (led by the Happy Hippies Team)

Aim/Outcome - To improve the outcomes of FNOF patients post discharge (improving Mental Wellbeing).

Findings - There was a perception that patients with dementia deteriorate following a procedure for FNOF.

Update on Progress - Data was presented which showed that patients with dementia were no more likely to be readmitted following FNOF than those without. Inpatient admissions for FNOF for patients with dementia were linked to contacts with MH services.

Improving Diabetes Care (started July 2015)

In May 2015 a group of professionals working in this area met to begin to scope the focus for the improving diabetes care work for the coming year, namely:

a) **Self-Management Support –** particularly focused on people with newly diagnosed type 2 diabetes.

b) **Foot Care -** reducing amputations.

c) **Reducing Inequality -** associated with elective in-patient care for people with diabetes.

Improving Dementia Care (started March 2015)

The areas currently being looked at, arising from the scoping workshops are:

a) **Referral to the Memory Service –** variation in the process of referral; the variation in wait for the memory service appointments; the quality

of the referral; and the impact of all this on both patients and carers wellbeing.

b) **Medicines Management –** optimisation in terms multiple prescriptions; what do patients want to take; timing of medications; variation in frequency of review and who reviews; how does this information follow the patient.

c) **Diagnosis and post-diagnosis support** – variation in the ability of GPs and acute clinicians ability to diagnose dementia; variation in what consultants do after diagnosis at LYPFT; awareness of services.

Improving Cancer Care (started Oct 2015)

a) **Comorbidities -** To improve the outcomes and reduce inequalities in care for older people with cancer.

b) **Access -** the focus will be access for people with haematuria.

c) **Follow-up -** A huge amount of work is already being done on two week waits for the breast cancer pathway, and there is learning for other pathways. The focus will be Colorectal urgent referral follow-up (both without cancer and with cancer)

The 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.

3.6 Performance against national priority indicators

The Trust's performance against the national priority indicators is summarised in Appendix F.

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, Clinical Information and Outcomes Team and the Information Technology Training Team.

4.1 Review of Services

During 2015/16 the Leeds Teaching Hospitals NHS Trust provided NHS services across 120 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 2015/16 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.

4.2 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 58 specific national audits that all hospitals in England should contribute data to, if relevant to the services they provide. The Trust contributed data to 98% (46) of the recommended national clinical audits and 100% (4) 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, together with individual participation rates.

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

National Clinical Audit Title	Reason for Non Participation
National Comparative Audit of Blood Transfusion Programme: Audit of Lower Gastrointestinal Bleeding and the Use of Blood	Participation in this audit would have been a major undertaking, both in terms of the number of patients who met the criteria for inclusion and the amount of data required for each patient, and it was not practical to allocate a doctor to collect the data. Audits of a similar nature in the future will be assessed to identify if the burden of data collection on clinicians can be reduced to allow participation.

The reports of 27 national clinical audits, and of 842 local clinical audits, were reviewed by the Trust in 2015/16. 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.

End of Life Care

In June 2014 national guidance, One Chance to get it Right, described the approach that should be taken for care of patients in the last hours to days of life. In November 2014, the Trust introduced a new multidisciplinary care plan for care of the dying person, based on the recommendations contained in One Chance to get it Right. Audits of the care of dying patients were included as part of the Trust's 2015/16 Annual Clinical Audit Programme, having previously been audited as part of the 2014/15 programme. The aim of the audits were to improve the planning of end of life care for patients whose deaths are expected, to increase patient involvement in treatment decisions towards the end of life, and to assess implementation of the multidisciplinary care plan. The results showed there had been an improvement in recognising dying patients, and that the majority had "do not attempt resuscitation" orders and defined care plans in place; improvements in prescribing medications to alleviate pain and nausea, and assessment of hydration, were also noted. The audit highlighted that improvements could be made in routinely assessing the patient's preferred place of death, discussing the potential side effects of medications with patients and their relatives, and discussing the reason for using syringe drivers. To ensure patients' preferred place of death is routinely assessed, the nursing specialist assessment documentation has been amended. Prompts to communicate potential side effects of medication, and the reason for using syringe drivers, are planned for inclusion in the electronic prescribing system. CSU's individual results have been fed back to the CSU management teams, and educational sessions highlight the need to assess and discuss preferred place of death, potential side effects of medications, and the reason for using syringe drivers.

Audit of Osteoradionecrosis

Osteoradionecrosis (ORN) is a potential complication for patients who receive radiotherapy for treatment of oral cancer; the condition can cause chronic bone pain, ulceration, and can lead to bone loss. ORN occurs more often in patients who have teeth extracted following radiotherapy treatment; pre-radiotherapy dental assessment and treatment to eliminate dental disease and remove teeth that might need extraction in the future is therefore recommended, preferably up to three weeks prior to starting radiotherapy. An audit was carried out to determine if patients receiving radiotherapy for head and neck cancers were receiving timely pre-radiotherapy assessments; results showed that more than 80% of patients received a timely pre-radiotherapy dental assessment. The findings of this audit will be shared with the Maxillofacial and ENT teams to ensure that all patients undergoing radiotherapy in the future are referred for a pre-radiotherapy assessment; the Head & Neck Oncology Multidisciplinary Team proforma will also be amended to include a prompt for a pre-radiotherapy dental assessment. The findings of this audit were shared with other centres in the region.

National Heart Failure Audit

The 2013-14 National Heart Failure Audit (published in October 2015) showed the Trust's heart failure service compares favourably to hospitals of similar size. The results show high rates of specialist review of heart failure patients, and discharge planning including appropriate medication prescription; heart failure nurse follow-up rates after discharge are also high. The results did not show the Trust as a negative outlier for any of the areas compared to national averages. Since this audit was carried out, the Trust has appointed another heart failure specialist nurse and consultant cardiologist specialising in heart failure to further strengthen the heart failure service.

Audit of Percutaneous Endoscopic Gastrostomy (PEG) Pathway for Motor Neurone Disease patients

Osteoradionecrosis (ORN) is a potential complication for patients who receive radiotherapy for treatment of oral cancer; the condition can cause chronic bone pain, ulceration, and can lead to bone loss. ORN occurs more often in patients who have teeth extracted following radiotherapy treatment; pre-radiotherapy dental assessment and treatment to eliminate dental disease and remove teeth that might need extraction in the future is therefore recommended, preferably up to three weeks prior to starting radiotherapy. An audit was carried out to determine if patients receiving radiotherapy for head and neck cancers were receiving timely pre-radiotherapy assessments; results showed that more than 80% of patients received a timely pre-radiotherapy dental assessment. The findings of this audit will be shared with the Maxillofacial and ENT teams to ensure that all patients undergoing radiotherapy in the future are referred for a pre-radiotherapy assessment; the Head & Neck Oncology Multidisciplinary Team proforma will also be amended to include a prompt for a pre-radiotherapy dental assessment. The findings of this audit were shared with other centres in the region.

Patients with Motor Neurone Disease (MND) can have difficulty swallowing food and drink because of weakness in the mouth and throat muscles, leading to poor nutrition; the resulting weight loss can lead to increased infections, or quicker progression of MND. A PEG feeding tube can be passed into a patient's stomach to allow the introduction of food and fluids without the patient having to swallow. The need to update the pathway for MND patients to receive a PEG procedure was identified, and the service was redesigned by a team including gastroenterology, respiratory, anaesthetic, and neurology doctors. Using the old pathway, more than half of patients had multiple admissions prior to undergoing a PEG procedure, and 42% of scheduled procedures were cancelled; following the procedure, the average length of stay in hospital was 7 days, and more than half of patients used a critical care bed. Since the introduction of the new pathway, only 20% patients required multiple admissions prior to the procedure, and only 1 case was cancelled; the results also showed that the length of stay in hospital following the procedure was reduced, and no critical care beds were used.pathway, more than half of patients had multiple admissions prior to undergoing a PEG procedure, and 42% of scheduled procedures were cancelled; following the procedure, the average length of stay in hospital was 7 days, and more than half of patients used a critical care bed. Since the introduction of the new pathway, only 20% patients required multiple admissions prior to the procedure, and only 1 case was cancelled; the results also showed that the length of stay in hospital following the procedure was reduced, and no critical care beds were used.

4.3 Information Governance and Data Quality

Statement on relevance of Information Quality and actions to improve

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources throughout the Trust. It plays a key part in clinical governance, service planning and performance management.

It is of paramount importance that information is efficiently managed, and that appropriate policies, procedures, management accountability and structures provide a robust governance framework for information management, to assure and demonstrate the proactive use of information as determined by legislative acts, statutes, regulatory requirements and best practice.

Information Governance is a "framework for handling information in a confidential and secure manner to appropriate ethical and quality standards in a modern health service". It brings together within a singular cohesive framework, the interdependent requirements and standards of practice within the Trust.

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 2015/16.

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 2015/16 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 for the period April 2015 to February 2016 which included a valid NHS number can be seen in the table below.

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	99.9%	0.6%
Accident and emergency care	96.1%	0.5%

The percentage of records in the published SUS Data Quality Dashboard for the period April

2015 to February 2016, 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%	0.2%
Accident and emergency	99.5%	0.5%

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 a Review of non-electivity activity which involved a clinical coding audit; this was carried out in December 2015, and was undertaken by CHKS. These audits provide a summary of the accuracy of clinical coding across the NHS and help inform improvements in practice. The Audit involved 500 cases across Medicine, Trauma & Orthopaedics, Respiratory and Gastrointestinal. The Trust accuracy rates reported for primary and secondary diagnosis and treatment coding in the preliminary report were:

Areas of Clinical Coding	Accuracy of clinical coding
Primary diagnosis	88.9 %
Secondary diagnosis	93.6%
Primary treatment	91.1%
Secondary treatment	91.2%
Coding accuracy that attributed to the correct Health Care Resource Group	91.2%

According to the Audit Commission, this places the Trust higher than average, but not in the top 25% of Trusts.

Recommendations from the December 2015 audit were:

- All of the errors identified should be reviewed, fed back to the Clinical Coding Team and incorporated into relevant training.

- Coding Leads to ensure Coders only use National Guidance and local policies that are signed off. Any other guidance which is 'passed down' from other experienced coders should be disregarded until they have verified.

- Coding Leads to send a query to the HSCIC to see if the radial artery line procedures should be coded, and if they should, what codes to use. The outcome of this query should be feedback to the CCG when this has been resolved.

- Trust to work with clinicians to ensure that injuries are clearly documented in the notes as soft tissue injuries rather than generically as pain where this is deemed clinically relevant.

- Trusts to engage with clinicians to reiterate the importance of documenting all information and the correct primary diagnosis in the discharge summary.

The Trust has taken the following steps in response to these recommendations:

- All coders have been provided with a copy of the audit report and discussions have been undertaken with regards to the findings.

- To coincide with the introduction of ICD-10 5th edition, e-versions of both ICD-10 and OPCS 4 have been annotated with national guidelines and local policies (that have been developed with Clinical staff):

- The coding query with regards to radial artery lines has been sent to HSCIC and a resolution is awaited.

The final two recommendations relate to clinical documentation, which is being addressed through ongoing work with clinical teams to improve documentation; different methods are being used such as audit feedback, presentations to clinical groups and general discussions in meetings.

Section 4
Quality Account

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 2015/16. 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	Jan-16
Month End	66.4%	76.2%	86.95%	94.9%
5th Working Day (after Month End)	80.3%	89.3%	98.6%	97.6%
Payment by Results Flex Date	86.4%	95.9%	100%	98.7%
Payment by Results Freeze Date	99.9%	100.0%	100%	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 2015/16 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 13 (2015-2016)	0	0	24	21	45	82%	Satisfactory
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

4.4 Goals agreed with Commissioners (CQUINS)

Local Quality Incentive Scheme CCG 2015/16

Due to the contract that we agreed with our commissioners for 2015/16, a Local Quality Incentive Scheme replaced the previous CQUIN scheme (Commissioning for Quality and Innovation).

We focussed on five improvement goals identified in the table overleaf:

Goals	Description	Q1	Q2	Q3	Q4
1. Acute Kidney Injury	LTHT is asked to identify key areas of the Trust in which to focus work on Acute Kidney Injury - this is to include a minimum of 2 CSUs	Achieved	Achieved	Achieved	On track
2. Sepsis	Develop and implement protocols for screening for sepsis within the Emergency Department and in the Medical and Surgical Admissions wards where patients are directly admitted and to ensure that intravenous antibiotics are initiated within 1 hour	Achieved	Achieved	Achieved	On track
3. Transfer of Care	The Trust to participate in joint review of incidents and complaints relating to transfers of care, and to jointly plan solutions to prevent re-occurrence	Achieved	Achieved	Achieved	On track
4. Leeds Institute for Quality Healthcare Programme	LTHT staff will continue to contribute to the LIQH and Transformation programmes for: Falls, Diabetes, Cancer, COPD & Cardiovascular disease	Achieved	Achieved	Achieved	On track
5. Pressure Ulcers	Collaborative work to support the continued reduction in the prevalence of pressure ulcers	Achieved	Achieved	Achieved	On track

2016/17

The national scheme for 2016/17 includes new national quality goals for improvement relating to NHS staff health & well-being, sepsis, cancer 62 day waits and antimicrobial resistance. The NHS England and local CCG CQUINs are set out in Appendix E.

Participation in Clinical Research

We know that high quality clinical research and innovation improves outcomes for patients. Our vision, and the aim of our 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. The new R&I Strategy was launched in April 2015 and 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 have published a delivery plan detailing how our strategic aims will be realised.

During 2015/16 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. Our research information hub provides live research performance and activity information to operational departments and we plan to connect further with CSU performance and governance structures during the coming year.

Research Performance

During 2015 the Trust has steadily and significantly improved its performance in meeting the National Institute for Health Research (NIHR) initiation and delivery research targets for clinical trials. This means trials are being set up and patients are being recruited to trials faster and more effectively.

R & I performance in initiation and delivery of research (Jan - Dec 2015)

2015	Initiation (70 day) % of trials meeting benchmark	Delivery - % of trials recruiting to time and target
Q4	53.7	41.2
Q1	62.1	56.8
Q2	79.7	63.8
Q3	92.4	60.5

During 2015/16 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 11,221 patients in 479 research studies.

R & I Participation: Top 10 Trust Comparison (2015/16)
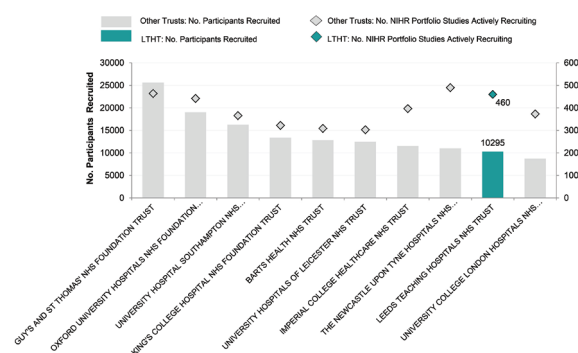
National Institute for Health Research

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:

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. 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.

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. 2015 has seen the progression of plans for further investment and expansion of the CRF which are being led by its newly appointed clinical management team.

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.

National Centre for Translational Hyperpolarised Magnetic Resonance

In this programme of research led by Professor Sven Plein, a clinical cardiologist, the Universities of Leeds and York, supported by the Trust and industry partners, aim to establish a National Centre for Translational Hyperpolarised Magnetic Resonance to take a novel form of MR imaging (SABRE hyperpolarisation) from bench to bedside within 5 years. Target conditions in the areas of cancer, cardiovascular and musculoskeletal disease, all areas of international excellence in Leeds, will be investigated.

What Others Say About Leeds Teaching Hospitals NHS Trust

6.1 Care Quality Commission

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 were 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 (IMR)

The most recent CQC Intelligent Monitoring Report was published in May 2015. The Trust's overall rating has remained in band 3 (although the banding was replaced with – 'recently inspected'). The number of elevated risks (reds) remained at 1 in May 2015 (whistleblowing alerts); the number of risks (ambers) had fallen from 8 to 7.

The Trust's Whistleblowing Policy was launched in 2103 and outlines the different ways in which staff can raise concerns and the action that will be taken to address them. Since then we have worked closely with Public Concern At Work to regularly provide external challenge to our processes and to support us in identifying and implementing best practice. The organisation has also continued to promote the importance of an open culture through staff events and regular communications.

Inspection visits 2015/16

The CQC did not undertake any unannounced compliance inspection visits in 2015/16.

The CQC had undertaken a comprehensive inspection of the Trust in March 2014 and the final report was published in June 2014.

A follow up visit is planned for May 2016 and will be preceded by a detailed programme within the Trust to prepare for the inspection, led by the Chief Nurse and the Executive team. This involves 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 CQC's inspection approach involves identifying the key questions to ask about the quality and safety of care, based on the things that matter to people. The CQC uses 5 key questions 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 CQC programme of inspections includes the use 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

Outstanding
Good
Requires improvement
Inadequate

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	Acute Medical Pathways	Acute Surgical Pathways
Children and Young People	A&E	Maternity	End of Life Care

The findings in the report from the CQC inspection in March 2014 was based on a combination of what the CQC found when they visited the Trust, 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:

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: www.cqc.org.uk/provider/RR8

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, and also discussed at regular meetings with the TDA. Reports on progress have been provided to the Quality Management Committee and Trust Board, and progress has been discussed with commissioners at NHS Leeds West CCG at the monthly quality meetings.

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

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. The Trust identified 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 were completed and 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 2015/16 and we welcome further feedback from the forthcoming CQC inspection to help us make further improvements in the care we provide for our patients.

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

28/06/2016

.... Date   .... Chair

28/06/2016

.... Date   .... Chief Executive

Appendix B

Statements from Local Stakeholders

Comments from Healthwatch Leeds on
Leeds Teaching Hospitals NHS Trust Quality Account 2015-16

Introduction

While the Trust will publish separate details of its accounts and financial performance, it would seem reasonable that the Trust should comment in general terms on the impact of the financial challenges facing the NHS and specifically in terms of the impact on its priority areas.

Furthermore, given that around 20% of Leeds' population includes Black and Minority Ethnic (BME) communities, it is hoped that more can be done to understand and tailor services to meet the needs of all communities.

Joint comments for inclusion in the Quality Account

Due to the size and complexity of the organisation the Quality Accounts are extensive with quite a lot of national benchmarks and indicators. The national measures and percentages are not always clear for lay people; and we would welcome some clearer linkage to the section where the indicators can be found.

While the Trust will publish separate details of its accounts and financial performance, it would seem reasonable that the Trust should comment in general terms on the impact of the financial challenges facing the NHS and specifically in terms of the impact on its priority areas.

We recognise the significant amount of work that has been invested in patient experience by the Trust with a range of engagement methods, improvements in both handling and experience of complaints and concerns. There were also examples of Quality Improvement work and information on staff experience and feedback. Good practise examples also included an extension of PALS presence and patient experience informing the Trust wide quality dashboard.

However, given that around 20% of Leeds' population includes Black and Minority Ethnic (BME) communities, it is hoped that more can be done to understand and tailor services to meet the needs of all communities.

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 2015-16. Our statement is as follows:

NHS Leeds West Clinical Commissioning Group (CCG) is pleased to provide this statement for Leeds Teaching Hospitals NHS Trust's (LTHT) Quality Account for 2015-16. The Quality Account has been reviewed in accordance with the National Health Service Regulations and NHS Leeds West CCG is providing this statement on behalf of all three Leeds CCG's (NHS Leeds South and East and NHS Leeds North) following consultation.

The Leeds CCGs continue to develop a positive relationship with colleagues across the Trust. Quality of service provision, the impact on quality of some performance measures and the experience of patients are reviewed on a bi-monthly basis at the Leeds CCGs and LTHT Quality meetings. This is our opportunity to gain assurance that the Trust has the correct 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 true representation of the Trust's achievements over the last year, and accurately describes its commitment to continuously improve the quality of care delivered.

It is pleasing to see that the Trust has continued its commitment to Quality Improvement programmes. The continued reduction in hospital acquired pressure ulcers and falls, and development of safety huddles demonstrate the positive impact of this work with partners such as the Yorkshire and Humber Improvement Academy and the Leeds Institute for Quality Healthcare. As in previous years there is a focus on the testing of key actions from previous work and sharing learning across the Trust to support sustainable, long term improvement.

We are particularly interested to hear of the work streams planned using the Leeds Improvement Method in collaboration with the Virginia Mason Institute and look forward to seeing how this innovative work will bring added benefits for patient safety and the experience of those receiving care at the Trust.

The Trust has identified Priority Improvement Areas for 2016/17 and a number of these are continuations of programmes from 2015/16, particularly in relation to patient safety. The CCG is supportive of the planned work, particularly on the proposals to improve the understanding of feedback and capturing actions from Friends and Family Test data. We are also pleased also to note the focus on antimicrobial stewardship supported by training for all staff.

Whilst the Trust have worked collaboratively on improving the quality of discharge for patients and their families, we would have liked this to have been identified as a major priority for 2016/17, particularly given the challenges over the winter period in ensuring timely and high quality discharge.

The CCG is impressed with the work undertaken to improve the experiences of patients with learning disabilities and the Trust's work on engagement with patients in this area. The work undertaken to improve the care of patients with a diagnosis of dementia is extensive and we are pleased to see the implementation of initiatives such as John's Campaign. Development of the Carer's Charter and proposals to develop a Patient Reference Group and a Patient Leader programme will significantly improve engagement with patients and carers by the Trust.

There has been excellent progress in complaints handling due to work undertaken on complaints management process and the improvements can be seen in the reduction of the number of complaints received. Improved accessibility due to the 'Speak to Sister…' posters appears to have increased local resolution leading to fewer concerns being dealt with via the complaints process.

We acknowledge the continued progress and expansion to new areas of the Ward Healthcheck. We are pleased to see that this positively drives improvement at ward level and this has been confirmed to us on quality visits to the Trust when staff have been eager to show their Patient Safety Boards to the visiting team. The improvement in percentage of staff recommending the Trust as a provider of care to family and friends over the past four years (47% in 2012 to 69% in 2015) is very impressive, and reflective of the efforts and work that we have seen across the Trust and by the executive team.

The CCG would like to compliment the Trust for its continued commitment to working in a cooperative and transparent manner. We look forward to continuing to work in partnership with LTHT in delivering high quality, effective care for our patients.

Kind regards

Director of Nursing and Quality

Independent Auditors' 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 2016 ("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 2016 subject to limited assurance are the:

- Percentage of patients risk-assessed for venous thromboembolism (VTE): and
- Rate of clostridium difficile infection.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

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 DH on 29 January 2015 ("the Guidance") and applicable to 2015-16; 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 April 2015 to May 2016;
- papers relating to quality reported to the Board over the period April 2015 to May 2016;
- feedback from the Commissioners dated 24 May 2016;
- feedback from Local Healthwatch dated May 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social

Services and NHS Complaints (England) Regulations 2009, dated June 2016;

- the latest national patient survey 2015;
- the latest national staff survey 2015;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016;
- the annual governance statement dated 26 May 2016; and
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015.

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 the 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 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;
- documenting key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator 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 the 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 2016:

- 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.

Suresh Patel, Director for and on behalf of Mazars LLP

Tower Bridge House, St Katharine's Way, London, E1W 1DD

24 June 2016

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.

Datix: Patient safety and risk management software for healthcare incident reporting and adverse events.

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.

Haamla: Haamla is a unique service that provides essential support for pregnant women, and their families, from minority ethnic communities, including asylum seekers and refugees, throughout their pregnancy and postnatal period.

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 Formulary: The Leeds Formulary provides information for Leeds health care professionals and patients on medicines available at LTHT, supporting safe, evidence-based, cost effective practice. It includes the traffic light status for the wider Leeds prescribing community and links to a variety of medicines effectiveness sites.

Leeds Institute for Quality Healthcare (LIQH): The Leeds Institute for Quality Healthcare is a partnership initiative between the University of Leeds, the three Clinical Commissioning Groups, Leeds City and the three NHS Trusts in Leeds. Based on international best practice, it aims to secure improvements in healthcare across the city.

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.

Plan, Do, Study, Act (PDSA): The PDSA cycle is shorthand for testing a change - by planning it, trying it, observing the results, and acting on what is learned.

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 Leeds Way: The 'Leeds Way' is the Values of Leeds Teaching Hospitals Trust created by staff. It defines who we are, what we believe and how we will work to deliver the best outcomes for our patients. The Values are Fair, Patient Centred, Collaborative, Accountable and Empowered.

The Sign up to Safety campaign: Sign up to Safety is a national initiative to help NHS organisation's and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. At the heart of Sign up to Safety is the philosophy of locally led, self-directed safety improvement.

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*
Acute Pancreatitis	83%
Care of patients with mental health problems in acute general hospitals	Not yet available**
Chronic Neurodisability	Not yet available**
Young People's Mental Health	Not yet available**

National Audit	Participation Rate*
Bowel Cancer (NBOCAP)	100%
Cardiac Rhythm Management (CRM)	100%
Care of the Dying in Hospital (NCDAH)	100%
Case Mix Programme (CMP)	100%
Congenital Heart Disease (Paediatric Cardiac Surgery)	100%
Emergency Use of Oxygen	100%
Falls and Fragility Fractures Audit Programme: National Hip Fracture Database	95%
Falls and Fragility Fractures Audit Programme: National Audit of Inpatient Falls	100%
Inflammatory Bowel Disease (IBD): Biological Therapy	100%***
Lung Cancer (NLCA)	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	100%
Myocardial Ischaemia National Audit Project (MINAP)	99%
National Adult Cardiac Surgery Audit	100% ****
National Cardiac Arrest Audit (NCAA)	100%
National Comparative Audit of Blood Transfusion Programme: Audit of Patient Blood Management in Scheduled Surgery	73%
National Comparative Audit of Blood Transfusion Programme: Audit of Red Cell & Platelet Transfusion in Haematology	100%
National Complicated Diverticulitis	47%
National Diabetes Core Audit	99%
National Diabetes Foot Care Audit	100%

National Diabetes Inpatient Audit	100%
National Emergency Laparotomy Audit (NELA)	100%
National Heart Failure Audit	71%
National Joint Registry (NJR)	82%
National Ophthalmology Audit	100%
National Paediatric Diabetes Audit (NPDA)	100%
National Pregnancy in Diabetes Audit	94%
National Prostate Cancer Audit	100%
National Vascular Registry	96%
National Neonatal Audit Programme (NNAP)	100%
Oesophago-gastric Cancer (NAOGC)	100%
Paediatric Asthma	100%
Paediatric Intensive Care (PICANet)	100%
Patient Reported Outcome Measures - Varicose Veins	62%
Patient Reported Outcome Measures - Hernia	42%
Patient Reported Outcome Measures - Hip replacements	87%
Patient Reported Outcome Measures - Knee replacements	99%
Percutaneous Coronary Intervention (PCI)	98%
Procedural Sedation in Adults	100%
Renal Replacement Therapy (Renal Registry)	100%
Rheumatoid and Early Inflammatory Arthritis	Denominator not known
Sentinel Stroke National Audit Programme (SSNAP)	100%
Trauma Audit & Research Network (TARN)	72%
UK Cystic Fibrosis Registry	100%
UK Parkinson's Audit	100%
Vital Signs in Children	**100%**
VTE Risk in Lower Limb Immobilisation	**100%**

*   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.

**   Study currently taking place; participation rate not available

***   Participation rate in audit for paediatric patients

****   Participation rate for the first six months of 2015; the second six months of 2015 will be submitted to NICOR following completion of migration to an updated clinical system

Appendix E: CQUINS 2016/17

National CQUINs

NHS Staff Health & Well-being	Option B - Introduction of initiatives covering physical activity, ental health & improving access to physiotherapy.
NHS Staff Health & Well-being	Healthy food for NHS staff, visitors and patients.
NHS Staff Health & Well-being	Improving the uptake of flu vaccinations by front line staff with providers.
Sepsis	Timely identification and treatment for Sepsis in emergency departments.
Sepsis	Timely identification and treatment for Sepsis in acute inpatient settings.
Antimicrobial Resistance	Reduction in antibiotic consumption (per 1,000 admissions).
Antimicrobial Resistance	Empiric review of antibiotic prescriptions.

Local CQUINs

Respiratory Pathway review	With Leeds Community Healthcare & Primary Care, to carry out a collaborative, comprehensive end to end review of current major respiratory pathways to optimise for best care. The reviews must be based on the relevant NICE quality standards and other relevant best practice standards which describe pathways of care.
Cardiology Pathway Review	The Provider is to work jointly with Leeds Community Healthcare to conduct a collaborative, comprehensive review of current Cardiology pathways. The review will focus on scoping, identifying gaps and optimising the pathway for: Acute Coronary Symptoms and Heart Failure.
Smoking in Pregnancy	To contribute to reducing the prevalence of smoking among pregnant women.
Acute Kidney Injury	1. Building on the preparatory work undertaken in 2015-16 to support the early identification and treatment of patients with acute kidney injury, provider to roll out the project to the pilot wards.

2. Audits of randomly selected patients with AKI on the pilot wards (30 LGI patients and 30 SJUH patients) to be conducted every quarter to assess the quality of care of patients who have been diagnosed with AKI. |
| Development and implementation of post procedure follow-up arrangements | Make best use of outpatient capacity, patient and clinical time by agreeing, implementing and auditing pathways for common procedures. |

Specialist Commissioning

LOCAL QIPP Engagement & Delivery	Engagement with NHSE local QIPP proposals & delivery of agreed savings.
Improving Hepatitis C Virus Treatment Pathways through Operational Delivery Networks	Providers need to participate in ODN; and HCV patients' access to treatment should accord with ODN guidelines.
Enhanced Supportive Care for Advanced Cancer Patients	Adoption of audit tool to assure that patients are: (i) Identified as having advanced progressing disease (75%), (ii) Given the opportunity to discuss their prognosis (75%), (iii) Given the opportunity to be involved in decision-making about their individual management plan (90%), (iv) Offered referral to specialist/community palliative care services (90%), (v) Supported with communication with the patient's GP about advance care planning (80%).
Optimal Device	Maintenance/improvement in optimisation of device usage during the year of transition to a centralised national procurement and supply chain arrangement.
CAMHS Screening for Paediatric Patients with Long Term Conditions	SDQ screening for paediatric in-patients with relevant (listed) LTCs. Minimum coverage 30% for 4 LTCs.
Improving Haemoglobinopathy Pathways Through Operational Delivery Networks	To improve appropriate and cost effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance.
Multi-System Auto-Immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance	Review of specialised patient cases across Network by MDTs, with data flowing to registries.
Spinal Surgery: Networks, Data, MDT Oversight	Setting up regional MDT; entering surgery into British Spinal Registry or Spine Tango, and no surgery except with MDT sanction.
Nationally Standardised Dose Banding Adult Intravenous SACT	Standardisation of chemotherapy doses through a nationally consistent approach to dose banding.
Local Adult Critical Care	Reduction in delayed discharges - 24 hours +
Audit of Day Case Activity	A prospective audit of daycase activity carried out in accordance with the Terms of Reference issued by the service commissioner.
Secondary Care Dental – Orthodontic Data Collection	Collect information on waiting times, PAR scoring and the complexity of cases referred into secondary care.
Health Inequalities	To improve uptake of Public Health Screening and Immunisation Programmes for people with learning difficulties or mental health conditions , including those in Health and Justice settings.

Appendix F: Performance against National Priority Indicators

Performance Measures	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Section A - National Operational Standards													
RTT Incomplete	>=92	93.56	93.65	93.37	94.09	93.60	93.88	93.56	94.01	93.24	92.52	92.47	92.11
RTT Failing Specialties: Incomplete	=0	5	5	6	5	6	6	4	3	3	5	5	5
A&E Performance	>=95	97.38	96.94	95.63	96.10	96.07	94.97	93.79	92.20	90.62	87.83	89.81	87.14
Diagnostic Waits	>=99	98.94	98.69	98.34	98.11	99.11	99.80	99.75	99.69	99.70	98.37	99.57	95.87
Cancelled Ops: Not rebooked within 28 days	=0	8	12	3	4	4	2	3	3	6	16	4	19
Cancer: 62 Day: GP/Dentist Referrals	>=85	82.57	74.68	79.25	81.20	83.12	80.00	85.45	84.99	85.15	86.31	85.98	
Cancer: 62 Day: Screening	>=90	100.00	94.87	97.96	91.55	96.36	91.30	96.61	100.00	93.22	88.68	94.29	
Cancer: 31 Day: 1st Treatment	>=96	96.69	97.02	97.53	97.79	99.10	98.61	98.12	98.34	99.78	97.29	97.59	
Cancer: 31 Day: Subsequent Surgery	>=94	94.66	98.74	97.78	95.81	97.04	97.75	95.40	98.17	96.69	95.45	96.32	
Cancer: 31 Day: Subsequent Drug	>=98	100.00	99.61	100.00	100.00	100.00	99.60	99.63	100.00	99.17	99.63	100.00	
Cancer: 31 Day: Sub Radiotherapy	>=94	99.04	98.94	99.77	100.00	98.92	100.00	100.00	99.50	100.00	100.00	100.00	
Cancer: 14 Day: Urgent GP Referrals	>=93	90.62	93.65	92.51	94.28	91.73	94.92	94.93	96.38	94.24	91.18	93.20	
Cancer: 14 Day: Breast Symptoms	>=93	91.05	92.10	96.82	91.97	73.84	90.74	94.75	93.25	94.44	93.45	98.10	
Mixed Sex Accommodation Breaches	=0	0	0	0	0	0	0	0	0	0	0	0	0
Section B - National Quality Contract Requirements													
HCAI: MRSA	=0	0	1	0	1	0	3	0	0	0	2	0	0
HCAI: CDiff	<=119	15	7	16	13	11	12	10	9	16	11	8	11
VTE Risk Assessment	>=95	96.18	95.67	95.95	96.34	95.67	96.14	96.21	96.79	96.69	96.95	95.31	
VTE RCA Completion Rate	=100	100.00	100.00	100.00	90.91	89.47	95.45	85.71	85.71	92.86			
RTT Incomplete 52+ Week Waiters	=0	0	0	0	0	0	0	0	0	0	0	0	0
Cancelled Ops: Urgent Cancels 2nd/Sub	=0	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance Handovers: 30 - 60 mins	=0	49	32	37	26	25	23	26	28	45	45	49	103
Ambulance Handovers: Over 60 mins	=0	0	1	0	0	0	0	2	0	0	0	0	6
A&E 12 Hour Trolley Waits	=0	0	0	0	0	0	0	0	0	0	0	0	0
Friends and Family Test: Response Rate - Inpatients	>=25	30.43	34.25	35.81	36.71	28.66	31.48	30.69	22.01	45.00	32.02	35.39	31.73
Friends and Family Test: Response Rate - A&E	>=15	19.13	17.63	25.97	27.18	27.84	29.19	25.04	20.50	31.27	24.39	29.10	27.45
eDAN: Completed	-	94.18	94.14	93.44	94.24	93.10	93.68	92.88	92.41	93.16	93.53	91.46	91.35
eDAN: Sent to GP within 24 hrs	>=90	85.15	83.98	83.40	84.85	83.16	85.41	84.17	84.33	84.67	84.38	82.94	81.62
Complaints: Total	-	65	59	71	83	56	59	62	66	44	53	44	58
Emergency Readmissions Within 30 Days	-	2.0	2.1	2.1	1.9	2.0	2.0	2.1	2.2	2.2	2.3	2.3	1.7
Performance Measures	**Target**	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Section C - NHSE Quality and Contract Requirements													
Serious Incidents (SUIs)	-	9	15	7	4	3	9	9	5	0	5	6	5
HCAI: MSSA	<=59	7	6	7	4	3	9	4	4	5	8	3	7
Gynae Cytology 11 Day TATs	>=98	32.60	65.14	99.43	99.38	99.19	98.94	98.30	99.58	99.44	99.63	88.96	43.19
Harm Free Care	>=95	93.82	94.75	94.03	95.06	94.92	94.31	95.72	93.50	94.59	95.30	95.21	93.76
Readmissions to PICU Within 48 Hours	<1	0.00	0.00	0.00	0.01	0.00	0.01	0.00	0.01	0.00	0.00	0.00	0.00
Section D - Local Quality and Contract Requirements													
Cancer: 62 Day: Consultant Upgrade	>=85	92.11	63.64	76.74	91.18	90.24	78.13	100.00	97.56	97.30	76.92	83.33	85.71
OP FUP Backlog: > 3 Mths Overdue (Total Pts)	-	6,550	6,164	6,141	6,267	6,593	6,158	5,787	6,448	6,391	6,452	6,829	7,071
OP FUP Backlog: > 3 Mths Overdue (Specialties >100 Pts)	-	19	16	15	17	20	18	15	18	17	17	19	21
MRSA Screening	>=95	96.00	96.44	96.38	94.60	86.11	88.74	96.10	90.10	89.35	94.92	95.44	94.49
Section E - Internal Monitoring													
Dementia Performance: Stage 1	>=90	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
Dementia Performance: Stage 2	>=90	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
Dementia Performance: Stage 3	>=90	100.00	100.00	100.00	100.00	100.00	100.00	100.00	96.97	100.00	100.00	100.00	
Pressure Ulcers (Grade 3) (developed)	-	3	10	5	2	3	3	5	7	4	5	4	2
Pressure Ulcers (Grade 4) (developed)	-	0	0	0	0	0	0	0	0	0	0	0	0
Histo & Diagnostic Biopsy 7 Day TATs	>=45	27.26	39.11	39.18	35.18	45.80	35.46	40.90	37.03	23.11	30.96	36.37	32.74
Histo & Diagnostic Cytology 14 Day TATs	>=80	71.70	83.31	83.53	78.99	77.96	80.33	84.12	80.81	64.16	78.21	78.07	71.82
OP Appts Cancelled 2 or More Times (Total)	-	2,079	1,975	2,480	2,635	2,287	2,692	2,720	2,595	2,596	2,918	2,798	3,280
OP Appts Cancelled 2 or More Times (By Hospital)	-	972	825	1,032	1,091	963	1,029	1,037	1,020	895	1,128	1,119	1,411
Research Studies Recruited to Time and Target	>=80	60.00	50.00	100.00	66.67	50.00		100.00					
Research Studies First Patient Recruited Within 70 Days	>=80	50.00	28.57	50.00	60.00	66.67	50.00	64.29	35.29	42.86	16.67	0.00	

Section 5

Financial Statements for 2015-16

Accounts for 2015-16

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 Hospitals NHS Trust for the year ended 31March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 (the 2015-16 MfA) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff 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 tables of exit packages and related notes;
- the analysis of staff numbers and related notes; and
- pay multiples and related narrative notes.

This report is made solely to the Board of Directors of the Leeds Teaching Hospitals NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of 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 require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 1O(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;

- the reasonableness of significant accounting estimates made by the Directors; and

- the overall presentation of the financial statements.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Leeds Teaching Hospitals NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and

- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve

the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under Section 24, Schedule 7 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the Trust under Section 24, Schedule 7 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Exception report

Auditor's responsibilities
We report to you if we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Basis for qualified conclusion (except for)
The Trust has delivered a year-end financial outturn at 31 March 2016 of a £30.2 million deficit against a £37.2 million deficit agreed with the NHS Trust Development Agency (TDA). The outturn reflects £6 million additional revenue from TDA and £1 million capital to revenue transfer also approved by TDA. The year-end target included the delivery of £69.2 million from cost improvement plans (CIPs). The Trust has put in place arrangements at a corporate and clinical service unit (CSU) level to deliver its CIP target but has relied on £25.5 million of non-recurrent measures.

For 2016/17 the Trust Board has agreed a financial plan forecast to deliver a £1.2 million surplus, including the delivery of £65.6 million of CIPs. At the date of this report the Trust has identified just over half of the required CIPs, although the CSU budgets have been reduced for their CIP allocation. This position is similar to the prior year at an equivalent date. The Trust is committed to securing long term financial sustainability through transformational

change and reduced reliance on non-recurrent measures. However for 2015/16 the level of non-recurrent measures relied upon to achieve the CIP target indicates that the Trust did not have proper arrangements in place to secure sustainable resource deployment.

Qualified conclusion (except for)
On the basis of our work, having regard to the guidance issued by the C&AG in November 2015, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Suresh Patel, Audit Director

for and on behalf of Mazars LLP, Appointed Auditor

Tower Bridge House, St Katharine's Way London, E1W 1DD

31 May 2016

5.2 The Leeds Teaching Hospitals NHS Trust - Annual Accounts 2015-16

Statement of comprehensive income for the year ended 31 March 2016

	Note	2015-16 £000s	2014-15 £000s
Gross employee benefits	9.1	(651,993)	(632,102)
Other operating costs	7	(468,472)	(452,179)
Revenue from patient care activities	4	943,383	925,514
Other operating revenue	5	172,337	161,124
Operating (deficit)/surplus		(4,745)	2,357
Investment revenue	11	124	111
Other gains and (losses)	12	(80)	112
Finance costs	13	(12,567)	(12,438)
(Deficit) for the financial year		(17,268)	(9,858)
Public dividend capital dividends payable		(9,963)	(10,130)
Retained (deficit) for the year		(27,231)	(19,988)
Other comprehensive income			
Net (loss) on revaluation of property, plant & equipment		0	(4,558)
Total comprehensive income for the year		(27,231)	(24,546)
Financial performance for the year			
Retained (deficit) for the year		(27,231)	(19,988)
IFRIC 12 adjustment (including IFRIC 12 impairments)		0	5,243
Impairments (excluding IFRIC 12 impairments)		0	(8,140)
Adjustments in respect of donated asset reserve elimination		(2,963)	(1,501)
Adjusted retained (deficit)		(30,194)	(24,386)

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. In 2015/16 the Trust ceased to incur additional costs arising from its PFI schemes.

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 192-228 form part of these financial statements.

Statement of financial position as at 31 March 2016

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets:			
Property, plant and equipment	14	**618,492**	615,948
Intangible assets	15	**2,835**	2,225
Trade and other receivables	18.1	**9,930**	11,165
Total non-current assets		631,257	629,338
Current assets:			
Inventories	17	**16,539**	17,484
Trade and other receivables	18.1	**53,928**	61,955
Cash & cash equivalents	19	**3,362**	3,298
Total current assets		73,829	82,737
Total assets		**705,086**	**712,075**
Current liabilities			
Trade and other payables	21	**(78,672)**	(89,469)
Provisions	25	**(775)**	(2,292)
Borrowings	22	**(4,957)**	(4,702)
DH capital loan	22	**(4,812)**	(4,927)
Total current liabilities		(89,216)	(101,390)
Net current liabilities		(15,387)	(18,653)
Total assets less current liabilities		615,870	610,685
Non-current liabilities			
Trade and other payables	21	**(2,188)**	(2,109)
Provisions	25	**(5,231)**	(5,679)
Borrowings	22	**(193,112)**	(198,069)
DH revenue support loan	22	**(37,329)**	0
DH capital loan	22	**(45,113)**	(44,715)
Total non-current liabilities		(282,973)	(250,572)
Total assets employed		332,897	360,113
Financed by:			
Public Dividend Capital		**332,848**	332,833
Retained earnings		**(77,209)**	(49,978)
Revaluation reserve		**77,258**	77,258
Total Taxpayers' Equity:		332,897	360,113

The notes on pages 192-228 form part of these financial statements.

The financial statements on pages 188-228 were approved by the Board on 26 May 2016 and signed on its behalf by: Julian Hartley, Chief Executive

Statement of changes in taxpayers' equity for the year ending 31 March 2016

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2015	332,833	(49,978)	77,258	360,113
Changes in taxpayers' equity for 2015-16				
Retained (deficit) for the year	0	(27,231)	0	(27,231)
Permanent PDC received - cash	1,015	0	0	1,015
Permanent PDC repaid in year	(1,000)	0	0	(1,000)
Net recognised revenue/(expense) for the year	15	(27,231)	0	(27,216)
Balance at 31 March 2016	332,848	(77,209)	77,258	332,897

	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 and permanent 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

Statement of cash flows for the year ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Operating (deficit)/surplus		**(4,745)**	2,357
Depreciation and amortisation	7	**24,717**	21,658
Impairments and reversals		**0**	(2,897)
Interest paid		**(12,541)**	(12,437)
PDC Dividend paid		**(10,348)**	(10,370)
Decrease in inventories		**945**	151
Decrease/(increase) in trade and other receivables		**8,811**	(14,417)
(Decrease) in trade and other payables		**(6,789)**	(6,825)
Provisions utilised		**(1,808)**	(2,775)
(Decrease)/increase in movement in non cash provisions		**(157)**	2,057
Net cash (outflow) from Operating Activities		**(1,915)**	(23,498)
Cash Flows From Investing Activities			
Interest received		**124**	111
Payments for property, plant and equipment		**(30,042)**	(37,229)
Payments for intangible assets		**(1,151)**	(1,655)
Proceeds of disposal of assets held for sale (PPE)		**124**	269
Net Cash Outflow from Investing Activities		**(30,945)**	(38,504)
Net Cash Outflow before Financing		**(32,860)**	(62,002)
Cash Flows From Financing Activities			
Gross temporary (2014/15 only) and permanent PDC received		**1,015**	68,679
Gross temporary (2014/15 only) and permanent PDC repaid		**(1,000)**	(29,800)
Loans received from DH - New Capital Investment Loans		**5,394**	11,000
Loans received from DH - New Revenue Support Loans		**63,179**	0
Loans repaid to DH - Capital Investment Loans repayment of principal		**(5,112)**	(3,356)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(25,850)**	0
Capital element of payments in respect of finance leases and On-SoFP PFI		**(4,702)**	(4,459)
Net Cash Inflow from Financing Activities		**32,924**	42,064
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**64**	(19,938)
Cash and Cash Equivalents at 1 April 2015		**3,298**	23,236
Cash and Cash Equivalents at 31 March 2016	19	**3,362**	3,298

5.3 Notes 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 Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 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 accounts.

1.1   Accounting convention

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

1.2   Going concern

The Directors formed a judgement at the time of approving the financial statements that there is a reasonable expectation that the Trust has access to adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. See note 33.1 for further explanation.

1.3   Charitable Funds

Under the provisions of IFRS 10 Consolidated 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.

1.4.1 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.

1.4.2 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 14
- Provision for Impairment of Receivables - Note 18.3
- Provisions - Para 1.18 and Note 25

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 NHS 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 NHS

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

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. 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.

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 NHS body 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 to, 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 current 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 current 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. Current 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 current 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 current 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

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 £5000.

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.

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 NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS 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 NHS 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.

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

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit 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 of 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 NHS 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 NHS 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 NHS 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 -1.55% in real terms (1.37% 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 25.

1.20 Non-clinical risk pooling

The NHS 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 NHS 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 NHS Trust. A contingent asset is disclosed where an inflow of economic benefits 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 NHS 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.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets; and

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

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 34 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.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

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 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 NHS body 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 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 HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

- IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted

- IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. 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 18 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.

3. 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 sufficiently material to warrant separate disclosure. The revenues and expenditure relating to these schemes are included in note 5.

4. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS England	460,543	439,566
Clinical Commissioning Groups	462,945	456,501
Foundation Trusts	91	0
NHS Other (including Public Health England and Prop Co)	1,960	1,853
Additional income for delivery of healthcare services	7,000	14,000
Non-NHS: Local Authorities Private patients Overseas patients (non-reciprocal) Injury costs recovery Other	936 4,715 592 3,766 835	4,197 4,832 656 3,309 600
Total revenue from patient care activities	943,383	925,514

5. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	10,766	9,057
Education, training and research	100,886	102,026
Charitable and other contributions to revenue expenditure - NHS	888	1,102
Charitable and other contributions to revenue expenditure - non NHS	913	941
Receipt of donations for capital acquisitions - Charity	4,390	2,824
Non-patient care services to other bodies	39,981	36,916
Rental revenue from operating leases	1,152	681
Other revenue	13,361	7,577
Total other operating revenue	172,337	161,124
Total operating revenue	1,115,720	1,086,638

Other revenue incorporates income received for goods and services which are incidental to the Trust's core activity, for example, car parking, creche fees, access to records charges and catering.

6. Overseas visitors disclosure

	2015-16 £000s	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	592	656
Cash payments received in-year (re receivables at 31 March 2015)	36	11
Cash payments received in-year (iro invoices issued 2015-16)	127	281
Amounts added to provision for impairment of receivables (re receivables at 31 March 2015)	197	291
Amounts added to provision for impairment of receivables (in respect of invoices issued 2015-16)	337	73
Amounts written off in-year (irrespective of year of recognition)	89	194

7. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	526	0
Purchase of healthcare from non-NHS bodies	12,212	11,849
Trust Chair and Non-executive Directors	96	89
Supplies and services - clinical	309,083	302,187
Supplies and services - general	8,580	8,705
Consultancy services	585	1,161
Establishment	7,651	8,009
Transport	3,471	3,084
Service charges - On-SoFP PFIs and other service concession arrangements	13,185	14,911
Business rates paid to local authorities	4,781	4,574
Premises	34,310	37,807
Hospitality	146	154
Insurance	741	1,069
Legal fees	698	663
Impairments and reversals of receivables	959	1,401
Depreciation	24,176	21,388
Amortisation	541	270
Impairments and reversals of property, plant and equipment	0	(2,897)
Audit fees	120	160
Other auditor's remuneration - Quality Accounts	12	12
Clinical Negligence Scheme for Trusts - membership contribution	29,909	19,296
Education and training	4,702	3,202
Change in discount rate	(14)	112
Other	12,002	14,973
Total operating expenses (excluding employee benefits)	468,472	452,179
Employee benefits		
Employee benefits excluding Board members	650,563	630,686
Board members	1,430	1,416
Total employee benefits	651,993	632,102
Total operating expenses	1,120,465	1,084,281

Services from NHS bodies does not include expenditure which falls into a category in the remainder of note 7.

Included in Service charges - On-SoFP PFI is expenditure associated with building lifecycle costs for the Bexley Wing and Wharfedale Hospital PFI schemes. Historically these costs have been accounted for by the Trust as revenue expenditure. During 2015-16 the information in the operators' models was reviewed and information provided by independent valuers which led to a change in the technique used to estimate these costs. A proportion of the remaining lifecycle costs throughout the concession periods is now assessed as capital expenditure. In 2015-16 the effect of this has been to reduce the revenue cost by £1 million.

Expenditure associated with lease cars is included in Other above. In previous years the Trust has charged all lease car costs to revenue expenditure in the year in which invoices were paid. Following changes to the way car leases are administered in the Trust additional information has been made available to enable costs to be fully spread across 12 months. The effect of this has been to allocate appropriate expenditure to 2016-17 by including a prepayment in the accounts and reducing 2015-16 expenditure by £1.9 million.

Other expenses incorporates the costs for goods and services which are incidental to the Trust's core activity, for example, hosted services, childcare vouchers and lease cars (both recovered through income).

8. 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:

8.1 Operating leases

	Buildings £000s	Other £000	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense				
Minimum lease payments	923	4,210	**5,133**	7,859
Contingent rents	0	0	**0**	0
Sub-lease payments	0	0	**0**	0
Total	923	4,210	**5,133**	7,859
Payable:				
No later than one year	1,135	3,582	**4,717**	4,784
Between one and five years	3,970	2,961	**6,931**	6,726
After five years	3,211	0	**3,211**	3,214
Total	8,316	6,543	**14,859**	14,724

8.2. Leeds Teaching Hospitals NHS 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 had a twenty year term, due to expire in 2015. This has been extended to July 2016. Annual income is £250k. Other leases relate to various retail facilities provided across the Trust's sites.

	2015-16 £000	2014-15 £000
Recognised as revenue		
Rental revenue	**1,152**	681
Receivable:		
No later than one year	**874**	246
Between one and five years	**2,973**	688
After five years	**2,301**	2,339
Total	**6,148**	3,273

9 Employee benefits and staff numbers

9.1 Employee benefits

	Total £000s	Permanently employed £000s	Other £000s
Employee benefits - Gross expenditure 2015-16			
Salaries and wages	**556,196**	494,853	61,343
Social security costs	**36,614**	36,614	0
Employer contributions to NHS BSA - Pensions Division	**60,084**	60,084	0
Other pension costs	**13**	13	0
Termination benefits	**57**	57	0
Total employee benefits	**652,964**	591,621	61,343
Employee costs capitalised	**971**	971	0
Gross employee benefits excluding capitalised costs (note 7)	**651,993**	**590,650**	**61,343**
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 - including capitalised costs	**632,991**	566,305	66,686
Employee costs capitalised	**889**	889	0
Gross employee benefits excluding capitalised costs (note 7)	**632,102**	**565,416**	**66,686**

9.2 Staff numbers

	2015-16 Total number	Permanently employed number	Other number	2014-15 Total number
Average staff numbers				
Medical and dental	**1,949**	1,826	123	1,922
Administration and estates	**2,557**	2,429	128	2,447
Healthcare assistants and other support staff	**3,144**	2,847	297	3,023
Nursing, midwifery and health visiting staff	**4,156**	3,866	290	4,017
Nursing, midwifery and health visiting learners	**4**	4	0	9
Scientific, therapeutic and technical staff	**1,932**	1,846	86	1,794
Social care staff	**12**	0	12	12
Healthcare science staff	**908**	873	35	862
Other	**442**	434	8	401
Total	**15,104**	**14,125**	**979**	**14,487**
Of the above - staff engaged on capital projects	**22**	22	0	19

9.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total days lost	**122,507**	123,022
Total staff years	**13,886**	13,225
Average working days lost	**8.82**	9.30

	2015-16	2014-15
Number of persons retired early on ill health grounds	**25**	25

	2015-16 £000s	2014-15 £000s
Total additional pensions liabilities accrued in the year	**1,081**	1,238

9.4 Exit packages agreed 2015-16

Exit package cost band (including any special payment element)	2015-16					
	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages
	Number	£s	Number	£s	Number	£s
£50,001-£100,000	0	0	1	57,069	1	57,069

Exit package cost band (including any special payment element)	2014-15					
	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages
	Number	£s	Number	£s	Number	£s
£50,001-£100,000	1	54,935	0	0	1	54,935

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change. 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.

9.5 Exit packages - other departures analysis

	2015-16		2014-15	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Mutually agreed resignations (MARS) contractual costs	1	57	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

9.6 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

9.7 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 133 employees enrolled in the scheme (122 at 31 March 2015). Further details of the scheme can be found at www.nestpensions.org.uk.

10. Better Payment Practice Code

10.1 Measure of compliance

	2015/16 Number	2015/16 £000s	2014/15 Number	2014/15 £000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	219,731	494,089	232,738	526,444
Total non-NHS trade invoices paid within target	203,551	416,744	208,856	459,267
Percentage of non-NHS trade invoices paid within target	**93%**	**84%**	**90%**	**87%**

	2015/16 Number	2015/16 £000s	2014/15 Number	2014/15 £000s
NHS payables				
Total NHS trade invoices paid in the year	6,050	87,664	6,345	60,328
Total NHS trade invoices paid within target	4,517	79,587	3,835	47,695
Percentage of NHS trade invoices paid within target	**75%**	**91%**	**60%**	**79%**

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.

10.2 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.

11. Investment revenue

	2015/16 £000s	2014-15 £000s
Interest revenue		
Bank interest	124	111

12. Other gains and losses

	2015/16 £000s	2014-15 £000s
(Loss)/gain on disposal of assets held for sale	(80)	112

13. Finance costs

	2015/16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	1,570	1,189
Interest on obligations under finance leases	8	9
Interest on obligations under PFI contracts: main finance cost	10,962	11,203
Total interest expense	**12,540**	**12,401**
Provisions - unwinding of discount	27	37
Total	**12,567**	**12,438**

14.1 Property, plant and equiment

2015-16	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
Cost or valuation:									
At 1 April 2015	20,475	568,183	2,352	19,352	200,080	884	55,872	1,387	868,585
Additions of assets under construction	0	0	0	9,573	0	0	0	0	9,573
Additions purchased	0	7,134	0	0	6,030	0	778	0	13,942
Additions - Purchases from cash donations & government grants	0	1,865	0	288	1,256	0	0	0	3,409
Reclassifications	0	13,340	0	(19,078)	0	0	5,738	0	0
Reclassifications as held for sale and reversals	0	0	0	0	(7,028)	0	0	0	(7,028)
At 31 March 2016	20,475	590,522	2,352	10,135	200,338	884	62,388	1,387	888,481
Depreciation:									
At 1 April 2015	(639)	57,155	473	0	155,718	840	37,721	1,369	252,637
Reclassifications as held for sale and reversals	0	0	0	0	(6,824)	0	0	0	(6,824)
Charged during the year	0	9,202	36	0	9,281	15	5,629	13	24,176
At 31 March 2016	(639)	66,357	509	0	158,175	855	43,350	1,382	269,989
Net Book Value at 31 March 2016	21,114	524,165	1,843	10,135	42,163	29	19,038	5	618,492
Asset financing:									
Owned - Purchased	21,114	355,519	1,843	9,847	28,839	29	18,707	5	435,903
Owned - Donated	0	12,644	0	288	5,203	0	331	0	18,466
Held on finance lease	0	639	0	0	0	0	0	0	639
On-SoFP PFI contracts	0	155,363	0	0	8,121	0	0	0	163,484
Total at 31 March 2016	21,114	524,165	1,843	10,135	42,163	29	19,038	5	618,492

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Revaluation reserve balance for property, plant & equipment									
At 1 April 2015	310	69,662	0	0	5,953	14	364	955	77,258
Movements	0	0	0	0	0	0	0	0	0
At 31 March 2016	310	69,662	0	0	5,953	14	364	955	77,258

Additions to assets under construction in 2015-16									
Buildings exc. dwellings				5,507					
Plant & Machinery				4,066					
Balance as at YTD				9,573					

14.2 Property, plant and equipment - prior year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
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	0	14,941	0	7,680	0	26,618
Additions - Purchases from cash donations & government grants	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

	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
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/ negative indexation charged to operating expenses	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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
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

14.3 (cont). Property, plant and equipment

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 2016 a further exercise was undertaken by the valuer to assess movement in building cost indices since 1st April 2015 and the impact of capital expenditure during the year. The results of this exercise indicated valuation increases estimated at up to £7 million offset by potential reductions of a similar amount for other factors including the impact of VAT on PFI assets. The adjustments were not considered sufficiently material to change the carrying value of assets. In 2016/17 the Trust will have an interim estate valuation.

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 grants and donations to fund assets from the following:

	2015-16 £000s
Interest	
Medical Research Council	2,834
NHS Litigation Authority - Patient Safety	681
Leeds Teaching Hospitals Charitable Foundation	839
Others	36
Total	**4,390**

15. Intangible non-current assets

15.1 Intangible non-current assets

2015-16 Cost or valuation:	IT - in-house and 3rd party software £000s	Computer licences £000s	Total £000s
At 1 April 2015	4,055	944	4,999
Additions - purchased	170	0	170
Additions - Purchases from cash donations and government grants	789	192	981
At 31 March 2016	5,014	1,136	6,150

Amortisation:			
At 1 April 2015	2,469	305	2,774
Charged during the year	364	177	541
At 31 March 2016	2,833	482	3,315
Net Book Value at 31 March 2016	2,181	654	2,835

Asset financing:			
Purchased	1,360	440	1,800
Donated	821	214	1,035
Total at 31 March 2016	2,181	654	2,835

15.2 Intangible non-current assets - prior year

2014-15	IT - in-house & 3rd party software £000s	Computer licences £000s	Total £000s
Cost or valuation:			
At 1 April 2014	2,640	704	3,344
Additions - purchased	1,395	209	1,604
Additions - donated	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

15.3 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). The carrying amount if assets had been held at historic cost would be £5,184k.

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 licences	5	5
Licences and trademarks	5	5

16.   Commitments

16.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016 £000s	31 March 2015 £000s
Property, plant and equipment	3,100	7,015
Intangible assets	766	268
Total	3,866	7,283

17. Inventories

	Drugs £000s	Consumables £000s	Energy £000s	Total £000s
Balance at 1 April 2015	7,215	10,002	267	17,484
Additions	163,165	100,598	18	263,781
Inventories recognised as an expense in the period	(163,992)	(100,624)	(110)	(264,726)
Balance at 31 March 2016	6,388	9,976	175	16,539

18.1 Trade and other receivables

	Curent		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS receivables - revenue	24,169	29,800	0	0
NHS prepayments and accrued income	438	4,079	0	0
Non-NHS receivables - revenue	7,930	12,678	0	0
Non-NHS receivables - capital	87	291	0	0
Non-NHS prepayments and accrued income	8,188	6,284	0	0
PDC Dividend prepaid to DH	590	205	0	0
Provision for the impairment of receivables	(2,896)	(2,744)	(804)	(654)
VAT	2,505	1,956	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	6,754	3,329	7,076	8,357
Other receivables	6,163	6,077	3,658	3,462
Total	53,928	61,955	9,930	11,165
Total current and non current	63,858	73,120		

There are no prepaid pension contributions included in NHS receivables.

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.

18.2 Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	2,738	5,881
By three to six months	797	264
By more than six months	1,710	499
Total	5,245	6,644

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.

18.3 Provision for impairment of receivables

	31 March 2016 £000s	31 March 2015 £000s
Balance at 1 April 2015	(3,398)	(2,285)
Amount written off during the year	657	288
Increase in receivables impaired	(959)	(1,401)
Balance at 31 March 2016	(3,700)	(3,398)

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.

19. Cash and cash equivalents

	31 March 2016 £000s	31 March 2015 £000s
Balance at 1 April 2015	3,298	23,236
Net change in year	64	(19,938)
Balance at 31 March 2016	3,362	3,298

Made up of:		
Cash with Government Banking Service	3,252	3,221
Commercial banks	92	60
Cash in hand	18	17
Cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows	3,362	3,298
Patients' money held by the Trust, not included above (note 34)	19	17

20. Non-current assets held for sale

	Plant & Machinery £000s
Balance at 1 April 2015	0
Plus assets classified as held for sale in the year	204
Less assets sold in the year	(204)
Balance at 31 March 2016	0
Liabilities associated with assets held for sale at 31 March 2016	0

	Plant & Machinery £000s
Balance at 1 April 2014	0
Plus assets classified as held for sale in the year	157
Less assets sold in the year	(157)
Balance at 31 March 2015	0
Liabilities associated with assets held for sale at 31 March 2015	0

During the year the Trust sold items of plant and minor equipment which had become surplus and obsolete. The sales resulted in a loss on disposal of £80k (Note 12).

21. Trade and other payables

	Curent		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000
NHS payables - revenue	2,573	3,534	0	0
NHS accruals and deferred income	2,911	2,978	0	0
Non-NHS payables - revenue	24,978	29,786	0	0
Non-NHS payables - capital	3,198	7,152	0	0
Non-NHS accruals and deferred income	23,731	24,523	2,188	2,109
Social security costs	5,806	5,626	0	0
Accrued interest on DH Loans	80	54	0	0
Tax	6,219	6,320	0	0
Other	9,176	9,496	0	0
Total	78,672	89,469	2,188	2,109
Total payables (current and non-current)	80,860	91,578		

Included above:				
Outstanding pension contributions at the year end	8,551	8,144		

22. Borrowings

	Curent		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Loans from Department of Health	4,812	4,927	82,442	44,715
PFI liabilities - Main liability	4,920	4,665	192,702	197,622
Finance lease liabilities	37	37	410	447
Total	9,769	9,629	275,554	242,784
Total other liabilities (current and non-current)	285,323	252,413		

Borrowings / Loans - repayment of principal falling due in: 31 March 2016	DH £000s	Other £000s	Total £000s
0 - 1 years	4,812	4,957	9,769
1 - 2 years	5,077	5,899	10,976
2 - 5 years	42,406	24,663	67,069
Over 5 years	34,959	162,550	197,509
Total	87,254	198,069	285,323

23. Deferred income

	Curent		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Opening balance at 1 April 2015	5,846	4,358	2,291	2,376
Deferred revenue addition	4,965	2,810	1,472	1,222
Transfer of deferred revenue	(3,880)	(1,322)	(1,575)	(1,307)
Current deferred Income at 31 March 2016	6,931	5,846	2,188	2,291
Total deferred income (current and non-current)	9,119	8,137		

24. 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 lease payments		Present value of minimum lease payments	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Within one year	45	45	37	37
Between one and five years	179	179	156	153
After five years	269	313	254	294
Less future finance charges	(46)	(53)		
Minimum lease payments / Present value of minimum lease payments	447	484	447	484

Included in:				
Current borrowings			37	37
Non-current borrowings			410	447
			447	484

25. Provisions

	Total £000s	Early departure costs £000s	Legal claims £000s	Other £000
Balance at 1 April 2015	7,971	5,957	423	1,591
Arising during the year	458	211	167	80
Utilised during the year	(1,808)	(358)	(250)	(1,200)
Reversed unused	(628)	(232)	0	(396)
Unwinding of discount	27	27	0	0
Change in discount rate	(14)	(14)	0	0
Balance at 31 March 2016	6,006	5,591	340	75

Expected timing of cash flows:				
No later than one year	775	360	340	75
Later than one year and not later than five years	1,440	1,440	0	0
Later than five years	3,791	3,791	0	0

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 (£258k in 2014/15) which are being handled on behalf of the Trust by the NHS Litigation Authority who have advised on their status. The value represents amounts which the Trust may bear as its share of any settlement. The balance of claims are being dealt with directly by the Trust as they represent settlement values likely to fall below the NHS Litigation Authority's excess level.

Other provisions include those for employment related claims where the Trust disputes liability but recognises some probability of payment. Provision was made in previous years to meet sums payable to staff as part of the Trust's transition arrangements following service restructuring. Those amounts have now been utilised.

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities: £000s				
As at 31 March 2016	337,256			
As at 31 March 2015	164,851			

The NHS Litigation Authority has advised that the increase in provisions they are carrying is the result of changes to actuarial factors and the discount rate applied to possible long term settlements.

26. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(122)**	(162)
Employment Tribunal and other employee related litigation	**0**	(9)
Other	**(1,083)**	(998)
Net value of contingent liabilities	**(1,205)**	(1,169)

NHS Litigation Authority contingent liabilities consist entirely of claims for personal injury 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" contingencies include £433k of personal injury claims. Those claims 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 assessment of the Trust's potential exposure in light of recent Employment Tribunal decisions which may have future implications for leave related pay. The assessment 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.

27. PFI - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts:

	2015-16 £000s	2014-15 £000s
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	**13,185**	14,911
Payments committed to in respect of off SoFP PFI and the service element of on SoFP PFI		
No later than one year	**10,444**	10,207
Later than one year, no later than five years	**44,262**	43,254
Later than five years	**169,777**	181,228
Total	**224,483**	234,689
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	**70,076**	67,774
Later than five years	**249,594**	267,521
Sub-total	**335,295**	350,920
Less: Interest element	**(137,673)**	(148,633)
Total	**197,622**	202,287
Present value imputed "finance lease" obligations for on SoFP PFI contracts due, analysed by when PFI payments are due		
No later than one year	**4,920**	4,665
Later than one year, no later than five years	**30,406**	26,754
Later than five years	**162,296**	170,868
Total	**197,622**	202,287
Number of on SoFP PFI Contracts		
Total number of on SoFP PFI contracts	**2**	2
Number of on SoFP PFI contracts which individually have a total commitments value in excess of £500m	**1**	1

28. Impact of IFRS treatment

The information below is required by the Department of Heath for budget reconciliation purposes:

	2015-16 Expenditure £000s	2014-15 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI)		
Depreciation charges	**4,531**	4,471
Interest expense	**10,961**	11,201
Impairment charge - AME	**0**	5,243
Other expenditure	**13,339**	14,911
Impact on PDC dividend payable	**(765)**	(765)
Total IFRS expenditure (IFRIC12)	**28,066**	35,061
Revenue consequences of PFI schemes under UK GAAP / ESA95 (net of any sublease revenue)	**30,946**	(31,550)
Net IFRS change (IFRIC12)	**(2,880)**	3,511

Capital consequences of IFRS : PFI and other items under IFRIC12		
Capital expenditure 2015-16	**836**	1,258
UK GAAP capital expenditure 2015-16 (Reversionary Interest)	**3,023**	**2,911**

29. Financial instruments

29.1 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 2016 are in receivables from customers, as disclosed in the trade and other receivables note (Note 18).

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.

29.2 Financial assets

	Loans and receivables £000s
Receivables - NHS	24,608
Receivables - non-NHS	8,776
Cash at bank and in hand	3,362
Total at 31 March 2016	**36,746**

Receivables - NHS	30,825
Receivables - non-NHS	16,873
Cash at bank and in hand	3,298
Total at 31 March 2015	50,996

29.3 Financial liabilities

	£000s
NHS payables	11,124
Non-NHS payables	48,512
Other borrowings	87,253
PFI & finance lease obligations	198,069
Total at 31 March 2016	**344,958**

NHS payables	12,128
Non-NHS payables	59,790
Other borrowings	49,642
PFI & finance lease obligations	202,771
Total at 31 March 2015	324,331

30. 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

31. 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. In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

	Expenditure with Related Party £000	Income from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
NHS Airedale, Wharfedale and Craven CCG	0	6,653	0	50
NHS Bradford Districts CCG	0	10,417	34	40
NHS Calderdale CCG	0	5,492	0	114
NHS Greater Huddersfield CCG	0	6,744	0	150
NHS Harrogate and Rural District CCG	0	6,585	0	31
NHS Leeds North CCG	0	84,774	566	459
NHS Leeds South And East CCG	0	138,016	927	835
NHS Leeds West CCG	0	154,789	923	775
NHS North Kirklees CCG	0	7,752	77	21
NHS Vale Of York CCG	0	8,636	21	97
NHS Wakefield CCG	0	15,182	93	42
NHS England	61	469,329	40	10,314
Department of Health	0	14,833	0	704
Leeds Community Healthcare NHS Trust	857	6,491	269	524
Mid Yorkshire Hospitals NHS Trust	1,562	3,550	260	1,661
Bradford Teaching Hospitals NHS Foundation Trust	1,112	8,262	387	2,058
Leeds And York Partnership NHS Foundation Trust	156	3,503	7	589
Sheffield Teaching Hospitals NHS Foundation Trust	122	7,274	23	133
University of Leeds	15,994	4,442	5	690
NHS Health Education England	24	71,076	24	170
NHS Litigation Authority	30,602	72	4	0
NHS Blood and Transplant	7,385	2,202	103	0

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, Dr 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 Group. During the year the Trust paid £112k to Town Centre Securities Plc Group for estates consultancy support and provision of car parking. The financial statements of the Charitable Foundation are published separately and can be obtained from:

www.leedshospitalsfundraising.org.uk/ index.php

Professor Paul Stewart, Non Executive Director, is Dean of the School of Medicine, University of Leeds. Caroline Johnstone, Non Executive Director and Chair of the Trust's Audit Committee is a Member of the Council of the University of Leeds and its audit committee.

The Trust's Director of Finance, Tony Whitfield is a Trustee of the Healthcare Financial Management Association. In 2015/16 the Trust made payments totalling £16k to the Association for corporate membership, training materials and attendance at training events.

32. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total value of cases £s	Total number of cases No.
Losses	695,120	465
Special payments	290,915	219
Total losses and special payments	986,035	684

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

Losses and Special payments relate to cases not specifically funded and which, ideally should not arise. They cover bad debts written off, losses from theft or accidental damage and claims for personal loss or injury which are not reimbursed from insurance arrangements.

33. 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 were set for those years.

33.1 Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	757,446	793,445	871,680	910,556	934,527	970,709	1,002,444	1,044,916	1,086,638	**1,115,720**
Retained surplus/ (deficit) for the year	355	3,093	471	(43,426)	5,799	2,829	1,498	496	(19,988)	**(27,231)**
Adjustment for:										
Impairments	0	0	0	42,075	(5,813)	0	0	0	(2,897)	**0**
Impact of policy change re donated/ government grants assets	0	0	0	0	0	0	353	150	(1,501)	**(2,963)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12	0	0	0	2,314	2,065	1,378	1,238	969	0	**0**
Break-even in-year position	355	3,093	471	963	2,051	4,207	3,089	1,615	(24,386)	**(30,194)**
Break-even cumulative position	304	3,397	3,868	4,831	6,882	11,089	14,178	15,793	(8,593)	**(38,787)**

* 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.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (i.e. is it equal to or less than 0.5%):										
Breakeven in-year position as a percentage of turnover	0.05	0.39	0.05	0.11	0.22	0.43	0.31	0.15	(2.24)	**(2.71)**
Breakeven cumulative position as a percentage of turnover	0.04	0.43	0.44	0.53	0.74	1.14	1.41	1.51	(0.79)	**(3.48)**

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.

Going Concern

In both 2015-16 and the prior year the Trust has reported deficits and required revenue support. The directors have been mindful of this in considering if it is appropriate to prepare the financial statements on the basis that the Trust is a going concern. In reaching their conclusion, directors have taken into account that in both years the deficits and support were planned as part of a longer term return to sustainable break even. In 2016-17 the Trust has a plan to deliver a surplus and no requirement for revenue support. The plan is backed by confirmed income agreements with our principal commissioners and in the event of circumstances changing and funding being required to meet immediate obligations an agreed working capital facility is in place. In light of these factors the directors have concluded that it is appropriate to prepare the financial statements on the basis that the Trust is a going concern.

33.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

33.3 External financing limit

The Trust is given an External Financing Limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External Financing Limit (EFL)	33,223	62,199
Cash flow financing	32,860	62,002
External financing requirement	32,860	62,002
Undershoot against External Financing Limit	363	197

33.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	28,075	42,341
Less: book value of assets disposed of	(204)	(157)
Less: capital grants	(3,515)	0
Less: donations towards the acquisition of non-current assets	(875)	(2,824)
Charge against the capital resource limit	23,481	39,360
Capital resource limit	23,759	40,819
Underspend against the capital resource limit	278	1,459

34. 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 19).

	31 March 2016 £000s	31 March 2015 £000s
Patient monies held by the Trust	19	17

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 devlop our hospitals 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:

Corporate Communications Team
Trust Headquarters
The Leeds Teaching Hospitals NHS Trust
Beckett Street
Leeds LS9 7TF