NHS
The Leeds Teaching Hospitals
NHS Trust

Annual Report and Accounts

2016/17

Incorporating the Annual Quality Account

Contents

Overview

This section introduces the work of Leeds Teaching Hospitals NHS Trust. It sets out the Trust's core vision and values and highlights some of our strategic developments and achievements over the 2016/17 financial year. It also summarises our performance over the year and the key risks we faced in achieving our vision to provide the best possible specialist and integrated care for patients in Leeds and the wider region.

Chair and Chief Executive's statement

We begin 2017/18 with real cause for optimism which stems not only from the significant progress we have continued to make as a Trust over the past year but also, the excellent news that this work was recognised by the Care Quality Commission (CQC) in its rating of us as a 'Good' Trust.

We want to start by saying thank you to all of our 17,000 dedicated staff who worked extremely hard to achieve this and for continuing to ensure that we provide the best possible care for our patients.

It has been a year of unprecedented demand on the NHS and LTHT has been no different. Our Emergency Departments (ED) struggled to see, treat, discharge or admit 95% of patients within the four hour target all year. A number of factors contributed to this, including high volume of patients, increased number of complex and very unwell patients, alongside staffing, capacity and the ability to discharge. There was an increase in the number of admissions made to hospital this year and this, alongside a high number of delayed transfers of care, meant that we experienced difficulties with patient flow through the organisation.

However, during 2016/17 we have continued to deliver against the five goals we have set out in our strategy and, more than ever, **The Leeds Way values - patient-centred, accountable, collaborative, fair and empowered** - continue to underpin every decision we make and every action we take for our patients.

Patient safety and high quality care

Ensuring our patients receive the safest and highest quality care is at the root of all our ambitions at the Trust and this is reflected in our recent 'Good' rating from the CQC and also in our feedback from patients through the Friends and Family Test, with more than 90% of patients recommending our hospital for care.

Our performance against national standards to deliver timely care reflects our determination to achieve the best for our patients. Since September 2016, for example, the Trust has achieved the standard that 99% of patients should wait less than six weeks for diagnostic tests. We've also seen significantly fewer cases of Clostridium Difficile than in 2015/16, from 139 to 115, which is testament to our commitment to harm-free patient care.

The increasing growth in demand experienced by the NHS nationally during the year made it difficult for us to consistently achieve against all of the national performance standards however. Winter was particularly busy with more than 97,000 people attending our EDs - an unprecedented number.

We took a number of significant actions, in addition to our already extensive capacity plans, to respond to this demand and improve the care we were providing for our patients.

These included:

- opening two new units at Wharfedale Hospital for older patients who have finished their acute care and are medically fit for

discharge but are waiting for an assessment or package of care from an alternative provider

- introducing GP streaming in EDs to treat people who need primary care support
- opening of a new discharge lounge to enable patients to get home quicker
- increasing ambulatory care provision to treat people appropriately and reduce the need for hospital admission

These projects were funded as part of the West Yorkshire Acceleration Zone work that we carried out in collaboration with provider trust partners across West Yorkshire and Harrogate and our commissioners. This innovative approach enabled us to achieve a 10% increase in the number of people being seen within four hours in ED in 2016/17 and we are continuing to review learning from this work to ensure we continue to improve our services. If we are to address the challenges facing the NHS and provide the best possible care for our patients we must continue to work with partners across Leeds and the wider West Yorkshire region.

A key challenge for us during the year was an IT failure in our Pathology system which caused delays in our pathology service. Despite the disruption, our staff worked tirelessly to restore the system and we collaborated with partners to keep them informed and ensure we continued to deliver safe services to our patients. The learning from this incident will enable us to put a number of improvements in place to offer patients the safest and highest quality service in the future.

Patient safety is of course paramount at the Trust, and our patient safety huddles – ward-based meetings on patient safety and care - continued to attract national attention and have contributed to real improvements on our wards. Our focus has been to spread the use of these huddles and they are now held by more than 80% of wards. This has contributed to a 17% reduction in patient falls and a 4% drop in pressure ulcers. Other targeted quality improvement initiatives have resulted in a Trust-wide decrease in cardiac arrest calls of over 25%.

Portering safety huddles, an initiative launched by the Trust's portering team in 2016, have also played an important role in improving patient safety. The huddles – the first of their kind in the UK – build on our porters' unique access to every ward or clinical area within the Trust, enabling the porters to highlight potential patient safety or wellbeing issues with colleagues so improvements can be made. The huddles have been very successful, winning Best Support Team at the Trust's Time to Shine awards in March 2017.

Staffing levels, and in particular nurse staffing levels, continue to be a priority for the Trust and thanks to an ongoing recruitment drive, 485 registered nurses, midwives and theatre practitioners were recruited last year. This is an impressive result that will make a huge contribution to patients' safety and welfare. Work continues to develop new and innovative roles to support the nursing workforce including the introduction of the Nursing Associate training programme with partners across Leeds and Bradford.

Improving the experience our patients have when visiting our hospitals is important for us and one of our aims during 2016 was to 'make it easier to hear the patient voice'. To do this, we held a 'Big Event' in November to encourage people to start a patient reference group that already has more than 30 members and has met three times. The group is working with us to develop a patient experience strategy: their support and that of many other advocacy groups and community forums is invaluable in helping the Trust to deliver the best possible patient care.

The Leeds Improvement Method

The Trust is one of only five in the UK to be working with the prestigious Virginia Mason Institute in Seattle on a five-year programme known in our hospitals as the Leeds Improvement Method (LIM).

The programme aims to advise and coach staff on how to make the best use of their skills, time, systems and resources to deliver the most efficient and effective care possible to our patients.

Now in its second year, the Leeds Improvement Method has achieved some really exciting results, including reducing the waiting time for orthopaedic surgery, improving theatre turnaround times and ensuring certain patients who have had prostate surgery are discharged more quickly and safely.

For more information on LIM, please see our recent animation clip explaining the programme in Leeds. You can find it at **www.leedsth.nhs.uk/about-us/the-leeds-way/the-leeds-improvement-method**

Embedding this culture of continuous improvement into our daily work at the Trust is central to our ambition to become the best hospital trust for patient safety and care in the UK. To support this and ensure we spread a culture of improvement, we have declared 2017 a Year of Improvement. In March 2017 we held an event with 600 front line staff to share skills around 'waste walks' and '5 S' techniques and encouraged them to pledge to make small improvements in their areas using these. By taking this learning back to their teams and making continuous small improvements to the way we do things, we become more efficient and use our resources in the most effective way for our patients.

Best place to work

Our staff are the lifeblood of the Trust. Their expertise, motivation and compassion drive our ambition to deliver the very best treatment and care to every patient, every time.

We are incredibly proud to have some of the leading experts in their fields working at the Trust. They are pioneering treatment and research and receive the very highest accolades in their professions, including national and international recognition.

As the values of The Leeds Way become embedded in everyday working life at the Trust and we continue to make tangible progress in patient treatment and care, our hospitals are vibrant and rewarding places to work.

This is increasingly reflected in the results of the NHS Staff Survey which once again showed significant improvement in staff satisfaction in 2016. For the second year running, we had the highest number of staff who completed the survey and we were one of the top performing trusts nationally for appraisals. For the first time in 2016/17, we saw the majority of our scores move into the average, better than average and best categories with improvements in 21 of the 32 key findings and six of these now in the top 20% of acute trusts. Our overall score on staff engagement – a measure of staff advocacy, motivation and ability to contribute to improvements – is above the national average and continues to move in the right direction.

These are fantastic improvements which show how a good working environment can make a real impact on staff wellbeing, and in turn, on the quality of our patient care.

The Leeds Way is about valuing and recognising our staff so in March 2017 we were delighted to host our second Time to Shine staff awards attended by more than 600 people celebrating exceptional work and contribution. We also held two events to recognise long-serving staff members and our first event for around 400 volunteers who generously give their time to help us improve the hospital experience for our patients.

Our volunteer Get Me Better Champions, who are an integral part of the Learning Disabilities team and enable our staff to adjust their practices and care so it best meets the needs of patients with learning disabilities, were awarded the Yorkshire Evening Post's Healthcare Team of the Year in December 2016.

Specialist services, research, education and innovation

Supporting ground-breaking research is an organisational priority for our Trust. We are a world-leader in clinical research and innovation working closely with the University of Leeds and other key partners to improve the way we care for patients and improve outcomes.

In 2016/17, we recruited more than 12,000 participants to 477 research studies as part of National Institute for Health Research (NIHR) programmes, making us one of the best performing hospital trusts in England for the number of trials and the top performing in the country for the number of complex studies undertaken.

Last year we took significant steps towards expanding our ambitions with the construction of a new £1.2 million Research and Innovation Centre at St James's. We also approved the development of a new £3 million, 18-bed, state-of-the-art early phase Clinical Research Facility based in Bexley Wing at St. James's, increasing our capacity for research into new treatments and medical technologies. Both the Research and Innovation Centre and the new Clinical Research Facility are flagship developments that will promote collaborative working with our partners, enhance our research profile and ultimately benefit patient care.

We were also delighted to be awarded a £5.2 million grant from our partners Yorkshire Cancer Research to enable us to run the largest trial in the UK assessing the effectiveness of lung cancer screening. The trial begins next year and will make a significant contribution to the early detection of lung cancer.

There are many more research successes and you can read about them on page 35.

During the year our specialist services continued to expand the horizons of what can be achieved for patients.

Shortly after NHS England announced that we were to be the national centre for hand and limb transplantation, Professor Simon Kay and his team carried out the UK's first double hand transplant. This was an amazing achievement and one that has transformed the life of the recipient Chris King.

In July 2016 we were delighted that NHS England named us as one of the centres that would continue to provide adult and children's Congenital Heart Disease services. This welcome news ended a difficult period of uncertainty for staff and patients in Leeds and recognised our ability and commitment to meet challenging new standards.

Our programme of education across the Trust went from strength to strength during the year, which is vitally important to the future of the Trust and the services we provide. In partnership with the University of Leeds and Leeds Beckett University, we deliver one of the largest medical education programmes in the NHS for more than 2,000 trainee doctors and medical students. Added to this, around 900 nursing, midwifery and allied health practitioner students complete clinical placements with the Trust and last year, we were joined by nearly 400 apprentices across all disciplines. We were named Employer of the Year for Apprenticeships in Yorkshire and Humber and National Employer of the Year by the Learning and Work Institute, which is great news.

We are one of nine Excellence Centres in a national network overseen by the National Skills Academy for Health. A partnership between our Trust and the Bradford District Care Trust, the West Yorkshire Excellence Centre will act as a regional hub for healthcare employers to work with education and training providers to ensure workers in healthcare support roles have access to good quality training in a planned and sustainable way. This is a fantastic initiative that links closely with the West Yorkshire and Harrogate Sustainability and Transformation Plan to provide an integrated workforce with the skills to deliver the highest quality care for people in the region.

Working with partners to deliver seamless and integrated care

The past year has seen us consolidate our already strong relationships with commissioners, and health, social care, research and voluntary sector partners, locally, regionally and at national level.

At a regional level, Sustainability and Transformation Partnerships (STP) which aim to support the delivery of the 'triple challenge' (better health, transformed equality of care delivery and sustainable finances) as set out in NHS England's ambitious Five Year Forward view, led to a partnership across West Yorkshire and Harrogate health and social care organisations.

In November 2016, the West Yorkshire and Harrogate STP published its draft plans for how local and regional services can be improved and how the health, social care and voluntary sectors should work together to make positive change. These plans are helpful to bring together the work across the six 'place' based plans but are by no means set in stone, and the views of health and care staff, people accessing services and the wider public will be sought to help shape them as they progress.

During 2016/17 we made significant progress through our work as part of the West Yorkshire Association of Acute Trusts (WYAAT) including agreed governance arrangements to ensure more streamlined decision making processes across the partnership. WYAAT is an innovative collaboration between the acute trusts across West Yorkshire and Harrogate which enables hospitals to work in partnership to give patients better access to services, facilities and appropriate experts. We have a number of work streams, which we are taking forward to see how we can work smarter and improve how we deliver services for people across West Yorkshire and Harrogate. WYAAT is responsible for taking forward the hospital and acute care development work of the West Yorkshire and Harrogate STP.

Locally we are working closely with partners to achieve seamless, integrated care across the Leeds health economy and during the year, we made great strides in moving closer to realising this vision. The Leeds Integrated Discharge Service, our excellent collaboration with local health, social care and third sector organisations is one example and was launched to improve discharge processes for our patients in the city.

As a key partner in the 100,000 Genomes Project, we're making huge advances in healthcare in the Yorkshire and Humber region. This groundbreaking initiative aims to decode the DNA sequences of 100,000 genomes from people who have a rare disease or condition, or certain cancers. We are working with Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's NHS Foundation Trust as part of the Yorkshire & Humber NHS Genomic Medicine Centre which has recently recruited its 1,000th patient to the project. This is a far-reaching research and innovation programme that also involves all 22 NHS health trusts in the region, supported by the Yorkshire and Humber Academic Health Science Network.

During the year, our expertise in medical training and cancer continued to attract international interest and has enabled us to develop fruitful partnerships with the Ministry of Health in Malta and the King Hussein Cancer Center in Jordan. These partnerships focus on training, the commissioning and installation of specialist equipment and service provision. We are also working with the Department of International Trade, through Healthcare UK and other professional contacts, and exploring opportunities for collaborations in countries like China and India where the demand for health services is growing. Partnerships like these promote our expertise globally, enable us to share our learning and bring economic benefits to the Trust.

Financial sustainability

As a Trust we are achieving the very best for patients in the context of a difficult financial environment. We ended the financial year with a small deficit of £1.9 million, a significant step

towards realising our plan for a sustainable financial surplus. This was in part the result of a £24.7 million award from the national Sustainability and Transformation Fund scheme, a joint initiative between NHS Improvement and NHS England, in return for meeting agreed financial and performance targets.

Thanks to the hard work of our staff, the Trust made £61 million in savings last year, without compromising patient care or safety. Our culture of continuous improvement is the key to bringing about lasting and sustainable change to the way we work, make best use of our resources and achieve long-term financial balance. Our work on the Leeds Improvement Method has started to make an impact across the Trust, as more teams begin to embrace the challenge of working more efficiently - refining our processes to reduce waste, improve benefits for patients, and along the way, save costs. Next year, we aim to be £9 million in surplus.

Building The Leeds Way

This year saw us make some real progress on our ambitious plans to redevelop the Leeds General Infirmary (LGI) site with a new healthcare building and the remodelling of the Leeds Children's Hospital. In October, we were honoured to be able to exclusively unveil our plans at a private viewing for HRH The Countess of Wessex, the Royal Patron of Leeds Children's Hospital and other guests. Following this, in January 2017, we submitted the strategic outline case to NHS Improvement and we expect to receive feedback later in the year.

The Building The Leeds Way plans will enable us to build on the progress we have already made in making the best possible use of our estate, and ensure that the facilities from which we provide our services truly reflect the world-class treatment and care our teams offer. The development supports the direction of travel of the West Yorkshire and Harrogate STP and will enable us to fully realise our full clinical services strategy.

The development on the LGI site will also play a pivotal role in the city's new Innovation District which is an exciting transformation of the area of Leeds bordered by LGI, the University of Leeds, Leeds Beckett University and Leeds Civic Hall. It offers us significant opportunities to work together to attract investment and drive forward change in infrastructure, education and healthcare that will have an impact far beyond the city.

All of this is only possible if we work closely with our partners, staff and patients and the public. We are continuing to develop the plans and later in the year we expect to be engaging more with patients and the public on this development as it progresses.

Collaborative working

Working collaboratively is one of The Leeds Way values and runs through the way we work at all levels.

During the year we have worked more closely than ever with our commissioners and health and social care partners locally and regionally to ensure that we are delivering the best possible services for the people of Leeds and beyond. We are also a member of the Health and Wellbeing Board for Leeds, making a valuable contribution to the future of health and wellbeing in Leeds.

We have continued to work closely with members of the Adult Social Care, Public Health and NHS Scrutiny Board ensuring that they are informed of the developments and decisions we are taking at the Trust and the challenges we face.

We work closely with our Charitable Foundation, The Leeds Hospital Charitable Foundation, and are extremely grateful for the support they provide. During the last year they have raised thousands of pounds to improve the environment for our patients, fund leading-edge research and buy new equipment.

In the past financial year, around £5 million was spent on charitable funding across the Trust, including funding the annual Nursing,

Midwifery and Allied Health Professionals conference and the Leeds Children's Hospital's exciting and unique initiative, Children's Hospital TV. During the year, we were awarded £950,000 over five years for a digital pathology development that will enable us to transform pathology reporting in the future and our charitable trustees also agreed in principle to provide £3.5 million funding for a new hybrid theatre – a combined theatre and radiology suite - at the LGI. This is a fantastic donation for an important clinical facility that will increase our capacity for plastic surgery, spinal surgery and neurosurgery. You can read about the work of the Charitable Foundation on page 100.

Working closely with members of the public and patients is important to us and over the year our membership of people who want to be involved in the development of our Trust has grown to more than 26,000. Feedback from our members in the past year has helped us to make changes to our services in a number of areas, including Theatres and Anaesthetics, improving Outpatient discharge letters and the rebranding of the Leeds Cancer Centre.

Our members' magazine, Connect, keeps members and other stakeholders informed of our work on a bi-annual basis and we also run an exclusive programme of Medicine for Members events on a wide range of topics, from genomic research to Osteoarthritis.

Finally, we would like to end with a few words written by a young oncology patient to our staff on ward J94. Thanking them, the youngster writes: "The positives I have gained far outweigh the negatives thanks to your characters, enthusiasm, patience and professionalism."

Such praise for our staff is wonderful, and common. The Trust has 17,177 staff and around 400 volunteers - over 17,500 reasons to be very proud of the work we do. On behalf of the Board, we would like to thank them all.

Linda Pollard *CBE DL Hon.DLL*
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
- 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 ED, outpatients, inpatients, maternity and older people services;
- highly specialised services for the population of Leeds, Yorkshire and the Humber, nationally and beyond.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our vision and values

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

Our vision is to be the best for specialist and integrated care.

To achieve this vision, we have developed a new strategy for the Trust for the next five years. 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 and is described below.

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


Patient-centred

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


Fair

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


Collaborative

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


Accountable

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


Empowered

Highlights of the year

This has been a fantastic year for the Trust, reflecting the exceptional achievements of our staff and their continued commitment to the best possible patient care. Below is just a small selection of the hundreds of successes for our hospitals this year – from UK firsts and groundbreaking research to the latest technologies and advancements in care. You can read more about our work on the Trust website, **www.leedsth.nhs.uk**, or by following us on Facebook and Twitter.

April 2016

We recruited our first patient to the 100,000 genomes project through the Yorkshire & Humber NHS Genomic Medicine Centre (GMC).

This is a collaboration between Leeds Teaching Hospitals, Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's Hospital NHS Foundation Trust. It also involves all 22 NHS health trusts in the region and is supported by the Yorkshire and Humber Academic Science Network.

The 100,000 Genomes Project aims to decode the DNA sequences of 100,000 genomes from people who have a rare disease or condition and people with certain cancers.

We made WiFi available free to access for patients and staff at our hospitals.

For the first year, access has been generously funded by the Trust Charitable Foundation. Our IT team worked with suppliers, Hospedia, to set up a system that ensures total security for the Trust network. We have received great feedback about the WiFi which has improved the experience of our patients and visitors.

May 2016

Leeds Cancer Centre cemented its position at the forefront of cancer treatment in the UK and Europe, thanks to an exciting, multi-million pound investment to renew its radiotherapy equipment.

Over the next four years, existing equipment will be replaced systematically with eight state-of-the-art linear accelerators. The centre was the first to use high-dose radiotherapy techniques using Elekta Versa HD Linac technology, which our teams co-developed with the manufacturer. The new machines mean our patients will continue to benefit from world-class cancer treatment and care.

The Day Treatment Unit at Wharfedale Hospital in Otley expanded its range of services in response to patient feedback.

The new service is tailored specifically to local patients' needs and provides treatment for various disorders.

This also allows beds to be released elsewhere in the Trust and streamlines the process at Wharfedale Hospital, with patients referred directly from Outpatient clinics.

The Trust was delighted to be awarded the CHKS Top Hospitals 2016 excellence in delivering 24/7 emergency care award, by providing an available and accessible service for patients outside of normal working hours.

The team was given the title after evaluation of the Emergency Departments at Leeds General Infirmary and St James's University Hospital.

Leeds Children's Hospital (LCH) scored a UK-first with the launch of a brilliant new initiative, Children's Hospital TV. The first service of its kind in the UK, LCHTV is aimed at children, young people and their families and provides an insight into the wards and departments at LCH and what it is like to be a patient there.

Short films made in conjunction with ward staff and sometimes by young people and their families share accessible, friendly information to help children and families staying in hospital.

Funded by the Leeds Children's Hospital Appeal, LCHTV is built on expertise already in place through JTV Cancer Support, a service aimed at young people with cancer nationwide. The LCH team have been awarded a Nursing Times award for their work on the project.

The neonatal unit at St James's celebrated one year of its Family Integrated Care programme, which is the first of its kind in the country.

The programme encourages and empowers parents to take control of their baby's care whilst on the neonatal unit. This has led to an increase in earlier discharge, fewer infections and better breastfeeding rates. As a result of the programme, parents go home feeling far more confident in being able to care for their baby.

June 2016

Rachel Westcott and Amy Cawthorne, two of our Advanced Nurse Practitioners (ANP) in the Emergency Departments, achieved national accreditation from the Royal College of Emergency Medicine (RCEM).

Amy and Rachel are two of only three ANPs in the country to have been recognised in this way as this is the first time the RCEM have accredited nurses. We have a growing number of trainee ANPs across the Trust and the RCEM accreditation will help us to further improve the quality of the emergency care we provide.

We welcomed the Chairman of NHS England, Sir Malcolm Grant, to the Trust.

We shared our exciting plans to transform healthcare in Leeds and Sir Malcolm was able to visit our Major Trauma Centre, starting with a trip to the helipad, to demonstrate the careful design and planning of new services. Later he visited Bexley Wing at St James's where he was given an overview of our Genomics work followed by a visit to the Haematological Malignancy Diagnostic Service.

We hosted our first conference for Trust support staff, organised by the Organisational Learning Talent for Care team and attended by more than 200 staff working in Band 1 – 4 roles.

The day promoted the training and development opportunities available and ended with an awards ceremony, congratulating support staff for their contributions to collaborative working, improving patient experience and outstanding achievement.

July 2016

The UK's first double hand transplant was successfully performed at Leeds General Infirmary by Professor Simon Kay and his team.

Chris King is only the second person in the country to have a hand transplant, following on from the single hand procedure also carried out at the LGI in 2012 on Mark Cahill.

Mr King is the first person to have undergone the groundbreaking procedure since NHS England awarded the contract to the Trust to become the UK's specialist centre for hand transplants.

NHS England named Leeds Teaching Hospitals as one of 10 centres nationally that would continue to provide adult and children's Congenital Heart Disease services.

This was very welcome news that ended a difficult period of uncertainty for staff and patients in Leeds and recognised our ability and commitment to meet challenging new standards.

August 2016

Our physiotherapy team staged a flashmob in Bexley Wing, St James's which went viral on Facebook.

Joined by their Adult Therapy colleagues, the team danced to the Macarena watched by a crowd of staff and patients. This was part of the 'Workout at Work' campaign that our physiotherapists were promoting across the Trust to encourage people to add a bit more exercise into their working lives, including walking meetings and exercise classes.

The West Yorkshire Excellence Centre, a partnership between Leeds Teaching Hospitals and Bradford District Care NHS Foundation Trust was launched to improve the training and skills of healthcare support workers across the West Yorkshire region.

The initiative brings together the resources and expertise of the two NHS trusts to enable staff in a variety of healthcare settings to access high-quality training and opportunities to develop in their roles.

It is one of nine in a national network run by the National Skills Academy for Health and the first in the North, acting as a hub in the West Yorkshire region for healthcare employers.

September 2016

The Leeds Musculoskeletal Biomedical Research Unit (LMBRU), based at Chapel Allerton Hospital, was awarded nearly £7 million as part of a record package of research funding from the government.

This funding will enable future research focusing on preventing inflammatory disease such as inflammatory arthritis, and optimising therapy for osteoarthritis.

The success of the LMBRU demonstrates our strong partnership with the University of Leeds and this new funding will allow us to continue working together to really drive musculoskeletal research on a national and international scale.

The Care Quality Commission (CQC) rated the Trust as 'Good' following an inspection in May. The CQC confirmed that significant improvements had been made since their last inspection in 2014, which is an excellent endorsement of The Leeds Way values and our staff's tireless work to deliver the best patient care.

October 2016

We welcomed the Royal Patron of the Leeds Children's Hospital, HRH The Countess of Wessex, who met members of the hospital's Youth Forum and officially opened their new, dedicated meeting space and activity centre The Place 2be @LTHT.

The facility is a dedicated space for teenagers to give them a meeting place and activity centre away from the wards. This was one of the top priorities Youth Forum members identified at their inaugural meeting two years ago.

The new Leeds Integrated Discharge Service (LIDS), a collaboration between the Trust, Leeds Community Health (LCH) and Leeds City Council was launched to improve discharge processes in the city.

The service brings together a range of professionals from across the city to better manage discharge processes in Emergency Departments, Medical Assessment Units and Medical Inpatient Units. It aims to ensure patients are treated in the right place at the right time and is a huge step forward in the Trust's vision to be the best for integrated care.

November 2016

A new purpose-built gynaecology ambulatory unit opened in St James's.

The move has created a new, modern setting for gynaecology outpatient procedures, helping us to improve the experience of women visiting our service by delivering one stop shop style clinics with assessment and treatment in the same area.

We were very pleased to receive £1.85 million from the Treasury's LIBOR fund to help with the cost of a new advanced brain and spine scanner for young patients at Leeds Children's Hospital.

We are thankful to Edward Ziff, Chairman of our Charitable Foundation, for securing the funding, which the Foundation has generously pledged to match. The children's 3T intraoperative MRI (Magnetic Resonance Imaging) suite will complement the existing children's neurosciences service and will be a major step forward in treating a number of conditions, including brain tumours.

December 2016

From campfires to crafting, it's all possible at the first Leeds Children's Hospital Guide and Scout unit, which was launched in Clarendon Wing.

This is a joint venture between Leeds Children's Hospital, Central Yorkshire Scouts and Girlguiding Leeds. Volunteers, along with members of the nursing team organise fun and adventure for any young patient and their siblings during their time in hospital.

We teamed up with local NHS organisations, Leeds City Council and partner organisations to develop the Leeds 'Stay Well This Winter' campaign.

It was aimed at helping people stay well over the winter months and reducing pressures on hospitals and ambulances in Leeds. A series of short films for social media were produced by our Medical Illustration team featuring NHS and council professionals, offering details and advice to help people get ready for winter and look out for those who are unwell.

The Trust's Get Me Better Champions and Learning Disabilities team were named the 'Healthcare Team of the Year' by the Yorkshire Evening Post.

This is an outstanding achievement recognising the team's hard work and commitment to raising awareness across the Trust of the needs of people with learning disabilities and how staff can adjust their practices to ensure they receive the highest standard of healthcare.

January 2017

The Trust was awarded £5.2 million funding by Yorkshire Cancer Research to run the largest trial in the UK assessing the effectiveness of lung cancer screening.

Lung cancer is the second most common cancer in Yorkshire, with around 4,500 people diagnosed every year. The four-year trial will take mobile screening vans to communities around the Leeds area. It could lead to 289 cancers being diagnosed and results from the trial could be used to plan a national programme.

The Bilberry Unit opened at Wharfedale hospital, a partnership with local home care provider Villa Care Group. A second unit, Heather Unit, opened in March. The units were initially funded for a period of six months and have been a success, reducing pressure on acute beds at St James's and the LGI and improving patient flow through the Trust.

The venture was funded by the West Yorkshire Acceleration Zone, which aims to improve hospital care in the region, working together with local CCGs and NHS Improvement.

The Trust welcomed Lord Carter of Coles, Non-Executive Director of NHS Improvement, to visit our teams and learn more about the improvement work being carried out across the Trust.

Our staff were able to show him progress in a number of areas, including procurement and e-rostering and our work with the Virginia Mason Institute on the Leeds Improvement Method (LIM). We have already seen outstanding results in the clinical areas that are working on LIM and we are very pleased to have Lord Coles's support.

February 2017

The latest Trauma Audit and Research Network figures showed that the Leeds Major Trauma Centre is the second busiest in the UK and joint second for patient outcomes.

Since April 2013, all adults and children from the region who need major trauma care are treated at the centre, and this ranking is testament to the dedication showed by the team to provide the best care for patients with life-threatening multiple injuries.

Our Transplant Immunology and Translational Genomics teams gained European Federation for Immunogenetics accreditation for their Next Generation Sequencing (NGS) service.

The service was noted in particular for validation and verification and its implementation into a clinical setting.

The team is one of only three services in Europe to hold this level of accreditation for NGS.

March 2017

We held our second Time to Shine Awards and received hundreds of nominations for staff across our seven hospitals.

The event celebrated the brilliant achievements of staff and was an opportunity to thank everyone involved. A special award named in memory of the late Dr Kate Granger, whose #hellomynameis campaign celebrated compassionate care was presented by her husband Chris Pointon to the Breast Care Unit Team for making a positive difference to patient experience.

British Cycling's head sprint coach Justin Grace visited the Trust to meet his consultants Mr Steven Pollard and Dr Mark Aldersley and thank the Trust transplant team following his successful liver transplant.

Justin was back on his bike just four months after the transplant and made an emotional appeal for organ donors after speaking about his donor for the first time. He coached Team GB cyclists to seven medals at the Olympic Games in Rio, and also announced that he will be participating in the Transplant Games with ambitions to represent Leeds, Yorkshire and the UK in future events.

Key risks to delivering services in 2016/17

In 2016/17, we identified a number of key risks that could affect the delivery of our services. These are outlined below:

- Achievement of national performance standards, including the Emergency Care standard, cancer waiting times, cancelled operations not rebooked within 28 days and the 18-week Referral to Treatment target.
- Financial issues around ensuring we were paid appropriately for the activity we deliver, and rigorous monitoring of costs so that our improvement plans to increase our efficiency and reduce wasteful practices could be delivered without compromising patient safety.
- Difficulties in meeting standards of safety and quality in our nurse and medical staffing levels, reduction of MRSA and C.difficile, failure to rescue a deteriorating patient.
- Challenges in managing the demand for health and care services with capacity to deliver, both at the Trust and more widely. In our hospitals, this has had an impact on patient flow and timely discharge.
- Ensuring we have the best systems in place to protect our staff from violence and to support them when it occurs.
- Dealing with infrastructure issues, including problems with IT systems, corroded heating pipes and power failures, and making sure these did not affect the quality of our patient care.
- The need to address the importance of 'out of hospital care' in the West Yorkshire and Harrogate Sustainability and Transformation Plan, so people do not need to be treated in hospital if their needs could be better met in the community.

The Trust's risk register is reviewed regularly by our Board and senior leaders as part of our governance processes. Further information on our risks and our monitoring and reporting of them can be found in the Annual Governance Statement, on page 59.

Section 1
Operating and Financial Review

Operating and Financial Review

1.1 Achieving quality, efficiency and financial sustainability

An important part of our approach in 2017 will be to build closer links with colleagues in our partner agencies. Elderly people, for example, often need support from social services and GP teams, as well as hospital care. Similarly, patients from further afield may be able to convalesce from specialist procedures in their local hospital. Improved care planning often means that patients have a better experience and resources are not wasted or duplicated.

To achieve this, we will continue to build on The Leeds Way values and the Leeds Improvement Method, engaging with NHS staff across Leeds and West Yorkshire in a culture of continuous improvement. Some of our priorities for next year are outlined below:

Trust goal: To be the best for patient safety, quality and experience

We will implement our Quality Improvement Strategy which, for 2017, includes falls prevention, the care of deteriorating patients, ward-led safety huddles, acute kidney injury, pressure ulcer prevention, sepsis, Parkinson's disease, end of life care and improving patient experience. Further work will also take place on providing services for our patients seven days a week.

Trust goal: To be the best place to work

We will invest in our staff to enable them to achieve the continuous quality improvement described above. There will be an ongoing review of roles and skill mix, and a focus on attracting and retaining key nursing and medical staff. This will include working with health and social care colleagues in Leeds and West Yorkshire to make the best use of our collective resources.

Trust goal: To be a centre of excellence for specialist services, research and innovation

We will work with the West Yorkshire Association of Acute Trusts to develop centres of excellence, service partnerships, standard patient pathways and the sharing of support services.

We will also work closely with Leeds Medical School and the city's universities to provide high quality education and skills training for staff, open a new research and innovation centre at St James's, and progress the plans for improving the Leeds General Infirmary site, including the Leeds Children's Hospital.

Trust goal: To offer seamless, integrated care

We will work with health and social care partners in Leeds to ensure patients have safe and appropriate care facilities available when they are medically fit to leave hospital. We will also seek to collaborate with local partners to provide alternatives to ED for patients who do not need hospital care. There are some specialties, such as paediatric surgery, endoscopy, spinal surgery and dental specialties, which are in particularly high demand and we will have further discussions with our commissioners on managing this workload.

Trust goal: To be financially sustainable

We will collaborate with agencies in Leeds and West Yorkshire to use our collective resources wisely and ensure patients are directed to care that best meets their needs. We will also engage with staff to improve our efficiency, reduce waste and agree a sustainable financial plan with our commissioners and regulators.

1.2 Our performance

In 2016/17, the Trust saw and treated 1,126,568 outpatients, 117,885 inpatients, 108,112 day case patients and 263,564 patients attending 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.

The Trust's performance is assessed externally against a range of national targets and standards. Last year, the increased numbers of acutely unwell patients who needed to be admitted to our care and the impact this had on our capacity to undertake planned patient operations presented difficulties for the Trust.

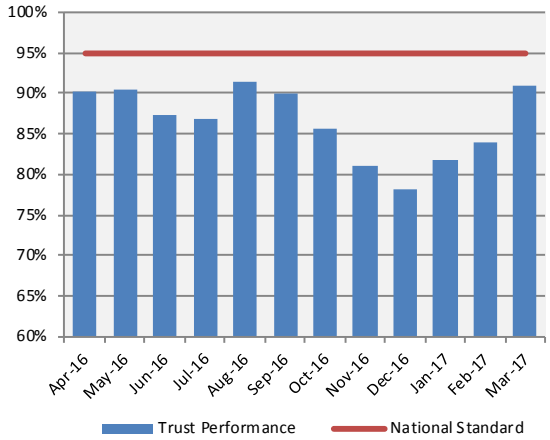
We faced challenges as we strived to balance the provision of the care we provide to our patients alongside dealing with an increasing workload and achieving demanding efficiency savings and financial sustainability.

Despite this, 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 ED



In 2016/17, our performance in our Emergency Departments remained below the 95% standard all year. ED struggled to see, treat, discharge or admit 95% of patients within four hours and we finished the year with an ECS of 86.51%.

A number of factors, including high volume of patients, increased number of complex and very unwell patients, alongside staffing, capacity and the ability to discharge patients in a timely manner continued to have a significant impact on our ECS.

During 2016/17 we agreed a performance improvement plan with NHS Improvement (NHSI), where we agreed to achieve 90% performance for March 2017, which we exceeded at 90.89%.

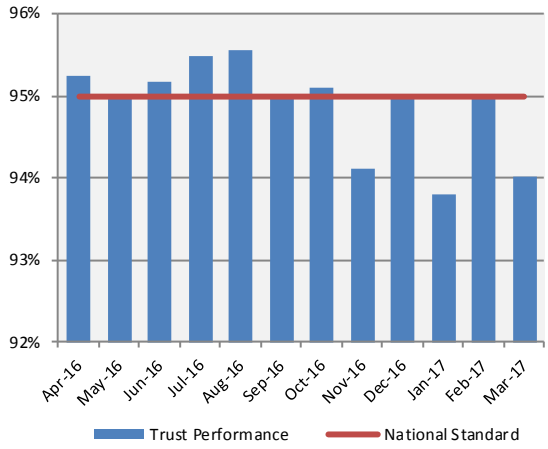
Teams across the Trust have continued to provide high-quality care to our patients during this period of increased demand. The dedication of our people as well as our ongoing approach to improving systems and procedures internally so that we can address concerns has ensured that we have maintained patient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

We will continue to refine our internal approach and work with commissioners and partners to build on our progress throughout 2017/18.

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



We saw some positive improvements in the number of falls and pressure ulcers happening in the Trust. This work has led to a 17% reduction in patient falls and a 4% drop in pressure ulcers during this year.

Trust wide we have seen a significant step reduction in cardiac arrests of 25%. We have 25% fewer cardiac arrests at LTHT than the national average. Our team has been asked to present at patient safety conferences so that other Trusts can learn from Leeds.

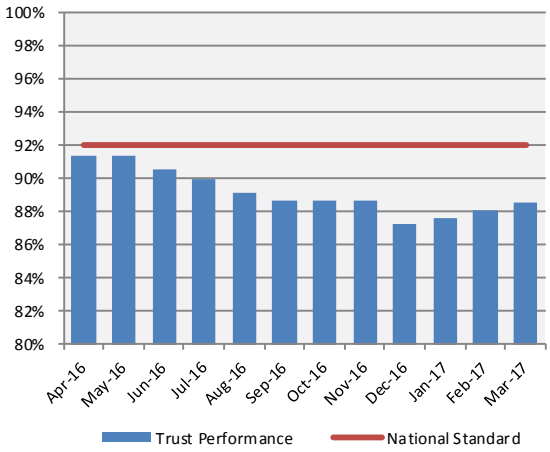
Our goal is to provide harm-free care to every one of our patients. This year, 94.9% of our patients received harm-free care and this has been largely sustained throughout 2016/17. Our priority for 2017/18 is to continue achieving this level of harm-free care in a more sustained way and identify areas for further improvement.

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.

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

Percentage of patients on incomplete pathways waiting over 18 weeks



The Trust achieved this standard in 2015/16, however during 2016/17 this has been affected by:

- the continued rises in demand across our elective specialties in key areas such as restorative dentistry, ENT, children's surgery and spines
- the volume of ED and acute admissions across our hospitals throughout 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

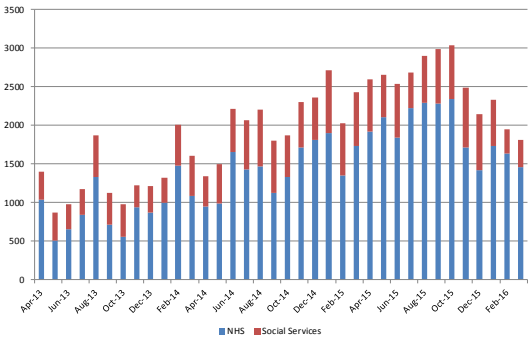
We have revised our plans to restore our performance to the Incomplete 18-week RTT standard in 2017/18. These are detailed in the section, ***Factors likely to affect performance in 2017/18.***

Delayed Transfers of Care (DTOC) - lost bed days

A DTOC is when a patient is ready to be discharged from hospital but is still occupying a bed. This could be due to a number of factors, including there not being suitable plans in place for their care following discharge.

This chart shows the number of lost bed days by delay source.

Delayed Transfers of Care (DTOC) - lost bed days



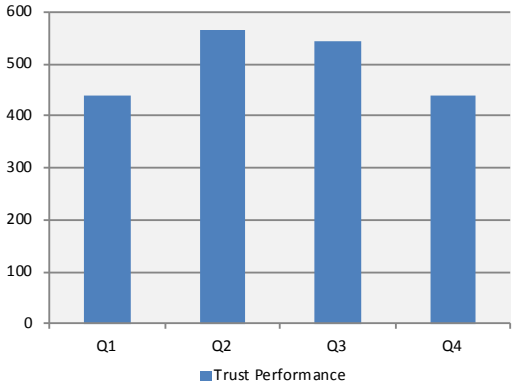
We have seen a high number of DTOCs throughout the year which have contributed to problems with patient flow through our hospitals. We continue to work with our health and social care partners across Leeds and further afield to ensure that a patient can be safely discharged from hospital as soon as they are well enough. To support that work further at the Trust we have undertaken a number of projects, which include:

- the opening of a new discharge lounge facility
- introduction of the integrated discharge team and the discharge to assess model
- the opening of the Bilberry and Heather step down facilities at Wharfedale in conjunction with Villa Care

Cancelled operations

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

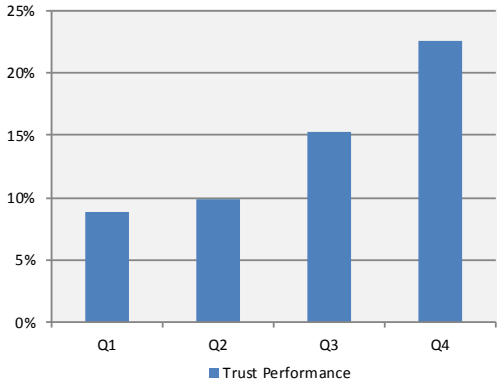
Number of last-minute cancelled operations



We recognise that last-minute cancelled operations are a distressing experience for patients and we worked hard to reduce the number of these during 2015/16. In 2016/17 however, this progress was significantly affected by the volume of acutely unwell patients in our beds leading to cancellations of planned operations.

When patients' operations are cancelled at the last minute there is a requirement to offer them a new date within 28 days. During 2016/17 the good progress made in 2015/16 was not sustained and so we will again focus on achieving better results in 2017/18.

Percentage of patients not treated within 28 days of cancellation

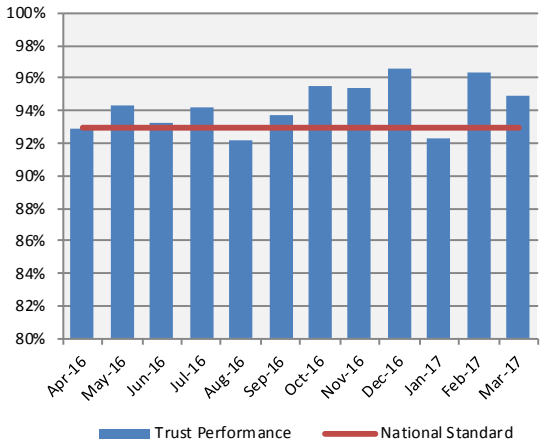


Cancer waiting times

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 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 on a two-week wait and receive a diagnosis of cancer are treated within 62 days of the date of receipt of the referral.

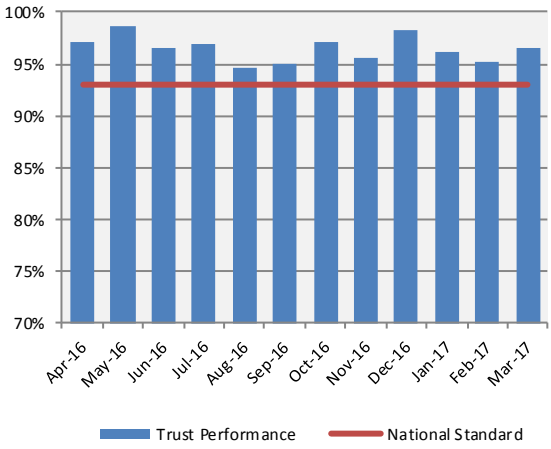
All subsequent treatments (surgery, radiotherapy, drug therapy or palliative care) must be delivered within 31 days of the decision to treat being agreed with the patient.

Cancer access target: urgent GP referrals seen within 2 weeks



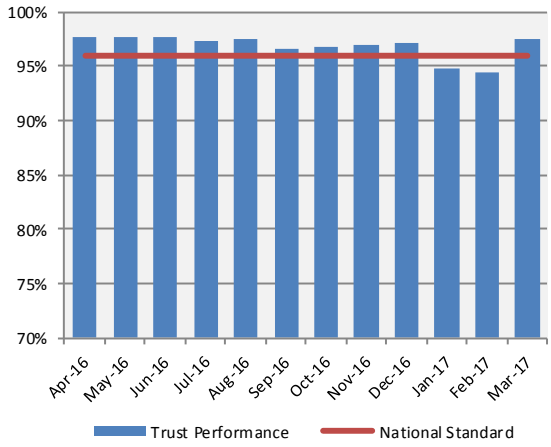
The standard to see urgent GP referrals for patients with suspected cancer within two weeks is 93%. There were some issues with endoscopy service capacity that affected performance. Once these were addressed we consistently met this target despite the continued increases in demand. The standard was not achieved in January 2017 due to large volumes of patients choosing to defer their appointment over the Christmas period.

Cancer access target: breast referrals seen within 2 weeks



The requirement to see patients referred with breast symptoms within two weeks was consistently achieved in 2016/17.

Cancer access target: first treatment within 31 days



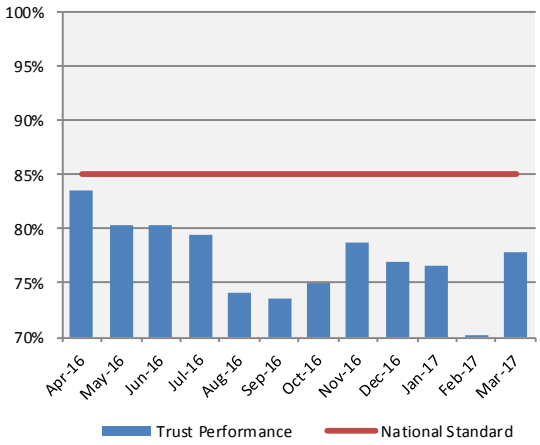
During 2016/17, we consistently achieved the target to treat patients with cancer who needed subsequent treatment with chemotherapy or radiotherapy within 31 days of a decision to treat.

For those patients who were having a first treatment, we achieved the standard for the first nine months but struggled with the impact of acute patient bed pressures in January and February 2017.

For patients who required a subsequent surgical treatment we have not achieved this standard since October 2016 due to some capacity issues in the Melanoma Plastics skin service and the impact of the acute patient bed pressures.

Plans are in place to restore performance against these two 31-day standards but risks will remain due to bed pressures.

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



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 numbers are increasing.

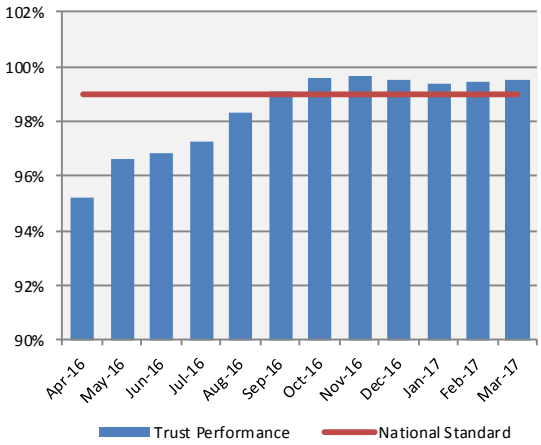
We are also reliant on other Trusts referring their patients onto us in a timely manner. If patients are referred late, including after the 62-day period has passed, Leeds Teaching Hospitals will incur the sometimes unavoidable performance breaches. Despite a significant amount of work with our referring Trusts we have not yet achieved any improvement in the proportion of patients that are referred to us within appropriate timeframes (by day 38), which remains at 50%.

During 2016/17 we began to see our internal performance improve in line with our Trust Board agreed recovery plan in Q3, however with the impact of bed pressures and cancellations of cancer surgery at levels not seen before performance improvement in this area is not expected to recover until 2017/18.

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 2016/17 significant progress was made in addressing and sustaining our diagnostic waiting times performance, which was achieved from September 2016. During this time performance was also achieved for Endoscopy as required for full Joint Advisory Group (JAG) accreditation.

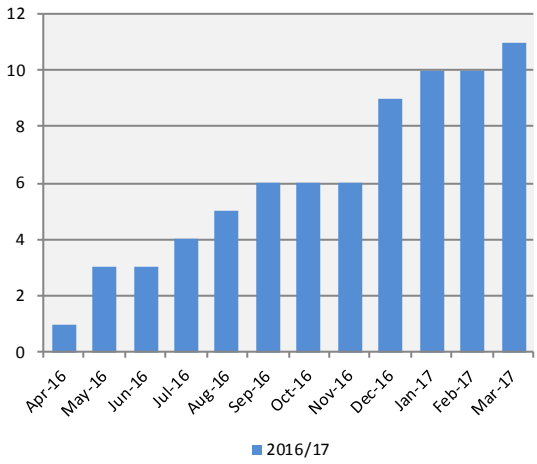
Continued growth in demand for Endoscopy and MRI scanning, coupled with near fully utilised internal capacity remain our biggest risks to achieving this standard during 2017/18 which we will continue to supplement with capacity at other providers and mobile facilities.

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 are committed to reducing the levels of hospital acquired infections and have put in place a number of measures and initiatives to support this.

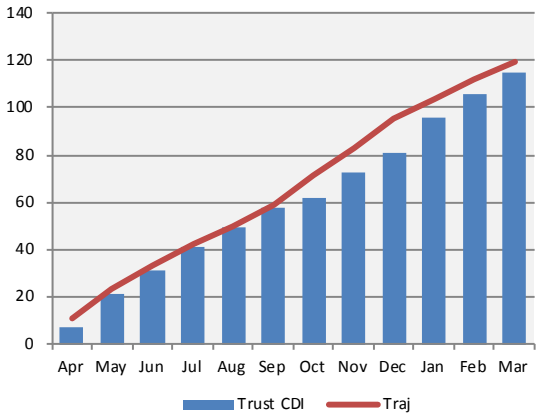
Number of MRSA cases attributed to the Trust (cumulative)



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 2016/17 we had 10 cases of MRSA bacteremia recorded against a zero tolerance standard, which is an increase of three when compared to the 2015/16 position. We will continue to strive to improve in this area as we continue to focus on keeping these infections to a minimum.

Number of CDI cases attributed to the Trust (cumulative)



There were a total of 115 cases of C difficile for 2016/17, against a trajectory of 119. This was a decrease from 2015/16 levels and an improved position, with our trajectory achieved. A detailed infection prevention plan remains in place to continue to support our aim to continue to reduce the risk for our patients and staff.

Factors likely to affect performance in 2017/18

Providing patients with the highest quality service continues to be our priority. 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 for our patients.

Emergency care

Delivering the four-hour target for patients in ED during the year was a pressure for the Trust this year. To recover our performance in 2017/18 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/ outflow issues and admissions avoidance schemes.

Referral to treatment

We want to restore our progress in reducing the numbers of patients who have waited more than 18 weeks for their procedure and 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 with a focus for the year on reducing first Outpatient waits and increasing the number of patients we treat as daycases.

We will ensure that any increased demand on our services above agreed levels that we have been commissioned to deliver is flagged to our commissioners as soon as possible to ensure we jointly address those areas as quickly as we can.

Cancer waiting times

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

In 2017/18, 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 accommodate.

For 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 late by surrounding hospitals. We will continue to work closely with them to affect the changes required so that these patients arrive at our hospitals in a timely manner (by day 38).

1.3 Improving quality

We aim to deliver only the best, safest and most compassionate care to every patient at the Trust. This ambition informs our values, underpins our goals and is reflected in our culture of continuous improvement.

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.

- The Care Quality Commission (CQC) awarded the Trust an overall rating of 'Good' following its inspection of our hospitals in May 2016. This is a significant achievement that reflects the progress we have made in improving our standard of patient care since the CQC's last inspection in 2014. Particular mention was made of our outstanding care for the dying person, good use of multi-media to benefit patients, like our newly-launched Children's Hospital TV, and our very good reputation for organ transplantation.
- Our nationally acclaimed ward safety huddles – short, ward-based meetings involving all staff – continue to make a real impact on patient safety and care. These have been embedded into more than 80% of wards. We have seen a 25% reduction in cardiac arrest calls Trust-wide and a 17% decrease in falls. Our ward healthcheck, an initiative that helps wards to identify areas where they are performing well and those where they can improve, is showing excellent results.
- We are continuing to strive to meet national performance targets. Since September 2016, we achieved the standard that 99% of patients should wait less than six weeks for diagnostic tests. We've also seen fewer cases of Clostridium Difficile than in 2015/16, which is testament to our commitment to harm-free patient care. Initiatives at St James's and the LGI and with local partners have enabled the Trust to improve patient flow through acute care.

- Our work with the prestigious Virginia Mason Institute in Seattle on a five-year programme known in our hospitals as the Leeds Improvement Method.

  The programme aims to advise and coach staff how to make the best use of their skills, time, systems and resources to deliver the most efficient and effective care possible to our patients. Now in its second year, the Leeds Improvement Method has achieved some exciting results, including reducing the waiting time for orthopaedic surgery, improving theatre turnaround times and ensuring certain patients who have had prostate surgery are discharged quickly and safely. In addition to its work in Elective Orthopaedics and Abdominal Medicine and Surgery, the programme was also launched in Outpatients, in collaboration with Head and Neck and in Ophthalmology, and Critical Care, working with Neurosciences. They will be running improvement events during 2017/18.

- Our work to 'make it easier to hear the patient voice' in 2017 has resulted in good collaboration between patient and advocacy groups, helping the Trust to shape services and care to offer patients the best possible experience. We relaunched the Friends and Family Test in 2016, introducing new ways for patients to share their feedback on our care and we made improvements to our complaints system.

Our Quality Improvement Strategy 2017 - 2020 was approved by the Trust Board in March 2017 and is shaped by our work with staff, patients, the Virginia Mason Institute, other partner organisations and our collaborative work on Quality Improvement.

We have worked with clinicians, managers and local partners at Leeds West Clinical Commissioning Group (CCG) and Healthwatch Leeds to identify the following priorities for 2017/18:

Patient safety

To continue our Patient Safety and Harm Free Care Improvement Programme which includes: acute kidney injury, sepsis, pressure ulcers, antimicrobial stewardship, falls, deteriorating patient, safety huddles and Parkinson's Disease.

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
- Outpatient services - Opthalmology
- Seven Day Services in Acute Medicine

Patient experience

- Demonstrating patient and public feedback is used to support service and Trust developments
- Learning from what patients and families tell us
- 'Always Events'

Further information on key improvements in our quality of care and patient safety, the Trust's performance against national targets in 2016/17, goals agreed with commissioners and our plans for 2017/18 can be found in our Quality Account, published on page 107.

1.4 The NHS Constitution

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

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

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

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.

1.5 Finance Review

At the end of the financial year 2016/17 the Trust is reporting a revenue deficit of £37 million. This figure reduces to a deficit of £1.9 million following adjustment for allowed technical factors (explained further in Section 5.2), including an impairment of £34.2 million following a fall in the value of our estate and meets the "control total" target agreed with our regulator, NHS Improvement. The original plan to deliver an adjusted surplus of £1.2 million was impacted as a result of the cost to the organisation when dealing with the failure of our Pathology information system during the summer of 2016. The result achieved, while still a deficit, represents a significant step forward in our drive towards achieving a sustainable financial surplus. Our plan for 2017/18 is to deliver a £9 million surplus.

Key Financial Results

	2016/17	2015/16
Revenue Deficit - adjusted	-£1.9m	-£30m
Capital Investment	£33m	£28m
Cash held 31 March	£20m	£3m
Invoices paid in 30 days	94%	93%

Revenue Summary

In 2016/17 the Trust benefitted from the national Sustainability and Transformation Fund scheme agreed between NHS Improvement and NHS England as a means of incentivising financial and service performance improvements. In return for meeting agreed targets throughout the year Trusts would be eligible to receive a share of the overall monies available. Having achieved all the necessary targets required, we received a total of £24.7 million, including bonus funding of £1.7 million. The inclusion of bonus funding is recognition from NHS Improvement of everything the Trust has done and continues to do to achieve financial sustainability.

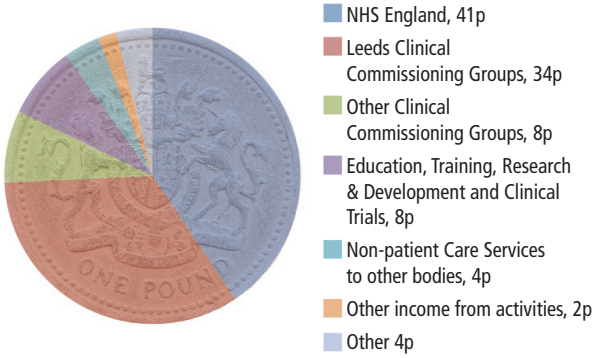
In meeting our agreed financial position we made £61 million of efficiency and other savings. In value terms the most significant of those was the reduction in the financing costs of our Bexley Wing Private Finance Initiative (PFI) agreement. A lengthy negotiation concluded in March 2017 with an overall reduction of £50 million in interest charges on the borrowing associated with the scheme. Of this amount, £10 million was brought into account in 2016/17 and the balance will be spread across the remaining 20-year life of the contract in the form of reduced annual payments of £1.9 million. The new agreement therefore secures a valuable future saving.

Total revenue income has increased by £56.7 million in the year of which £24.7 million is the Sustainability and Transformation money already mentioned. The remaining increase is predominantly revenue from patient care activity which has gone up by £32.1 million on 2015/16. This includes £11.9 million of price changes, £15.9 million in high cost drugs and medical device reimbursements and £4.3 million in activity changes. The movement includes a number of variations from our planned income levels which themselves serve to highlight how our revenue is affected by the type and volume of demand for our services.

Non-elective, or emergency, cases were more than 5,000 above expectation but because there is a point in the length of stay of such cases where we receive reduced payment our overall income for this activity was down by £5 million. The resulting pressure on planned admissions led to over 2,400 fewer cases than planned with our income being £8 million less than expected. There were offsets; Day cases and outpatients saw income in excess of plan of £2.7 million and £1 million respectively.

The chart below shows the sources of our income.

Where each £1 came from



Expenditure on pay increased by £27.6 million. This is partially explained by national pay awards but also by increased staff numbers. The table below shows how our permanent employee numbers have increased in recent years as we have reduced our reliance on agency staff. In 2016/17 our expenditure on agency staff was contained within the £26 million ceiling set for us by NHS Improvement.

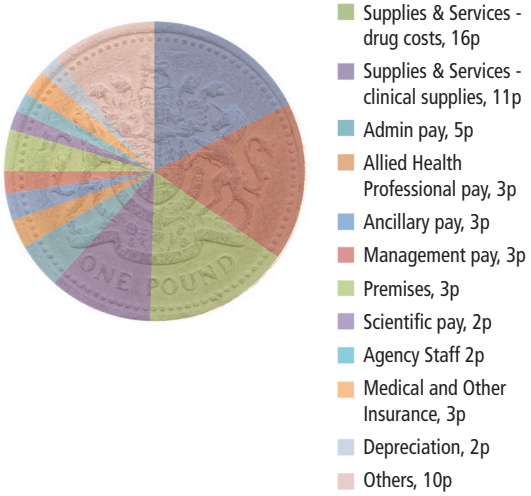
Movement in WTE*

	2016/17	2015/16	2014/15
Employees in post	+601	+771	+273
Of which - Medical/Dental - Nursing	 +58 +65	 +50 +134	 +23 +165
Agency/Bank	-70	-154	+325

* WTE = whole time equivalent

The illustration below shows how we spent the money we received.

How each £1 was spent



Non pay expenditure increased by £51.6 million, and a significant proportion of that was due to the £34.2 million impairment noted above which ultimately is adjusted out as part of the final reported deficit figure of

£1.9 million and high cost drugs and devices of £15.9 million for which the Trust is reimbursed by commissioners on a direct 'pass through' basis. The underlying change was therefore only £1.5 million which was principally due to increases in utility costs and the Trust's contribution to the NHS Litigation Authority, offset by reductions in PFI costs and usage of the Independent Sector for healthcare provision in specific circumstances.

Working Capital

There were times through the year when the Trust had to call on its agreed Working Capital Facility with the Department of Health in order to meet temporary cash shortfalls. In total we borrowed £23 million of temporary loans of which £8 million was repaid in year. Half of the outstanding £15 million balance was repaid in April 2017 and the balance will be repaid in full during 2017/18. Making use of the facility enabled the Trust to ensure that the overwhelming majority of our suppliers were paid within 30 days of us receiving their invoices. Our performance in recent years in meeting this commitment has improved steadily as illustrated below:

Invoices Paid in 30 Days

2016/17	2015/16	2014/15	2013/14
94%	93%	90%	66%

Going Concern

The knowledge that cash support is available if needed and the fact that we have plans in place to deliver breakeven in 2017/18, underpinned by signed income agreements with our major commissioners, has given Trust directors the assurance they require to complete the 2016/17 accounts on the basis that the Trust is a going concern.

Capital Investment

In 2015/16 we reported that the full ambitions of our capital investment plan could not be realised because of increasing constraints on the availability of loan or other central funding. Those pressures have continued through 2016/17 and look set to remain for 2017/18 and beyond. Despite the fact that we were not able to meet the entire £50 million expenditure programme we had planned at the outset of 2016/17 we nevertheless can report some success. Our bid to secure £11.6 million of additional loan funding to undertake the complete refurbishment of our power generating station at the LGI was approved and work has commenced. The scheme is a partnership arrangement with Engie Ltd and the University of Leeds which will see electricity supplied to the LGI and University for 25 years.

In total we spent £33 million on capital schemes associated with our estate, medical equipment and informatics infrastructure during the year; funded as follows:

Funding Source	£m
Depreciation	17
Capital Investment Loans	10
Private Finance Initiative (Equipment Replacement)	3
Public Dividend Capital	2
Grants/Donations	1
	33

There was slippage on some schemes including the generating station and our installation of a 3T MRI scanner which is being primarily funded by charitable donation. These schemes will proceed in 2017/18.

The table below identifies some of the capital investment schemes from 2016/17:

Scheme	£m
Generating Station Complex - Leeds General Infirmary	3.2
Safer Wards	1.9
Reconfiguration of Ward L50 - Leeds General Infirmary	1.2
2 Linear Accelerators - Bexley Wing (PFI Funded)	2.2
David Beevers Decontamination Unit - St James's	0.9
Gynaecology Minor Procedures Unit - St James's	0.9
E Medicines system	0.7
CT Scanner	0.7
Genomic Medicines Centre	0.7
10 Ventilator Systems	0.4
Haemodialysis Machines	0.3

Looking Ahead

As stated above the Trust plans to return to financial surplus in 2017/18 following three years of deficits as part of its agreed recovery programme with NHS Improvement. In summary we will:

- achieve a £9 million revenue surplus "control total" which will include £23 million of Sustainability and Transformation funding
- deliver efficiencies and waste reduction savings of £64 million
- repay all of the £15 million working capital loans carried over from 2016/17
- invest £39 million in capital schemes

These are ambitious plans in a time of widely recognised challenges facing the NHS and their achievement is subject to a number of risks. There is a risk that the full efficiency programme will not be delivered. A further year of unprecedented demand for emergency admissions could reduce our planned income. Either of these puts our ability to meet our agreed control target at risk and would mean the loss of some of our Sustainability and Transformation funding.

These risks must be recognised but there are reasons to believe our plans can be delivered. We have shown an excellent track record in recent years of meeting our savings requirement without compromising patient safety. There are well established mechanisms in place within the organisation for scrutinising all waste reduction plans, assessing their potential quality impact and then monitoring and supporting their delivery. As part of 2017 being our "Year of Improvement" we are taking our Leeds Improvement Method out to a much broader audience within the Trust and engaging with staff to ensure efficiency is embedded within our culture. We continue to roll out our Scan4Safety initiative as part of a national pilot to improve patient safety and make our procurement of medical supplies more efficient.

Similarly, we are working closely with all of our partners from across the city and beyond to manage demand for our services on a properly integrated basis. We are active participants in the local Sustainability and Transformation Partnership (STP) which is working towards delivering new collaborative arrangements across our health economy. Our new Bilberry and Heather wards at Wharfedale Hospital have improved our capacity to have patients who no longer require full acute or specialist treatment in a more appropriate setting, thereby making more beds available to admit new patients.

1.6 Future direction

In 2016 our Board revised the Trust's five-year strategy. The strategy reaffirmed our ambition for achieving the highest quality healthcare within a sound financial base. Our approach will be to work closely with colleagues in other health and social care agencies to ensure that patients' needs are met, wherever they are treated, without duplicating or wasting resource.

Our Trust vision is to be the best for specialist and integrated care in the country. We are very proud of the commitment of our staff who provide high quality care every day of the year. The Leeds Way values – that we are patient-centred, fair, collaborative, accountable and empowered – were agreed in consultation with staff and are increasingly embedded into how we provide care at the Trust. They have also empowered our staff to make the improvements in our services that we have seen over recent years, as we work to fulfil our five organisational goals.

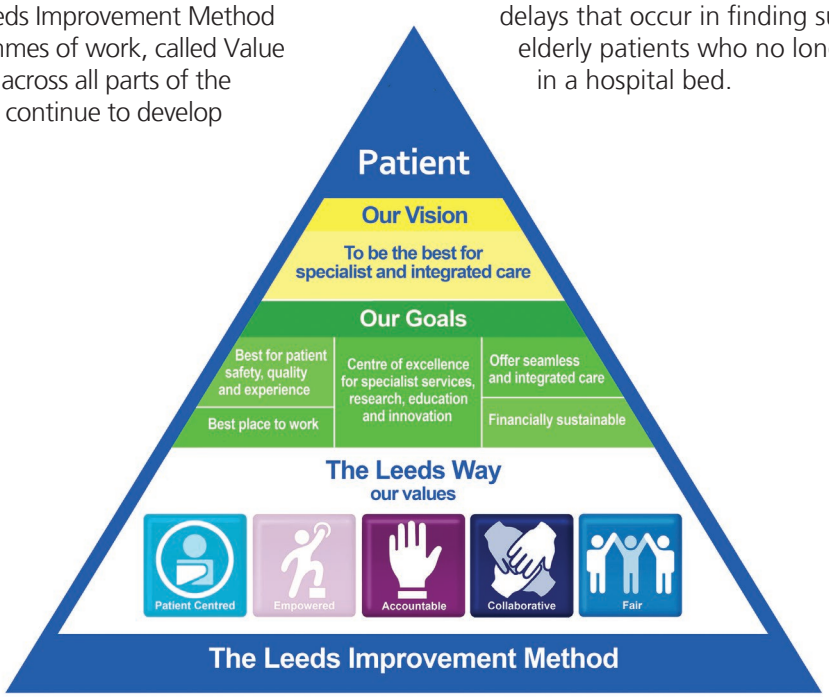
This was very evident in 2016, when our Trust's overall CQC rating was upgraded to Good. Our staff survey results also show that we have moved up six places to ninth in the rankings for staff engagement amongst the twenty largest teaching hospitals.

Building on work with NHS Improvement we have collaborated with the Virginia Mason Institute over the last 18 months to create a continuous improvement programme called the Leeds Improvement Method. This is aimed at reducing medication errors, hospital acquired infections, errors in care and wasteful processes for patents and staff. The Leeds Improvement Method now has programmes of work, called Value Streams, in place across all parts of the Trust that we will continue to develop these.

Our strategic approach is to bring together all these pieces of work and we believe that we are making real progress towards our ambition.

As well as the projects that we carry out inside the Trust, the work we do in cooperation with colleagues in other health and social care agencies is vital 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 timely high quality care.

Since 2016, each geographic area in England has been required to produce this kind of integrated plan for its health economy, called a Sustainability and Transformation Plan. The STP for our area is for West Yorkshire and Harrogate and it has a dedicated section that sets out the detail of our local approach in the city called 'The Leeds Plan'. As our patients come from Leeds, West Yorkshire and further afield we welcome this opportunity to work closely with colleagues from the West Yorkshire Association of Acute Trusts (WYAAT) and other agencies across our catchment areas. One area that we are focusing on, for example, is the delays that occur in finding suitable care for elderly patients who no longer need to be in a hospital bed.



One of the pieces of work that we are involved in is to treat patients in a non-hospital setting where this is possible. When people do need to come into hospital our aim will be to try to return them to follow-up care in their local community as soon as we can. Some patients with complex conditions or injuries will still need our care and these may be Leeds patients or they may be referred to us from across Yorkshire. For this group of patients we will continue to deliver specialist care and work with academic and research bodies to ensure that they have the best available treatment options and continually improving outcomes.

As more patients have been referred to us for specialist care over recent years, we have recruited a more specialist mix of medical and nursing staff. We needed to review the mix of facilities that are available to our clinical teams and so we have produced a medium-term plan entitled, 'Building The Leeds Way'.

Building The Leeds Way advocates a reduction in the size of the Trust's estate by demolishing some of the old Victorian buildings at the LGI that are no longer fit for healthcare use. These can then be replaced with new facilities that will provide purpose built day-case suites, new operating theatres and a critical care unit. It will also allow the development of the Leeds Children's Hospital in Clarendon Wing. The plan is at an early stage but it has been produced in conjunction with colleagues in other health agencies and the City Council to make a real impact on that care that can be offered in Leeds.

Overall we believe that our future direction is a positive one. We have made significant progress in improving our services and achieving a sound financial base. We will continue to engage with our staff, following our shared set of values to pursue our ambition to be the best for specialist and integrated care. We will also work closely with our partners in other health and social care agencies to develop Sustainability and Transformation Plans for our communities and look to invest 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 2016/17, work has continued to strengthen the risk management processes supporting delivery of the Trust's objectives and our continued journey of improvement. Our 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'.

During the year we have enhanced our use of the modules on Datix, the Trust-wide risk management database. Sometimes learning comes from trend analyses rather than a specific incident or event. The information we collect through Datix allows us to look at the trends in incidents, PALS, complaints and claims we receive and enables us to see how we can reduce the occurrence of problems that occur.

Following the introduction of on-line incident reporting we now use web-based modules for complaints, PALS and the Trust Risk Register. This has given our Clinical Service Units (CSU) management teams greater flexibility around the production of reports to enable focussed reviews of themes and trends. We have also being rolling out the Datix actions module across the Trust. This supports the CSUs in monitoring the implementation of action plans following incidents, complaints and claims. We will continue to embed this over the coming year.

This year, we have been working to improve the online incident reporting and review process for users. A questionnaire was issued across the Trust seeking feedback on the ease of use and any areas where positive changes could be made.

As a result of this feedback, we have simplified and shortened the on-line incident report and made some changes to the reviewer's form to make the review process flow more logically. These changes have been piloted in a small number of CSUs and have been received with great enthusiasm. The updated forms will be rolled out to the remaining CSUs from July 2017.

September 2016 saw the Trust wide launch of the Leeds Incident Support Team (LIST). The LIST is a voluntary group of Trust staff who have previously been involved in serious incidents. They have made a commitment to act as a 'buddy' and be available to talk to other staff who may become involved in a similar type of incident. LIST 'buddies' receive training on their role, which has now expanded to support staff involved in PALS and complaints.

The scheme has been cited as an example of good practice by the NHS Litigation Authority (now NHS Resolution) and it has published details on its website. Other Trusts have also begun to adopt the initiative.

In 2016, a national review by the Care Quality Commission (CQC) found that the NHS is missing opportunities to learn from patients' deaths and that staff completing investigations are not being provided with specialist training and support. Following this, we have been proud to lead on the development of the Level 5 Investigating Incidents in Healthcare Qualification, working with SFJ Awards to launch it. The qualification covers subject areas including the initial reviewing of an incident; investigative questioning and completing the investigation. Its introduction is intended to bring consistency to the investigative practices of healthcare organisations across the NHS.

We have continued to embed our processes for identifying and sharing learning, as well as trialling new methods with the aim of cascading learning to all staff. Our Lessons Learned group is responsible for producing a bi-monthly Lessons Learned bulletin. A Lessons Learned 'YouTube' channel has also been introduced to disseminate short videos of learning to our staff.

1.8 Research and innovation

Leeds Teaching Hospitals is committed to developing and supporting world-class research and innovation. It is 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.

Most importantly, advances in research and innovation benefit our patients, improving treatment and care and securing better outcomes. The clinical trials that take place at the Trust 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 participate in our studies.

We are among the top three hospital trusts in England for research projects recognised by the National Institute for Health Research (NIHR), involving more than 12,000 patients in 477 high quality research studies last year. We are first in England for the number of complex studies undertaken.

Supporting groundbreaking research is an organisational priority for the Trust, and in 2016/17, we took a significant step towards expanding our ambitions with the construction of a new £1.2 million Research and Innovation (R&I) Centre, based at St James's University Hospital. This will bring together our R&I department, the Leeds NIHR infrastructure programmes, the Yorkshire and Humber NIHR Clinical Research Network team and the University of Leeds' research governance (Quality Assurance) team, providing a central point for collaboration and integration.

The NIHR also announced a five-year investment in the Leeds Clinical Research Facility (CRF), which carries out clinical trials and other translational studies in experimental medicine. The investment recognises our strengths in the key disease areas of cancer, cardiovascular and

musculoskeletal disease as well as our expertise in imaging and informatics. Approval has been given for a new £3 million, 18-bed, state-of-the-art early phase CRF based at St James's, increasing our capacity for research into new treatments and medical technologies.

Both the R&I Centre and the new CRF are flagship developments that will drive forward academic, clinical and industry partnerships to pioneer research, innovate treatments and improve patient care.

Our research projects last year are outlined below.

NIHR Leeds Musculoskeletal Biomedical Research Unit (LMBRU) – now Biomedical Research Centre from April 2017

The LMBRU was awarded nearly £7 million funding over five years to become a prestigious Biomedical Research Centre (BRC). Based at Chapel Allerton Hospital, it is the only dedicated BRC in the country and aims to be a world-leading centre for translational research into individually targeted, patient-focussed therapies across the range of musculoskeletal diseases. In addition to groundbreaking research, its facilities include dedicated MRI and ultrasound imaging.

Case study: Augmented Microfracture for Improved Cartilage Report (AURA)

The AURA clinical trial is looking at a new way to improve cartilage repair using minimally manipulated stem cells from the patient's own knee. The study combines laboratory findings on adult stem cells with a simple and novel medical device surgeons can use during arthroscopic procedures - a type of keyhole surgery used to treat joint problems. It aims to investigate the safety and effectiveness of increasing stem cell numbers in combination with a routine cartilage repair procedure known as microfracture.

Participants in the study will have a preoperative MRI at the Biomedical Research Centre's 3 Tesla research scanner before being randomly assigned to standard or 'augmented' treatment groups. The standard treatment group will have the routine procedure, while the augmented group will have the routine procedure with the addition of the new device – a tiny brush that is used to increase the release of stem cells.

Each patient will be followed up for 12 months with two extra MRI scans to assess whether the new device has improved outcomes.

NIHR Diagnostic Evidence Co-operative (DEC)

Leeds hosts one of four UK NIHR DECs set up in 2013 to support the evaluation of innovative diagnostic tests that will underpin the delivery of personalised, accurate and timely healthcare that is also affordable.

The Leeds DEC is targeting cancer, musculo-skeletal diseases and diseases of the bladder, kidney, liver and bowel. It has established an internationally recognised multidisciplinary team of clinicians and methodologists in diagnostic test evaluation and together with the other DECs, it provides strong support to the diagnostics and precision medicine industries.

Our Leeds DEC team 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 research will enable patients to access the most appropriate treatments quickly and support the NHS to make the best use of its resources.

NIHR Health Technology Cooperative (HTC)

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

Case Study: Evaluation of a wearable wireless patch for vital signs monitoring after major surgery

Surgery is important in the management of many medical conditions, but can be high risk, with complication rates between 30% and 40% for major abdominal procedures. Complications add to the financial burden to the NHS and cause significant morbidity, and occasional mortality, for the patient.

Early recognition of postoperative complications is crucial in reducing morbidity and preventing long-term disability. It also brings cost savings, reducing the need for high dependency or intensive care and shortening a patient's stay in hospital.

The current standard of postoperative monitoring involves recording of vital signs (blood pressure, pulse, temperature and so on) using the National Early Warning Score (NEWS). Although NEWS has proven benefit, it is prone to human error and if the patient isn't monitored frequently enough, risks undetected deterioration.

SensiumVitals® is a new monitoring system that combines the benefits of a wearable patch with continuous monitoring of vital signs that are transmitted wirelessly to a central monitoring station or mobile phone, alerting staff to potential patient deterioration.

A feasibility study is being undertaken in the Trust of the SensiumVitals® patch as compared to standard NEWS monitoring to determine safety, efficacy, and patient/staff acceptance in the post-surgical environment. Five hundred patients who have undergone routine or emergency abdominal surgery will be allocated to either SensiumVitals® and NEWS monitoring or NEWS monitoring alone in the postoperative period. The study will measure the total number of admissions and total number of days spent in higher level care (HDU or ICU). It will also record the number and severity of complications, re-intervention rates, length of stay, mortality and patient and staff satisfaction.

The feasibility study will inform the design of a large, multicentre study evaluating the SensiumVitals® system, including cost-effectiveness, for submission for NIHR funding. If it proves to be successful, the system could eventually be used more widely within the NHS.

Advanced Imaging Centre for Hyperpolarised MRI

In January 2017 we opened a new £6.8 million Advanced Imaging Centre at LGI with identical facilities at the University of York. This is a fantastic achievement for the Trust and our partners which could revolutionise the diagnosis and treatment of patients with cancer, heart disease and musculoskeletal disease.

Researchers from the Trust, the University of Leeds and the University of York will work on a new imaging method that could boost the signal in MRI scanners by up to 200,000 times. This will give clinicians new insights into the workings of the human body in health and illness and could have profound benefits for patients through early diagnosis and the potential to make the development of new drugs more effective.

UK Centre for Rare Autoimmune and Primary Immunodeficiency Diseases

The Trust has been selected as a Core Centre for a new European Reference Network (ERN) in Rare Diseases.

ERNs for rare diseases have been created to allow scientific and clinical advances to be shared rapidly between experts to enable them to be translated as quickly as possible into treatment and care for patients. Following a rigorous selection process, we were awarded the bid in all three themes of the ERN: rare autoimmune disease, rare autoinflammatory disease and primary immunodeficiency syndromes.

The clinical teams leading on this initiative will be working closely with national patient organisations to build on our national, and now international, success in this area to enhance the clinical service we provide and our research.

1.9 Sustainability report

Environmental Impact Performance Indicators 2016-17

Area		Non-financial Metric	Non-financial Metric		Financial data (£,000)	Financial data (£,000)
		2016/17	2015/16		2016/17	2015/16
Waste minimisation and management	Clinical HTI	1,836 Tonnes	2,112 Tonnes	Total Waste Cost	£1,426	£1,345
	Clinical - Alternative	1,970 Tonnes	2,092 Tonnes			
	Landfill disposal	1,209 Tonnes	1,122 Tonnes			
	Recycling / Recovery	2,850 Tonnes	2,339 Tonnes			
Finite resources	Water / sewerage	818,913 m3	778,877 m^3	Water / Sewerage	£1,419	£1,372
	Electricity	*20.35* GWh	15.04 GWh	Energy	*£8,431*	£9,767
	Gas	*274.4* GWh	318.4 GWh			
	Oil	*0.02* GWh	0.35 GWh			

Leeds Teaching Hospitals has ambitions to become one of the greenest Trusts in the UK by 2020. Over the past financial year, we have been working towards this goal in a number of ways.

The GRASP campaign

Following on from the launch of our sustainability campaign GRASP in 2015, we now have a network of active environmental champions – staff who are working to promote sustainable behaviours and embed sustainable practices across the Trust. The GRASP campaign stands for be Green, Recycle, be Aware, be Sustainable for our Patients. It highlights the importance the Trust places on sustainability by integrating it into the values of the organisation and committing to take real and significant action across every area of the Trust.

Some of the highlights of the year include:

- developing our Sustainable Development Management Plan, which pulls together all of the Trust's environmental impacts and sets out a detailed plan for reduction in line with national targets
- promoting sustainable travel with the installation of electric vehicle charging points for staff, providing secure cycle storage and promotion of car share scheme
- being awarded a 4* rating from Eco stars in recognition of our green fleet and operating procedures
- saving 2,500 tonnes of CO_2 through energy effiency programmes

Green Spaces

A staff group has been formed to look at the management of our green spaces. It has a particular focus on promoting biodiversity across the Estate, enhancing the use of green spaces for the benefit of staff and patients and linking with external bodies to align the Trust green spaces plan with city-wide agendas. The group has successfully developed an organic vegetable garden at the St James's site, with a range of fruit, vegetables and fruit trees that staff are encouraged to tend and forage for. The garden benefits the environment by providing an urban habitat for local wildlife and is also somewhere for patients and staff to enjoy.

Waste: Reduce, Reuse and Recycle

We understand the importance of using resources efficiently, and as such we follow the waste hierarchy, ensuring we focus on minimising the amount of waste we produce and that waste receives the most appropriate disposal route.

During 2016/17, we implemented a waste reuse system, allowing staff to search for and advertise unwanted items. This will save us money through a reduction in purchasing and also saving on the cost of disposing of items that can be used elsewhere.

The Trust has a first-class decontamination contract in place, processing over 7.5 million medical devices every year. This ensures that we can utilise a reuse system when possible and reduce the usage of single use items and so minimise waste disposal.

For some clinical procedures, re-use is not an option and single use metal items must be used. We are one of a handful of Trusts in the UK operating a recycling scheme for single use metal items whereby items are decontaminated and sent for recycling and made into other metal products. In addition to the waste savings this brings, the container is also re-used ensuring no plastic waste is generated in the process.

We are the only Trust to employ a Specialist Waste Trainer to support and train staff ensuring they have the necessary skills to achieve best practice. As a consequence we have reduced the amount of clinical waste produced per patient by 14% over a three-year period.

We promote a number of initiatives to reduce our waste including minimising the amount of packaging being brought into the Trust and reducing paper usage by switching to duplex printing. Ninety percent of our domestic waste is now diverted from landfill and the Trust has effective recycling streams for cardboard alongside a dry waste recycling programme.

Golden Sharps 'Champion of Champions' Awards

In March 2017, we crowned the Golden Sharps 'Champion of Champions', an award which recognises departments' efforts to improve safe waste disposal and good segregation. The three shortlisted teams were:

1. The International Injectors Wards J19/20 (Acute medicine) at St James's have both been previous Golden Sharps champions and consistently post high audit scores for safe management of health care waste.

2. The Waste Warriors, Paediatric Patient Acute Care Unit (PPACU) at LGI has made significant changes to its waste streams to become more efficient at waste segregation within their units and improved upon their previous audit scores.

3. The Sharps Shifters, Seacroft Outpatients Department completely overhauled its waste segregation with the introduction of a waste plan and new waste bins. The team also improved its waste audit scores dramatically.

The Golden Sharps initiative has ultimately improved segregation across the Trust and in 2015/16 reduced the number of sharps containers used by around 16,000, equating to a saving of £19,000. In 2016/17, this figure rose to £28,000. With the introduction of a new theatre plus sharps receptable, a further cost saving of £4,626 will be made, so the overall cost saving over three years will rise to £32,626.

Energy saving

We have a long history of energy efficiency as we were a very early adopter of combined heat and power technology with the installation of our Combined Heat and Power (CHP) plant at LGI in 1974. We continue to build on this energy efficiency leader status and have recently embarked on a programme of works to refurbish and further improve the energy performance of the CHP plant. We anticipate

this will result in additional savings of 3,000 tonnes of carbon every year.

During 2016/17, we carried out a programme of insulation in plant rooms releasing savings of £6,000 a year.

We have upgraded the plant at Seacroft Hospital and rationalised the site. So far this five-year programme of works to improve energy efficiency has achieved annual savings of £400,000 and 2,500 tonnes of CO_2 - an amazing reduction of 75%.

A five-year reduction in water usage at Seacroft Hospital has seen a reduction of 60% in water and is a saving of £70,000 per year.

Transport

Our Trust participates in all available sustainable transport schemes to make active and sustainable travel as attractive as possible to our staff. All employees are also eligible to a 15% discount off metro travel.

The Trust has a comprehensive suite of efficiency management policies and we are very pleased that the Trust's fleet is one of the greenest in the United Kingdom, having been awarded 4 stars by the ECO stars fleet recognition scheme. This is a free scheme that aims to help fleet operators improve efficiency, reduce fuel consumption and make cost savings.

We recognise that access to charging stations can be an incentive for staff considering purchasing an electric vehicle. We wish to support staff considering the purchase of a low carbon car and have installed charging points at St James's.

Future plans

Sustainable Development Management Plan (SMDP)

We will follow the carbon reduction plan contained within our SMDP for reduction in line with national targets. We will continue to pursue low carbon options and promote sustainable behaviours across every part of the Trust.

Environmental Management System

Alongside the SDMP, we are working towards ISO 14001 accreditation.This environmental management system will enable us to fully measure and improve our impact on the environment.

Energy Generation

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 to sell power back into the grid.

Pollution and Health

We will continue to work with Leeds City Council to ensure that we contribute to the pursuit of improved air quality. We will actively promote sustainable options within staff travel policies and utilise the best available technologies and management processes to ensure the highest level of efficiencies and lowest level of emissions.

1.10 International partnerships

We are actively working to develop new partnerships with healthcare organisations across the world, sharing our experience and expertise with international colleagues.

This kind of international collaborative working means we can develop our global reputation of providing excellence in healthcare and will help us to achieve our vision of being the best for specialist care.

Department for International Trade (DIT)

Working with DIT through Healthcare UK and other professional contacts, our networking activity has ensured a steady flow of commercial leads. The growing demand for health services in countries such as China and India offers

opportunities, some of which we are exploring. Where appropriate, a collaborative approach with other trusts may be considered.

Ministry of Health, Malta

A second cohort of medical physicist students from Malta completed their 22-month training programme with the Trust and have taken up vital positions within the Sir Anthony Mamo Oncology Centre in Valletta. The Trust also completed the installation of three linear accelerators at the new centre. This involved not only the highly complex commissioning of the equipment but also its integration into the clinical pathways of the hospital. We have sought to build upon the relationship with Malta by hosting nurse visits and are working with their medical school to offer doctor placements.

King Hussein Cancer Center, Jordan

The Memorandum of Understanding between Leeds Teaching Hospitals and the King Hussein Cancer Center in Amman has enabled us to benefit from a fellowship programme that helps us share learning and experience between hospitals. We have commenced the provision of a genetic testing service and will continue to explore other opportunities including offering consultancy advice to develop their own capabilities within country.

Section 2
Accountability

Accountability

We have 17,177 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 is key to the success 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 2016/17

During 2016/17, the Board met bi-monthly 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 on the Trust's website at the 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

Tony Whitfield commenced long-term sick leave during April 2016 and formally retired on 2 March 2017. Jonathan Wood was seconded to the role of Interim Director of Finance, during June 2016 until 31 March 2017, until the successful appointment of Simon Worthington as the Director of Finance, with Jenny Ehrhardt acting as Director of Finance for a short period.

Bill Kirkup stood down as a Non-executive director at the end of September 2016 to carry out another high profile investigation for NHS Improvement. This vacancy is currently held.

Appointment of Non-Executive Directors

The Non-Executive Directors have been appointed by NHS Improvement (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 be carried out by the Chair of NHS Improvement.

All Board directors comply with the 'fit and proper person test' that was introduced from November 2014, with reconfirmation at a public Board meeting in January 2017.

Measuring the performance of the Board members

The Chair of the Board was appraised through the processes defined by NHS Improvement. 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 2016. 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 Board has refined the corporate objectives at their meeting on 30 March 2017 and these will be used to underpin the objectives for the Chief Executive and the executive team for 2017/18.

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. It commissioned an externally facilitated 360° evaluation process, which reported back to the Board in June 2016, and was reviewed in detail. This included feedback from external stakeholders.

Register of interests

The register of interests for Trust Board members is available on the Trust Website at the following link:

www.leedsth.nhs.uk/assets/Uploads/LTHT-31-March2017.pdf

Non-Executive Directors of the Board during 2016/17

Dr Linda Pollard CBE DL Hon.DLL

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 is a member of the NHSI Chairs' Advisory Group and a member of the Advisory Group on Gender Equality.

She has held posts as 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. She 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 Hospitals 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 over 30 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, a Non-Executive Director and Chair of the Audit Committee of Shepherd Group Limited, she provides consulting services to a range of global chemical industry 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 and Chair of the Quality Assurance Committee (from November 2016)

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 Committee

From 1 October 2013

Paul is the Executive Dean of Faculty 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. His clinical interest focusses on patients with Endocrine diseases, specifically disorders of the pituitary and adrenal glands and steroid hormones.

Paul has undertaken translational research funded by the Wellcome Trust, Medical Research Council and European Research Council that has increased our understanding of how steroid hormones work in man and developed new treatments that are under evaluation in patients with diabetes mellitus, osteoporosis and adrenal insufficiency. He holds several leadership roles nationally and internationally including Vice Presidency of the Academy of Medical Sciences, Medical Schools Council Executive, Northern Health Science Alliance Executive, Chair British Heart Foundation Chairs and Programmes committee and Secretary-Treasurer of the International Society for Endocrinology.

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

Allison Page

Non-Executive Director

From 1 January 2014

Allison is the Managing Partner for the Leeds office at DLA Piper, one of the world's largest specialist business law firms. She leads the firm's finance and infrastructure practice in Yorkshire, having worked on some of the largest and high profile PPP projects in the UK. In addition to her Non-Executive Director role, Allison is a business representative on Leeds City Council's Sustainable Economy and Culture Board.

Dr Bill Kirkup CBE

Non-Executive Director and Chair of the Quality Committee (until end September 2016)

From 19 May 2014 to 30 September 2016

Bill 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.

He 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 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 and a Director and Trustee of Yorkshire based charity Dementia Forward.

Carl Chambers

Non-Executive Director and Chair of the Finance and Performance Committee

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

Carl 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; and a Member of the Council of the University of Bradford. 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 at 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 CBE

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/ Deputy Chief Executive 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 19 years, Suzanne has had experience in Chief Operating Officer and Chief Nurse positions with two periods as Interim Chief Executive.

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

Tony Whitfield

Director of Finance

From 20 January 2014 – retired 2 March 2017

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 (CHFT). These culminated in her being appointed Executive Medical Director at CHFT in 2007. Yvette has extensive experience in leading major service change, reconfiguring hospital services and working across organisational boundaries to deliver improvements to care.

Yvette is a Trustee of Yorkshire Cancer Research and a Lay Member of Council for the University of Leeds.

Dean Royles

Director of Human Resources and Organisational Development

From 8 September 2014

Dean has been a leading figure in Human Resources (HR) within the NHS for nearly two decades. Dean was Chief Executive of NHS Employers before coming to Leeds. 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.

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.

Jonathan Wood

Interim Director of Finance

From 13 June 2016 to 31 March 2017

Jonathan was seconded to Leeds Teaching Hospitals in June 2016 until 31st March 2017, returning to his substantive role as Director of Finance and Deputy Chief Executive of East Lancashire Hospitals NHS Trust on 1st April 2017.

Jonathan began his career as an NHS finance trainee and has since worked in a range of organisations, including Salford Royal Hospitals and NHS North West. He has been Director of Finance at ELHT since 2009.

2.2 Attendance tables

Board of Directors

Name/Date	7 April '16		26 May '16		28 Jul '16		29 Sep '16		24 Nov '16		26 Jan '17		30 Mar '17	
Members:	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu
Linda Pollard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Carl Chambers	✓	✓	Apols		✓	✓	✓	✓	✓	✓	✓	✓	Sick leave	
Mark Ellerby	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bill Kirkup	✓	✓	✓	✓	✓	✓	✓	✓						
Caroline Johnstone	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Neville	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Yvette Oade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dean Royles	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tony Whitfield	Long Term Sick Leave													
Paul Stewart	Apols				✓	✓	✓	✓	Apols	✓	✓	✓	Apols	
Allison Page	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols
Mark Chamberlain	Apols		✓	✓	Apols		✓	✓	✓	✓	✓	✓	✓	✓
Jonathan Wood					✓	✓	✓	✓	✓	✓	✓	✓	Apols	
In Attendance:														
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

W'shop - Workshop
Pu - Public

Board Time-Outs

Name/Date	28 Apr '16	23 Jun '16	29 Jun '16	13 Oct '16	14 Oct '16	08 Dec '16	19 Jan '17
Linda Pollard	✓	✓	✓	✓	✓	✓	✓
Carl Chambers	✓	✓	✓	Apols	Apols	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	✓
Yvette Oade	✓	✓	✓	✓	✓	✓	✓
Dean Royles	✓	✓	✓	✓	✓	✓	✓
Tony Whitfield	Long Term Sick Leave						
Bill Kirkup	✓	✓	Apols				
Paul Stewart	✓	Apols	Apols	Apols	✓	✓	✓
Simon Neville	✓	Apols (1)	✓	✓	✓	✓	✓
Allison Page	Apols	Apols	Apols	Apols	Apols	✓	✓
Mark Chamberlain	✓	✓	✓	✓	✓	✓	✓
Mark Ellerby	Apols	Apols	✓	Apols	✓	Apols	✓
Caroline Johnstone	Apols	✓	✓	✓	✓	Apols	✓
Jonathan Wood		✓	✓	✓	✓	Apols (2)	✓
In Attendance:							
Jo Bray	✓	✓	✓	✓	✓	✓	✓

(1) Meeting in London at Royal College of Physicians (2) HFMA conference - London

Chairs of Committees Committee

Name/Date	23 Jun '16	08 Dec '16
Linda Pollard	✓	✓
Carl Chambers	✓	✓
Julian Hartley	✓	✓
Bill Kirkup	✓	
Mark Chamberlain	✓	✓
Caroline Johnstone	✓	Apols
Yvette Oade	✓	✓
In Attendance:		
Jo Bray	✓	✓

Audit Committee

Name/Date	06 April '16	05 May '16	25 May '16	24 Aug '16	01 Dec '16	08 Mar '17
Members						
Caroline Johnstone	✓	✓	✓	✓	✓	✓
Allison Page	✓	✓	Apols	✓	✓	✓
Carl Chambers	✓	✓	✓	✓	✓	✓
In Attendance:						
Jo Bray	✓	✓	✓	✓	✓	✓
Tony Whitfield	Long Term Sick Leave					
Jonathan Wood				✓	✓	✓
Attendance for Specific Issues						
Julian Hartley	✓	✓				✓
Simon Neville			✓	✓	✓	✓
Yvette Oade	✓			✓		
Dean Royles	✓			✓		
Bill Kirkup	✓					
Mark Chamberlain						✓
Linda Pollard	Observing			Observing		Observing

Finance and Performance Committee

Name/Date	06 Apr '16	27 Apr '16	25 May '16	29 Jun '16	27 Jul '16	24 Aug '16	28 Sep '16	26 Oct '16	23 Nov '16	21 Dec '16	25 Jan '17	01 Mar '17	29 Mar '17
Members													
Carl Chambers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols
Linda Pollard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Caroline Johnstone	✓	✓	✓	✓	✓	✓	✓	Apols	✓	✓	✓	Apols	✓
Tony Whitfield	Long Term Sick Leave												
Mark Ellerby	✓	✓	✓	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓
Jonathan Wood					✓	✓	✓	✓	✓	✓	✓	✓	Apols
In Attendance:													
Jo Bray	✓	✓	✓	✓	✓	✓	✓	Apols (1)	✓	✓	✓	✓	✓
Tracy Gill	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	Sick	✓	✓	✓	✓	✓		✓
Simon Neville	✓	✓	✓	✓	Apols (2)	Apols (3)	✓	✓	✓	✓	Apols (4)	✓	✓
Dean Royles	✓	✓	✓	✓	✓	✓	✓	Apols (1)	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols (5)	✓
Attendance for Specific Issues													
Yvette Oade								✓		✓	✓		✓

(1) Holiday
(2) GMC/Lab Configuration Partnership Board - Wakefield
(3) STP Impact Analysis Review Session
(4) Leeds Growth Strategy Summit
(5) Development of WY&H LMS - Huddersfield

Quality Assurance Committee

Name/Date	13 Apr '16	06 Jul '16	15 Sep '16	15 Dec '16	16 Feb '17
Members					
Bill Kirkup	✓	✓	✓	✓	✓
David Berridge	Apols	✓	✓	✓	✓
Craig Brigg	✓	✓	✓	✓	✓
Mark Chamberlain	✓	Apols	✓	✓	✓
Yvette Oade	✓	Apols (1)	Apols (2)	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓
Allison Page	✓	✓	✓	✓	✓
In Attendance:					
Jo Bray	✓	Apols (3)	✓	✓	✓
Linda Pollard	Observing				

(1) Leeds Clinicians' Workshop
(2) Holiday
(3) Speaking at MES Conference - London

Research, Education and Training (RET) Committee

Name/Date	03 May '16	05 Jul '16	06 Sep '16	01 Nov '16	17 Jan '17	07 Mar '17
Members						
Yvette Oade	✓	✓	✓	Apols (1)	✓	✓
Suzanne Hinchliffe	Apols (2)	✓	Apols (3)	✓	Apols (4)	Apols (3)
Paul Stewart	Apols	Apols	Apols	Apols	Apols	✓
Stuart Haines	✓	✓	✓	Apols	✓	✓
Jacqueline Andrews	✓	✓	✓	✓	✓	✓
Jon Cooper	✓	✓	✓	✓	Apols	✓
Claire Gaunt	✓	✓	✓	✓	✓	✓
Andrew Lewington	Apols	✓	✓	✓	Apols	Apols
Dean Royles	✓	✓	✓	✓	✓	Apols (5)
Ian Simmons						
Stephen Smye	✓	✓	✓	✓	✓	✓
Karen Vella	✓	✓	Apols	✓	✓	Apols
Heather Iles-Smith	✓	✓	✓	✓	✓	✓
Andy Thomas	✓	✓	✓	✓		
Klaus Witte		Apols	Apols	Apols	Apols	Apols
Adam Glaser	✓	✓	✓	Apols	Apols	✓
Anne-Maree Keenan						
Pam Jones		✓	✓	✓	✓	Apols
Mitch Waterman	✓	✓	Apols	✓	✓	✓
Kirste Mellish	Apols	✓	✓	✓	Apols	Apols
David Jackson	Apols					
Wayne Hamer	Apols	Apols	✓	✓	✓	
Alan Anthoney		✓	Apols	✓	✓	Apols
In Attendance:						
Donna Johnstone	✓	✓	✓	Apols	✓	✓
Pauline Binnie	✓		✓	✓	✓	✓
Kate Atkinson	✓	✓		✓	✓	✓
Richard Evans	✓	✓	✓	✓	✓	
Annette Clarkson		✓				
Julie Evans		✓				
Heather Rostron		✓				
Chris Twelves		✓				
Debbie Beirne		✓				
Khurram Mustafa			✓			

Jane Smith			✓			
Heather McClelland			✓			
Lynetty Makawa				✓		
David Jayne					✓	
Jane Smith						For Karen Vella
Helen Christodoulides						For Suzanne Hinchliffe
Rosalind Roden						✓
Mark Wright						✓
Julie Atkey						✓
Richard Evans						Apols
In Attendance:						
Linda Pollard	Observing					Observing
Heidi Siddle					Observing	
Ramini Yassi					Observing	

(1) Leeds in Healthcare event - Liverpool
(2) Meeting with CQC
(3) Holiday
(4) Attending Silver Command
(5) Royal Marines Training in Norway

Risk Management Committee

Name/Date	14 Apr '16	05 May '16	02 Jun '16	07 Jul '16	04 Aug '16	01 Sep '16	03 Nov '16	01 Dec '16	05 Jan '17	02 Feb '17	02 Mar '17
Members											
Julian Hartley	Apols (1)	✓	✓	Apols (2)	✓	✓	Apols (1)	✓	✓	✓	✓
Simon Neville	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols (4)
Dean Royles	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Tony Whitfield	Long Term Sick Leave										
Yvette Oade	✓	✓	✓	✓	✓	Apols (1)	✓	Apols (1)	✓	Apols (1)	✓
Jo Bray	✓	✓	Apols (1)	Apols (3)	✓	Apols (1)	✓	✓	✓	✓	✓
Suzanne Hinchliffe	Apols (5)	✓	Apols (1)	✓	✓	✓	✓	✓	✓	✓	✓
Jonathan Wood				Apols (6)	Apols (1)	✓	✓	✓	Apols (1)	✓	✓
In Attendance:											
Joan Shelton	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Linda Pollard			✓								
Carl Chambers											Observe

(1) Annual Leave
(2) HSJ Summit - Daventry
(3) NHSP Governance Conference - London
(4) On leave
(5) System resilience Group meeting for JH
(6) WYAC meeting

2.3 Governance

Annual Governance Statement (2016/17)

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 on-going 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 2017 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 Audit, Quality Assurance and Finance and 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 meeting on 8 March 2017. 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 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, with an annual report to the Board of Directors each July.

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 in March 2016. 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 as set out in the Corporate Risk Register and supporting report to each Board meeting and regular reviews of the Board Assurance Framework. This is supported by a recent

Internal Audit Report No. 2016/31, 'Framework of Assurance including Risk Registers', where Full Assurance was reported.

(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 31 March 2017, 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 and 31-day Subsequent Surgery Cancer and rate of Cancelled Operations not re-booked within 28 days with some risks being mitigated in diagnostic in MRI, Ultrasound and Endoscopy.
- Finance - The Trust is an organisation in financial recovery; the Executive Team has worked with NHS Improvement (NHSI) with the aim to return to financial sustainability within three years as defined in the 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 Waste Reduction Plans are delivered without compromise to clinical safety.
- Fundamental Standards of Safety and Quality - Nurse Staffing Levels, Medical Staffing, C. difficile and MRSA targets, Failure to Rescue a Deteriorating Patient.
- Performance and Regulation - A combination of demand and capacity factors giving rise to continued high levels of medical outlying and delayed discharges alongside the challenges 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 was a follow-up inspection undertaken by the Care Quality Commission in May 2016 relating to the inspection that took place in March 2014. The Trust received an overall Good rating when the final report from the follow-up inspection was published in September 2016. The Board of Directors welcomed the report and the significant improvement in the ratings. Progress continues to be made in accordance with the plan, which is monitored through the Quality Assurance Committee.

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 submitted its Operational Plan for 2017/19 in December 2016 to NHS Improvement, 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 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 towards the delivery of five year Sustainability and Transformation Plans (STPs) for both the West Yorkshire and Harrogate 'footprint' and the City of Leeds.

The Trust is a key member of the West Yorkshire Association of Acute Trusts (WYAAT) which during 2016/17 established a Committee in Common for the governance and accountability of work streams to support the STP.

The Trust established the inaugural Leeds STP Health and Social Care Board to Board meeting, with three meetings taking take during 2016/17.

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 and 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 and 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 a refresh at the March 2017 meeting setting out the strategy for 2017-2020) 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. Due to the changes in the rules around appointment of external auditors for NHS Trust, the Board of Directors appointed the External Auditors for the first time, with an extension to the contract by one 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 2016/17 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, and 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 External 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 the following: (i) Finance and 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 and all actions from the independent review have been delivered. Please note: the external review was a TDA / Monitor requirement (to be carried out every three years). We currently await further guidance from the recent consultation by the CQC on the 'Well-led Review', prior to commissioning our next external review.

The Board commissioned an independent 360° review which included feedback from external stakeholders and was reported and considered in detail at a Board timeout session during June 2016.

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 2016/17, the internal auditors have provided significant 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 two (out of 37) assignments for which Internal Audit reported the level of assurance as limited for the year ended 31 March 2017. 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 are 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 as defined by NHS Improvement, limited assurance on the Annual Quality Report.

15. Health & Safety

15.1 In 2016 the Trust was one of only a few Trusts to receive a Royal Society for the Prevention of Accident (ROSPA) Safety Gold Award for its H&S management arrangement; this is a significant achievement for an organisation. As Chief Executive I have signed the Annual Fire Safety Certificate of Compliance, as assurance was reported to the Risk Management Committee.

16. Promoting Safety

16.1 The Trust has appointed 'Freedom to Speak Up Guardians' with the aim of promoting a culture of openness for staff to express concerns about patient care and safety. The current Whistleblowing Policy will be revised and re-launched in Quarter 1 of 2017 as the Freedom to Speak up Policy.

16.2 The Trust has also appointed 'Guardians of Safe Working' for the support and development of Junior Doctors. The Board of Directors are sighted on these roles, with quarterly reports to the Research, Education and Training Committee and the first annual report plan for the Board in May 2017.

17. Significant In-Year Matters

The Board and its Committee structures receive reports on the performance of the organisation against its duties set out in the provider licence. Reporting information is supplied to provide insight to the actual performance position against constitutional standards, full year to date position, and where appropriate agreed trajectories, to enable actual comparisons to be made year on year.

(i) There were 74 reported events during the year that met the criteria for a Serious Incident (SI). Each case has been thoroughly investigated and reported to

local commissioners. Detailed action plans have been developed and implemented in response to specific cases.

(ii) There were four incidents which qualified for reporting as a Never Event, relating to wrong tooth extraction, wrong side anaesthetic block and wrong site surgery (2). These incidents have been subject to a Serious Incident investigation; the findings and actions have been discussed with commissioners and shared with staff across the organisation.

(iii) There were two formal Prevention of Future Death Reports (formerly known as Rule 43 and now known as Regulation 28 Reports) issued by the Coroner. The Trust had addressed the concerns raised by the Coroner in these cases.

(iv) There were 53 events that met the criteria for reporting to the Health & Safety Executive under the provisions of the Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) Regulations. The Trust has continued to raise the profile of safety management during the year, and has received reports on progress at the Risk Management Committee.

(v) At an aggregate level the Trust did not meet 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 are likely to close the year with an aggregate performance at 88.85% with seven reporting specialties not meeting the incomplete standard (Trauma and Orthopedics, Plastic Surgery, Urology, General Surgery, ENT, Oral Surgery and 'Others').

The main underperformance relates to the impact of the non-elective pressure on elective Inpatient activity, which despite significantly increased Daycase and Outpatient activity has been unable to keep pace with demand. This has continued to grow in 12 Outpatient specialties that received more than 5% above the contracted level of referrals (from all sources) alongside a 10% growth in Inpatient demand in a further 12 specialties.

(vi) The Emergency Care Standard (ECS) national target of 95% of patients being seen within four hours of presenting in our EDs was not achieved in 2016/17 with pressures at both sides of the city this year. Emergency pressures and unplanned increases in demand, combined with challenges to discharge patients continued at unprecedented levels due to pressures on out of hospital healthcare infrastructure. With system-wide actions such as placing GPs in EDs, the opening of Bilberry and Heather units (at the Wharfedale site), co-location of medical assessment in EDs, performance recovered in March to achieve an above 90% formally reported position which meant that the Trust achieved the ED trajectory agreed with NHSI for March 2017.

(vii) The continued bed pressures resulted in the Trust not meeting the national requirement for all last minute cancelled operations to be rebooked within 28 days. Although there had been substantial progress in 2015/16 to reduce these to 84 breaches of this target at the year end, compared to 132 in 2015/16, this was not sustained in 2016/17 with 276 breaches Year to Date.

(viii) The Trust met the national requirement to undertake 99% of diagnostic tests within six weeks of referral from September 2016 to March 2017, including achievement at Endoscopy level from September to support continued JAG full accreditation. Achievement has continued to be challenging during Quarter 3 and 4 particularly with MRI demand rises and capacity constraints.

(ix) The Trust has not achieved 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 since March 2016. The Trust continues to work closely with neighbouring providers, GPs, Commissioners and other stakeholders to improve the timeliness of referrals to the Trust, which includes local breach reallocation processes. Work to improve internal systems and processes and build capacity continues to improve performance in key challenged pathways. The process for the monitoring of long waiting patients, i.e. those waiting more than 104 days without treatment has continued with the position stabilized at the level of 50 patients per month despite the bed pressure position during the majority of 2016/17.

(x) 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 and ii) the breast symptomatic target, for all months in 2016/17 bar April, August and January. Concerning the suspected cancer standard, a repeated annual issue in January related to patient choice to defer their appointments over the Christmas period. The Trust closed the year with both these targets being maintained.

(xi) The Trust has not met the 31-day subsequent surgery standard since October 2016 due to issues related to bed pressure impact on surgical specialties at SJUH and demand and capacity issues within the Melanoma Skin service at LGI. Pace of recovery for these standards has been slower than hoped due to the reduced ability to accelerate surgical throughput, but is expected to be delivered in Q1 2017/18.

(xii) Good progress has been made in reducing Clostridium Difficile infection in our Trust. In 2016/17, 115 patients developed CDI in our hospitals against the nationally-set trajectory of 119 for the Trust, which is a significant reduction compared to last year when 139 patients were diagnosed with CDI whilst in our care. In addition we have continued to identify a greater proportion of the cases, in conjunction with our commissioners, as having no "lapse in care" whilst in our Trust.

In 2016/17, 10 patients developed an MRSA bacteraemia whilst in our care, plus one where the MRSA isolate was a sample contaminant. This total is an absolute rise on the number that we had last year, and nationally each NHS Acute Trust continues to have an MRSA bacteraemia annual target set at zero, which a handful of our peers have achieved. The circumstances of each event were thoroughly reviewed. The patients involved had a number of medical co-morbidities, necessitating complex medical and nursing care. However, whilst the absolute total has risen, we are not currently a "significant outlier" nationally. 2017/18 will see the development of a HCAI collaborative which will utilise the Model for Improvement as a framework for testing new interventions to reduce HCAI Blood Stream Infections.

(xiii) The Trust has faced a number of financial challenges in 2016/17, and has delivered a small deficit at the end of the year. Full achievement of the planned position; a surplus of £1.2 million; was impacted as a direct result of the additional costs incurred following a serious failure of our Pathology IT system. The Trust has submitted a plan to NHSI which will deliver a surplus of £9m in 2017/18.

(xiv) 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.

(xv) During the year the Trust has experienced growth in 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.

(xvi) 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 mitigated the numbers of patients being cancelled on the actual days of the strike action.

(xvii) On 16 September 2016, the Trust's Telepath, Pathology IT system, suffered an outage that could not be rapidly restored, resulting in a protracted, wide-scale Business Continuity incident across the Trust. The outage affected Blood Bank, Blood Sciences and Microbiology services within the Trust, but also had implications for Bradford Teaching Hospitals NHS Trust and primary care across Bradford and Leeds. Due to the potential risk to patient safety and impact on service delivery, the Trust activated its internal business continuity arrangements on 18 September and a Silver Command was established to manage the incident response. Initially, Silver Command met twice daily, this reduced to once a day from 1 October before the command and control arrangements were stood down completely on 10 October. At this stage, a Recovery Working Group was established to oversee the actions required for restoring full functionality to Pathology IT systems, to recover and reconcile data, and ensure future systems' resilience.

The Trust continues to experience issues with the IT infrastructure which was highlighted by the Pathology outage in autumn 2016. The Trust Board has approved a Strategic Outline Case to mitigate these issues which is awaiting approval from NHS Improvement. This is a result of historic under investment over a number of years in the IT infrastructure by previous Boards. The Trust has also undertaken a complete review of all the key and critical systems to seek assurance to minimise the risk of a future occurrence. All actions from an external review after the Pathology outage are being implemented.

18. Concluding Remarks

18.1 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 over three years have delivered in the region of £220m savings. We are an organisation in financial recovery; the Executive Team has worked with NHS Improvement (NHSI) with the aim to return to financial sustainability within three years as defined in the recovery plan. 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 31 March 2017 and up to the date of approval of the annual report and accounts.

Signed

Julian Hartley, Chief Executive

Date: 25 May 2017

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 2016/17 was £230-235k (2015/16, £230-235k). This was **8.66 times** (2015/16, 8.72) the median remuneration of the workforce, which was £26,854 (2015/16, £26,659). The highest paid director in both 2016/17 and 2015/16 was the Chief Medical Officer.

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 2017).

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

	2016-17					2015-16				
Name and title	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000
M Chamberlain Non-executive Director	5-10	5	0	0	5-10	5-10	4	0	0	5-10
C Chambers Non-executive Director	5-10	0	0	0	5-10	5-10	0	0	0	5-10
M Ellerby Non-executive Director	5-10	17	0	0	5-10	5-10	10	0	0	5-10
J.M. Hartley Chief Executive	225-230	0	0	57.5-60	285-290	225-230	0	0	42.5-45	270-275
Prof S Hinchliffe CBE Deputy Chief Executive and Chief Nurse	175-180	0	0	25-27.5	205-210	175-180	0	0	20-22.5	200-205
C.A. Johnstone Non-executive Director (Vice Chair)	5-10	6	0	0	5-10	5-10	5	0	0	5-10
Dr W Kirkup CBE Non-executive Director (to 30 September 2016)	0-5	35	0	0	5-10	5-10	13	0	0	5-10
S.H. Neville Director of Strategy & Planning	145-150	39	0	17.5-20	170-175	145-150	59	0	20-22.5	175-180
Dr Y.A. Oade Chief Medical Officer	205-210	0	25-30	30-32.5	265-270	205-210	0	25-30	25-27.5	260-265
A.J. Page Non-executive Director	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Dr L Pollard CBE DL Hon.DLL Chair	40-45	17	0	0	45-50	40-45	17	0	0	45-50
D.A. Royles Director of Human Resources & Organisational Development	165-170	0	0	27.5-30	195-200	165-170	0	0	52.5-55	220-225
Prof P.M. Stewart Non-executive Director	5-10	0	0	0	5-10	5-10	0	0	0	5-10
T.A. Whitfield Director of Finance (retired 02 March 2017)	155-160	0	0	0	155-160	175-180	0	0	15-17.5	195-200
J Wood Interim Director of Finance (from 13 June 2016 to 31 March 2017)	130-135	0	0	30-32.5	160-165	n/a	n/a	n/a	n/a	n/a

Taxable expense payments are rounded to the nearest £100 in the above table. Pension related benefts 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 Department of Health have clarified that for NHS bodies this is the 'Real increase in pension multiplied by 20 plus the real increase in lump sum less contributions made by the individual equals Accrued Pension Benefits'. 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.

TA Whitfield, substantive Director of Finance, was on leave due to illness until his retirement on 2 March 2017. The role of Director of Finance was covered by J Wood on secondment from East Lancashire Hospitals NHS Trust from 13 June 2016 until 31 March 2017.

Salary and Pension entitlements of Senior Managers

B) Pension benefits

Name and title	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age as at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 01 April 2016	Real Increase in Cash Equivalent Transfer Value
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
J.M. Hartley Chief Executive	2.5-5	0-2.5	60-65	165-170	1,078	984	60
Prof S Hinchliffe CBE Deputy Chief Executive and Chief Nurse	0-2.5	5-7.5	75-80	225-230	1,598	1,506	66
S.H. Neville Director of Strategy & Planning	0-2.5	5-7.5	55-60	175-180	1,185	1,118	46
Dr Y.A. Oade Chief Medical Officer	2.5-5	7.5-10	85-90	255-260	1,850	1,730	79
D.A. Royles Director of Human Resources & Organisational Development	0-2.5	5-7.5	65-70	200-205	1,308	1,230	54
J Wood Interim Director of Finance (from 13 June 2016 to 31 March 2017)	0-2.5	0-2.5	40-45	110-115	685	636	24

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

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

Staff numbers and costs

Average staff numbers	2016-17			2015-16
	Total Number	Permanently employed Number	Other number	Total number
Medical and dental	2,019	1,875	144	1,949
Administration and estates	2,621	2,581	40	2,557
Healthcare assistants and other support staff	3,357	2,980	377	3,144
Nursing, midwifery and health visiting staff	4,222	3,962	260	4,156
Nursing, midwifery and health visiting learners	1	1	0	4
Scientific, therapeutic and technical staff	1,878	1,817	61	1,932
Social care staff	10	0	10	12
Healthcare science staff	1,056	1,034	22	908
Other	471	452	19	442
Total	**15,635**	**14,702**	**933**	**15,104**

	2016/17	2015/16
Number of permanently employed staff	14,702	14,125
Other staff	933	979
Total average staff number	**15,635**	**15,104**
Staff engaged on capital projects	**20**	**22**

Employee benefits

Employee Benefits - Gross Expenditure (£000s)	2016/17			2015/16		
	Total £000	Permanently employed £000	Other* £000	Total £000	Permanently employed £000	Other* £000
Salaries and wages	568,864	516,714	52,150	556,196	494,853	61,343
Social security costs	48,390	48,390	0	36,614	36,614	0
Employer Contributions to NHS BSA - Pensions Division	63,072	63,072	0	60,084	60,084	0
Other pension costs	135	135	0	13	13	0
Termination benefits	0	0	0	57	57	0
Total employee benefits including capitalised costs	680,461	628,311	52,150	652,964	591,621	61,343
Costs capitalised as part of asset	(-909)	(-909)	0	(-971)	(-971)	0
TOTAL - excluding capitalised costs	**679,552**	**627,402**	**52,150**	**651,993**	**590,650**	**61,343**

*Other refers to any staff engaged on the objectives of the Trust, but do not have a permanent (UK) employment contract with the Trust.

Sickness absence data

Staff sickness absence and ill health retirements	2016/17	2015/16
Total days lost	132,409	122,507
Total staff years	14,614	13,886
Average working days lost	**9.06**	**8.82**
Number of persons retired early on ill health grounds	25	25
Total additional pensions liabilities accrued in the year (£000s)	1,227	1,081

Expenditure on consultancy

Consultancy Expenditure (£000s)	
2016/17	1,001
2015/16	585

During 2016/17 The Trust negotiated a revised PFI financing agreement in respect of Bexley Wing. This accounts for the increased cost of consultancy compared to 2015/16.

Off-payroll engagements

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

	Number
Number of existing engagements as of 31 March 2017	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 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	10
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	10
Number for whom assurance has been requested	2
Of which,	
assurance has been received	2
assurance has not been received	0
engagements terminated as a result of assurance not being received	0
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.	15

Of the 10 individuals engaged or reaching 6 months during the year 8 left before assurance could be sought and one after it was received.

Exit packages

None during this financial year.

2.5 Regulatory ratings

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 the visit in March 2014. We were delighted to be rated 'Good' by the CQC following their inspection, reflecting the significant progress we have made in improving our culture of quality and safety. A copy of the CQC report on the Trust can be found on our website at www.leedsth.nhs.uk.

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 associated 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.

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2016/17.

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

2.7 Modern Slavery Act 2015 - Transparency in Supply Chains

The Modern Slavery Act is a piece of legislation which sets out a range of measures on how modern slavery and human trafficking should be dealt with in the UK. Whilst not all of the Act is directly relevant for business, section 54 entitled 'Transparency in supply chains' impacts the corporate sector. The Act, which came into force on 29 October 2015, requires many businesses to disclose a 'slavery and human trafficking statement'.

The Trust complies with this requirement in the following statement:

"In relation to its procurement processes the Trust has recently introduced the new Supplier Questionnaire document published by Crown Commercial Services that asks specific questions around the Modern Slavery Act and any breaches of labour laws which result in disqualification of unsuitable organisations.

The Trust also purchases large amounts of products from 3rd party distributors such as NHS Supply Chain and utilises framework agreements from national framework providers such as Crown Commercial Services and North of England Commercial Procurement Collaborative who also include specific questions around the Modern Slavery in their procurement documentation."

In addition, an action plan is under development to ensure appropriate changes to policies and processes are made.

2.8 Our People

Leeds Teaching Hospitals' greatest asset is our people and we value our staff highly. Their skill and dedication means we have some of the country's leading clinical expertise and can offer patients the highest quality, most compassionate treatment and 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. With strong encouragement and leadership from our Chief Executive and senior team, engagement with people working in our hospitals has improved over the past 12 months, going from 3.76 in 2015 to 3.83 in 2016 (on a scale of up to 5).

Workforce statistics

Trust Board - at 31 March 2017

Gender	Job Role	Position Title	Number
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, as at 26 March 2017, is included below.

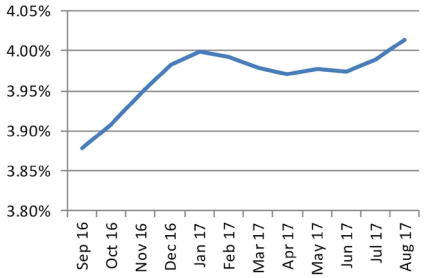
Gender	Head Count
Female	12,843
Male	4,334
Grand Total	**17,177**

This is an increase of 425 members of staff from last year. The Trust recruited over 2,600 people in the past 12 months.

Sickness absence

The sickness absence rate for Leeds Teaching Hospitals during 2016/17 was as follows:

12 month sickness trend
March 2016 - February 2017



Our sickness rate across the Trust decreased in 2015/16; however, the winter of 2016/17 saw an increase in our rate. Our Health and Wellbeing work is developing a range of approaches to support staff including an Employee Assistance Programme, which was launched in 2016. More information is provided below on health and wellbeing.

Our Human Resources service is supporting line managers to effectively manage sickness absence. The recent increase in absence rate was for both short and long term absence.

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

Leeds Teaching Hospitals provides a range of clinical placements for medical students from the University of Leeds Medical School, and delivers a range of high quality additional teaching sessions. During term time, around 370 medical students are on placement in our wards and departments, and Trust staff are engaged in a wide range of teaching activities, both in the Trust and at the University. Overall, the quality of experience provided to our students continues to improve.

Working with colleagues in Corporate Nursing, we have grown and developed our Multi Professional Student Forum to ensure students have a voice, and have regular access to senior leaders in the Trust. We are very pleased that in 2016 the Forum was shortlisted for a Health Service Journal (HSJ) Award.

During the 2016/17 academic year, the first cohort of Physician Associate students came into the Trust on placement, all from the University of Leeds. The range and scope of teaching in the state-of-the-art undergraduate hub and teaching ward in Gledhow Wing, St James's has grown during the year, along with the use of a new self-directed practice room, enabling students to hone their clinical skills.

Postgraduate Medical Education

Engagement between the team, Clinical Service Unit (CSU) leaders and junior doctors has improved this year. There has been a new quality review process put in place with CSUs which is being rolled out, enabling senior CSU leaders to review quality metrics and agree improvement plans. A Junior Doctor Forum has been developed, which gives trainees direct access to senior medical leaders. Considerable improvements have also been made in providing pastoral support for trainees, including the early identification of issues.

One of the most significant features of the year has been the implementation of the new Junior Doctor Contract, which began in December 2016. Nationally, the contract was the focus of industrial action and throughout this, Leeds Teaching Hospitals was able to maintain good working relationships with trainees. Two new Guardians of Safe Working Hours have been appointed, along with the Junior Doctor Body to ensure that trainees' working hours and their access to education are protected.

Clinical Skills, Simulation and Technology Enhanced Learning

The Leeds Institute for Minimally Invasive Therapy (LIMIT) enjoys an excellent reputation both regionally and nationally for the range and quality of education programmes it offers. In recent years, LIMIT has become the focal point for many of our postgraduate medical education courses and modules. The staff in LIMIT have considerable expertise in delivering high quality sessions, ranging from bench-top clinical skills simulation, human factors and team interaction activities, through to highly technical virtual reality surgical simulators.

Clinical skills teaching takes place in numerous dedicated facilities across the Trust. In addition, there are other CSU managed centres, including a paediatric facility in Martin Wing at the LGI and a cardiac 'wet lab', also at the LGI.

There is also a Health Education England funded Radiology Academy in Clarendon Wing at LGI.

The Technology Enhanced Learning team has produced a range of innovative educational products, including e-learning, mobile apps and videos.

NHS Staff Libraries and Evidence Service

We operate library facilities in three of our hospitals: LGI, St James's and Wharfedale. The main library facility is located at the LGI. It provides an excellent range of physical books and journals along with an extensive on-line collection, which is constantly reviewed and updated in line with feedback from users. We continue to co-operate the library in the Clinical Sciences Building at St James's with the University of Leeds. Both facilities provide extensive personal study space, and there is access to computer facilities. At St James's, we maintain the relatively compact Cookridge library in Bexley Wing along with a small undergraduate facility in J34. In signing up to the NHS staff library, Trust staff can also access library services provided by the University across their campus.

The Trust staff library works closely with other NHS and public health services across Leeds, and there are arrangements for inter-library lending. The team at Leeds Teaching Hospitals is working closely with the regional team to improve library and research facilities for all staff in the city.

The team is working hard with clinicians to bring library services, including evidence search facilities closer to the work place. We continue to support the on-line services, 'Athens' and 'Up-to-Date'.

Nursing and Allied Health Professional Education

The Trust is committed to recruiting the best professionals and supporting all nursing and midwifery staff to achieve their potential through education and development. We want to ensure that every patient receives the right care at the right time from the right person with the right training.

We offer high quality clinical placements in a wide range of settings for around 900 Nursing, Midwifery and Allied Health Practitioner (AHP) students from most of the universities in the Yorkshire and Humber region. Their learning is supported by more than 1,600 mentors and practice supervisors, including more than 230 new mentors who completed the Support for Learning in Practice programme in 2016/17.

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 2016/17 the Trust supported 498 applications in nursing and midwifery for higher education programmes, ranging from single modules to doctoral study. By working in close partnership with Health Education Yorkshire and Humber, as well as local and national education providers, we have helped staff to develop and deliver new roles. This includes 45 full-time training posts for Advanced Practitioners and a Foundation Degree level programme to develop Assistant Practitioners.

In October 2016 the Trust, as part of a partnership covering Leeds, Bradford and Airedale, was announced as one of only 11 pilot sites nationally to develop the Nursing Associate role. The partnership employers have worked with the three local universities to create academic programmes at Foundation Degree level. This is a work-based programme with trainees working clinically three days a week and in university or on placement for the rest. All programmes have now begun and trainees have already been out on placement, all of which have been positively evaluated.

Our Organisational Learning Team, in partnership with Learn Direct Apprenticeships, has increased the intake of our successful healthcare apprenticeship programme and offer training opportunities for up to 300 candidates a year. For our unregistered care staff already in post we have commenced apprenticeship programmes to develop higher-level skills that will be extended further in 2017/18 with the introduction of the apprenticeship levy.

All of this work is designed to develop the workforce for the future, with a career ladder full of opportunities to enable our staff to fulfill their potential.

Organisational Learning

Organisational Learning provides education, learning and development opportunities to all our staff.

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.

Inductions

Corporate induction is completed by 99.6% of new starters on their first day, which is a 1.6% increase from 2015/16.

To recognise the importance of further embedding The Leeds Way for staff in leadership and management roles, we have developed a New Leaders Network, which provides the opportunity for networking and peer support.

To ensure staff feel welcomed within the Trust and are aware of relevant local policies and processes staff are given a local induction within 28 days of starting their employment at the Trust. In the last 12 months, 89.2% of new starters have received a local induction.

Agenda for Change (AfC) Appraisal

Our 2016 Staff Survey shows that we are among the best performing Trusts nationally for the number of staff having an appraisal, with 96.1% of AfC staff receiving an appraisal in 2016/17. More than 2,000 staff attended training to ensure the appraisal experience was a positive one for all.

In addition the Trust has been recognised as having made significant improvements in terms of the number of staff stating that they have received a high quality appraisal.

Mandatory training

The mandatory training framework is made up of 11 overarching topics which ensure that all staff members receive the training and updates they need in order to perform their role. This includes completion of more than 70,000 training interventions on an annual basis.

Overall mandatory training within the Trust increased from 90% in March 2016 to 92% in March 2017. Technology Enhanced Learning tools such as eLearning and training films have been used to improve our staff's compliance with on-going mandatory training.

IT Training

In 2016/17 11,649 members of staff have been trained on IT and clinical systems. This was delivered either in face to face classroom sessions or by eLearning.

Talent and leadership update

Over the past 12 months 282 staff members took part in our medical and leadership development programmes, as shown in the table below:

Programmes

Apr 2015 - Mar 2016	Target Audience	Number of participants
CMI - Level 2 Team Leading	Team leaders and supervisors	14
CMI - Level 3 First Line Management	First line managers	42
CMI - Level 5 Management & Leadership	Middle managers	7
CMI - Level 7 Strategic Management & Leadership	Senior managers	9
Medical Leadership - Foundation	Doctors and above	23
Medical Leadership - Advanced	Doctors and above	20
Introduction to Management	Bands 3 - 7	113
Leading for Patients - B5	Nurses, healthcare scientists and allied health professionals	19
Leading for Patients - B6		14
Leading for Patients - B7		13
Delivering the Best	Bands 1 - 4	8

Mentoring for New Consultants

To ensure that all newly appointed consultant medical staff can access quality mentoring, we ran a schedule of regular training sessions. Feedback and take up has been positive, with 54 consultants completing the training in 2016/17.

Medical Leadership

A range of development and engagement opportunities for Trust medical leaders has taken place over the past 12 months. Examples are included below.

- 43 consultant staff enrolled on our Medical Leadership Development Programmes - Foundation and Advanced - which have been aligned to the Faculty of Medical Leadership and Management (FMLM) standards and include the FMLM 360° feedback tool.
- The Medical Leadership Networks provide the Trust's medical leaders, or aspiring medical leaders with the opportunity to network, share best practice, receive Trust updates and communicate with senior management. The networks provided include: New Consultants' Network, Consultant Forum, Lead Clinician Group and the Junior Doctors' Body.
- A mentoring training programme has been designed and implemented to provide and develop Trust Consultants with mentoring skills and 54 consultants have accessed this training.

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. In the financial year 2016/17, 257 members of staff were trained.

Work experience, schools engagement and employability

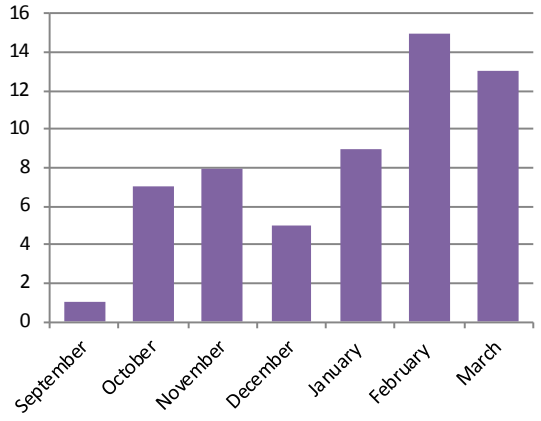
Our Health Education England 'partnership pledge', has seen the Trust working with our partner organisations to deliver a number of key strategic intentions incorporating widening participation, linked to the national framework, "Talent for Care".

We have been improving links with local schools, colleges and communities in a number of ways, including:

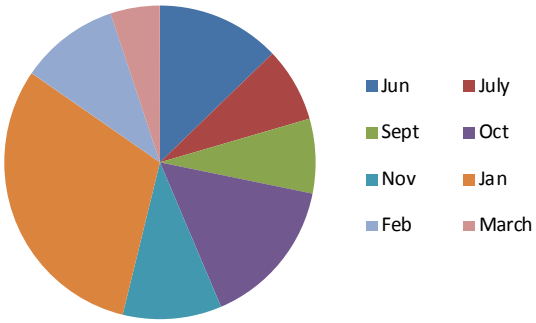
- recruiting a member of staff to develop links between schools and Leeds Teaching Hospitals, capture activity and support evaluation so as to identify which engagement activities provide most benefit for all parties.
- continuing our relationship with Inspiring the Future, a national charity that connects local schools and employers.
- the recruitment and development of over 200 Trust staff as volunteer Healthcare Career Ambassadors to promote NHS careers and jobs.
- the growth of partnership working with our two agreed partnership schools, Rodillion Academy and The Cooperative Academy and the recruitment of a third school - South Leeds Academy - that we will also work with in 2017/18.
- embedding our four-week internship placements to local schools, and mentoring students through the Career Ready programme.
- working with schools and relevant partners to develop appropriate resources and work-related engagement activities including three Apprentice information Open Days hosted by Organisational Learning.
- development of relationships with organisations including The Princes Trust, Department for Work & Pensions, Leeds City College, Leeds City Council, Johnson & Johnson and the Ministry of Defence. We will work with these partners to provide NHS work placements for individuals who may be interested in potential employment in the Trust.
- introduction of a Work Experience Welcome, ensuring that individuals coming into the Trust are well-equipped and supported to undertake their placement.

The tables below highlight the careers events and work experience activity in 2016/17.

Number of students attending work experience placements 2016/2017



External career events attended by LTHT HCCA 2016/2017



Apprentices

We are proud of our apprentice programme at the Trust. In 2016/17, we had 393 apprentice starts (excluding the Leeds Dental Institute) across a wide range of areas. The introduction of the Apprentice Levy has been a catalyst for exploring options to use apprenticeships across further disciplines and has allowed the Trust to consider options for working collaboratively with neighbouring Health and Social Care organisations.

In partnership with Bradford District Care Foundation Trust, we were successful in our bid to host the National Skills Academy for Health West Yorkshire & Harrogate Excellence Centre.

We will use this to drive a regional approach to the recruitment of apprentices.

The table below shows the apprenticeship qualifications undertaken at the Trust and the projected starts for 2017/18:

Apprenticeship Award	Number of starts 2016/17	Planned starts 2017/18
Intermediate Clinical Healthcare Support Worker	268	300
Advanced Clinical Healthcare Support Worker	46	75
Intermediate Business Administration	61	120
Advanced Business Administration	11	45
Advanced Mechanical Engineering	2	4
Advanced Horticulture	1	1
Advanced Pharmacy Services	4	20
Advanced Team Leader	N/A	70
Higher Certificate in Management	N/A	20
Degree in Management	N/A	20
Total (excluding dental school apprenticeships)	**393**	**675**

In June 2016, Organisational Learning was pleased to host the first Support Staff Conference, entitled 'Talent for Care The Leeds Way'. The event was aimed at both clinical and non-clinical staff who work in Band 1-4 roles in the Trust. Its goals were to recognise the contribution that our support staff workforce make to the delivery of great patient care and spread awareness of the training and development opportunities available. The event was well received and has seen a marked increase in enquiries across this group of staff regarding career progression routes.

Following the conference, there has been a review of Maths, English and IT training for our staff and we are now able to signpost staff to the most appropriate support either within or external to the Trust. The conference will now become an annual event, allowing us to better engage with frontline staff and encourage lifelong learning.

We have been named Employer of the Year for Apprenticeships in Yorkshire and Humber and National Employer of the Year by the Learning and Work Institute.

Learning Bursts

Learning bursts are a condensed training session designed to equip Trust staff 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.

During 2016/17, 1,551 members of staff attended these sessions, an impressive 45% increase in attendance (480 staff members) from the previous financial year.

Organisational Learning continually works to provide new and current learning topics for Trust staff. The new topics for 2016/17 include:

- Stress Awareness
- Emotional Intelligence
- Building Effective Work Relationships
- Creating a Mentally Healthy Workplace
- Team Resilience
- Personal Resilience
- Health and Wellbeing at Work

Sector-based Work Academy

In conjunction with Leeds City College and the Department of Work and Pensions, the Sector-based Work Academy aims to support unemployed adults back into work. The programme runs twice a year for six consecutive weeks, four of which are spent on placement in the Trust.

During 2016/17, the Trust hosted placements for nine Business Administration apprentices and 11 apprentice Clinical Support Workers.

Supporting our diverse workforce

The annual NHS staff survey tells us that our staff who have a protected characteristic including disability, gender and race are for the most part more positive about their working experiences than they were in 2014. 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 in relation to the key findings of:

- % experiencing discrimination at work in the last 12 months
- % believing the organisation provides equal opportunities for career progression
- Staff Engagement score

The staff survey data shows that the gap is closing for two of the three key findings. They are shown in more detail below. Work is underway to ensure all three of our five year targeted ambitions of at least 50% by 2020 are achieved.

In 2016, we were assessed to see if we were eligible to use the Disability Confident symbol (formerly Two Ticks). We were successful in achieving Level 1: Disability Confident Committed and are currently awaiting the outcome to our Level 2: Disability Confident Employer submission. We aspire to be awarded both Level 2 and the final Level 3: Disability Confident Leader in 2017.

In addition, we have also signed up to the Mindful Employer Charter and NHS Learning Disability Pledge. These are both voluntary commitments to work towards removing barriers in the recruitment and retention of staff with mental health problems and learning disabilities.

Also in 2016, Black Asian and Minority Ethnic (BAME) staff within the Trust set up a BAME staff network to work closely with staff from relevant areas of Human Resources to make sure the work experiences of BAME staff are improved.

In addition to our work on disability, race and gender, in 2016 the Trust became a Stonewall Diversity Champion and made progress against all five objectives of the Trans Equality Pledge to improve the work experiences of lesbian, gay, bisexual and trans staff.

Please see our Equality Factsheets for further information www.leedsth.nhs.uk/about-us/equality-and-diversity/public-sector-equality-duty-compliance-report

	2014			2016		
	White	BAME	% Gap	White	BAME	% Gap
% staff experiencing discrimination at work in last 12 months	10%	25%	15%	8%	24%	16%
% staff believing the organisation provides equal opportunities for career progression / promotion	89%	70%	19%	88%	76%	12%
	Disabled	Not disabled	% Gap	Disabled	Not disabled	% Gap
Overall staff engagement	3.45	3.71	0.26%	3.67	3.87	0.2%

Health and wellbeing

Leeds Teaching Hospitals takes the health and wellbeing of our staff seriously and we are dedicated to improving the quality of working life for all staff. We recognise the importance of investing in the health and wellbeing of the workforce by engaging with and encouraging staff to be more aware of their own wellbeing.

The Staff Health and Wellbeing team continues to provide a more co-ordinated approach across the Trust, being more visible to and engaging with staff to raise awareness of the health and wellbeing campaigns and services available. They attend staff huddles and meetings across sites to engage with staff groups, promoting campaigns and services available.

The Trust supports a holistic approach to health and wellbeing. Managers have the opportunity to attend training sessions to encourage and create a mentally healthy workplace, attendance management processes, managing difficult conversations and resilience training. All training courses are available to book via the training calendar.

There are a range of services that support staff and promote health and wellbeing. These include:

- Employee Assistance Programme
- Cycle to Work scheme
- Feel Good campaigns
- Health & Wellbeing Champions
- Health initiatives
- Health Trainers
- Occupational Health
- Staff Counselling service
- Staff Physiotherapist service
- Smoking Cessation
- Staff gyms, fitness tests and exercise classes
- Team challenges
- Wellbeing Zone

In October 2016 two new services were introduced to support the health and wellbeing of staff. The first was the Employee Assistance Programme, an advice, information and counselling service for staff. Trained counsellors and specialist advisors are available 24/7 to provide immediate support or offer one to one telephone counselling sessions within 48 hours.

The second was the introduction of the Leeds Teaching Hospitals Wellbeing Zone website, available as a desktop facility or mobile app. The website aims to improve lifestyles and encourage people to be more active and eat healthily.

Staff can complete personal wellbeing assessments and set personal goals and targets to improve their health and wellbeing. The website also lists active challenges, advice sheets and the staff health and wellbeing benefits available.

On the Trust's intranet, the Staff Health and Wellbeing page has been restructured to help staff access staff services easily, in one place. Staff can navigate the pages and have a clear view of the great health and wellbeing events, opportunities and services.

The Health and Wellbeing team also supports health initiatives to inspire staff motivation, including free exercise classes. In 2016/17 we held various health and wellbeing challenges and more than 1,100 staff participated.

In September 2016 the Staff Health and Wellbeing team was awarded a gold award from Sports and Physical Activity @Work. This was in recognition of our support for the Trust to create a more active and healthy workplace and for the energy and enthusiasm shown whilst encouraging staff to be more active.

Staff continue to be supported in balancing their home and work life. Three staff nurseries are available for the children of our employees. Advice on accessing externally provided care and financial support that may be available to working parents through tax credits, childcare vouchers and nursery salary sacrifice is also available.

Occupational Health Service

Occupational Health (OH) for the Trust is registered to the national accreditation scheme for Occupational Health providers, Safe Effective Quality Occupational Health Service (SEQOHS - www.seqohs.org). We were the first Trust in West Yorkshire to be accredited in 2012 and have maintained annual accreditation since that date.

Accreditation is awarded following formal inspection of evidence and working practice against the following standards:

- business probity
- information governance
- people
- facilities and equipment
- relationships with purchasers
- relationships with workers
- specific NHS standards covering scope of service, business and delivery service standards, audit.

OH leads the Trust staff flu campaign which this year began on 3 October 2016. By 30 November we had met the national target of 75% of frontline healthcare workers vaccinated – a month ahead of the CQUIN funding target date.

Final figures reported for staff flu vaccination were 79.9% of frontline healthcare workers and 76.7% of all staff vaccinated. This is a significant result and our highest figures since reporting began.

Alongside providing an OH service to Trust employees, all Leeds University healthcare students including student medics and dentists are also covered by this service throughout their course and not just whilst on placement at the Trust.

Nationally there is a shortage of qualified OH doctors and nurses and the service has struggled to recruit new staff. This has prompted a need to restructure the service and develop new ways of working with our HR partners.

Due to qualified staffing capacity, waiting times for in-service referrals did escalate up to six weeks. By working with HR colleagues and the private sector, OH was able to reduce waiting times back to within the national Key Performance Indicator (KPI). During the final quarter of 2016/17, the average waiting time to see a qualified OH clinician was 4.2 days.

The national requirement is for 98% of staff to be assessed for fitness to work within two days of receipt of form. The KPI for on-employment clearances of new staff has consistently been met during 2016/17.

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.

We have a Trust Board approved Health and Safety Policy, which explicitly details roles, responsibilities, arrangement and integration with the Trust corporate governance processes. It also includes our detailed procedures relating to specific risks such as fire safety, violence and aggression, radiation, COSHH and slip/trip prevention.

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.

In 2016, we conducted an audit of the previous year's performance in which 501 wards and departments - 97.75% of the total number across the Trust - took part.

Reactive monitoring of health and safety data, in particular RIDDOR reports following serious incidents, shows a declining number of serious health and safety incidents occurring / reported to the Health and Safety Executive (HSE) in 2016.

RIDDOR (staff) - significant work related injuries and diseases

Year	2010	2011	2012	2013	2014	2015	2016
RIDDOR's	117	109	97	69	76	65	48
All reported incidents	20679	21426	24214	25219	26285	28467	30785

In 2016 the HSE did not issue Leeds Teaching Hospitals with any statutory enforcement notices that require employers to take immediate action to improve health and safety risks.

Public / Employers liability claims following alleged harm due to negligent acts by the employer increased in 2016.

Injuries from used disposable medical devices, especially hollow bore needles that may be contaminated with blood and body fluids, is a major infection risk to healthcare employees. New statutory regulations became effective in May 2013 requiring employers to introduce devices to reduce the risk and the Trust has made good progress in complying with the new duty. Following their introduction, these types of incidents (RIDDOR Dangerous Occurrence) where the donor presents a high risk rose initially, although we are pleased to report that in 2016 they have been less frequent.

We are very proud to have been awarded the ROSPA gold award for our Health and Safety management systems and arrangements. This is a significant achievement and we are one of the first Trusts in the country to achieve this.

What did our staff tell us in the staff survey?

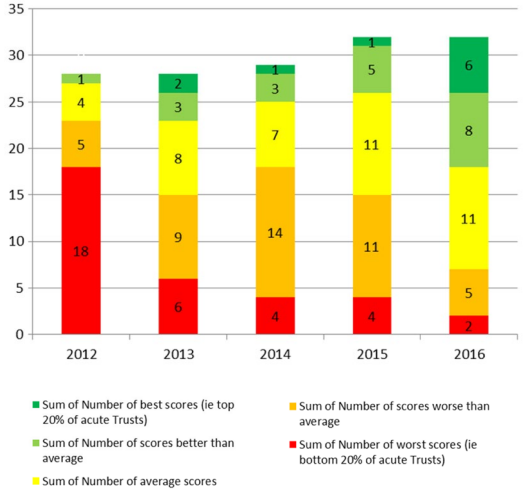
The NHS Staff Survey took place between October and November 2016 and is an annual indicator of how NHS staff feel about their working life and environment. The results are summarised in 32 key findings, which cover areas ranging from staff motivation at work to how well managers communicate with their teams.

At a national level the staff survey results have improved overall, which is reflected in the improvements we have seen in 2016. We have now moved from a position where the Trust was lagging behind the national average to one where the Trust is now in line with the national average for 11 key findings and above it for 14 key findings.

In 2016 a full census survey was undertaken for the second time. We were delighted that significantly more of our staff shared their experiences than any other trust and for the second year running, we had the highest number of responses nationally with 7,114 members of staff participating. This is an excellent result that shows our commitment to encouraging our staff to share their views on their working environment.

The Trust has shown good progress since 2015, improving in 21 of the 32 key findings with six now in the top 20% of acute trusts. For the first year, we now have the majority of the key finding scores average or above. This is great progress and the table below shows how we have improved our position year on year.

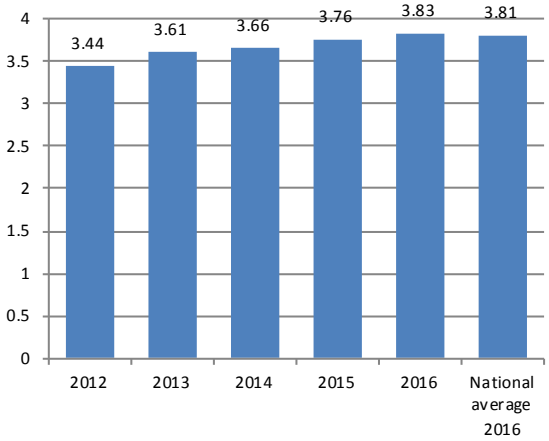
Annual Progress



In the 2016 survey, when comparing key finding results to 2015, we have improved in 21 of the key findings, stayed the same in 11 and deteriorated in none.

A key measure from the staff survey is staff engagement, which is scored out of five. This measure looks at three areas; staff advocacy, motivation and ability to contribute to improvements. We have seen a steady increase in the staff engagement score, which demonstrates the impact The Leeds Way is having. For the first time the Trust's score is now above the national average.

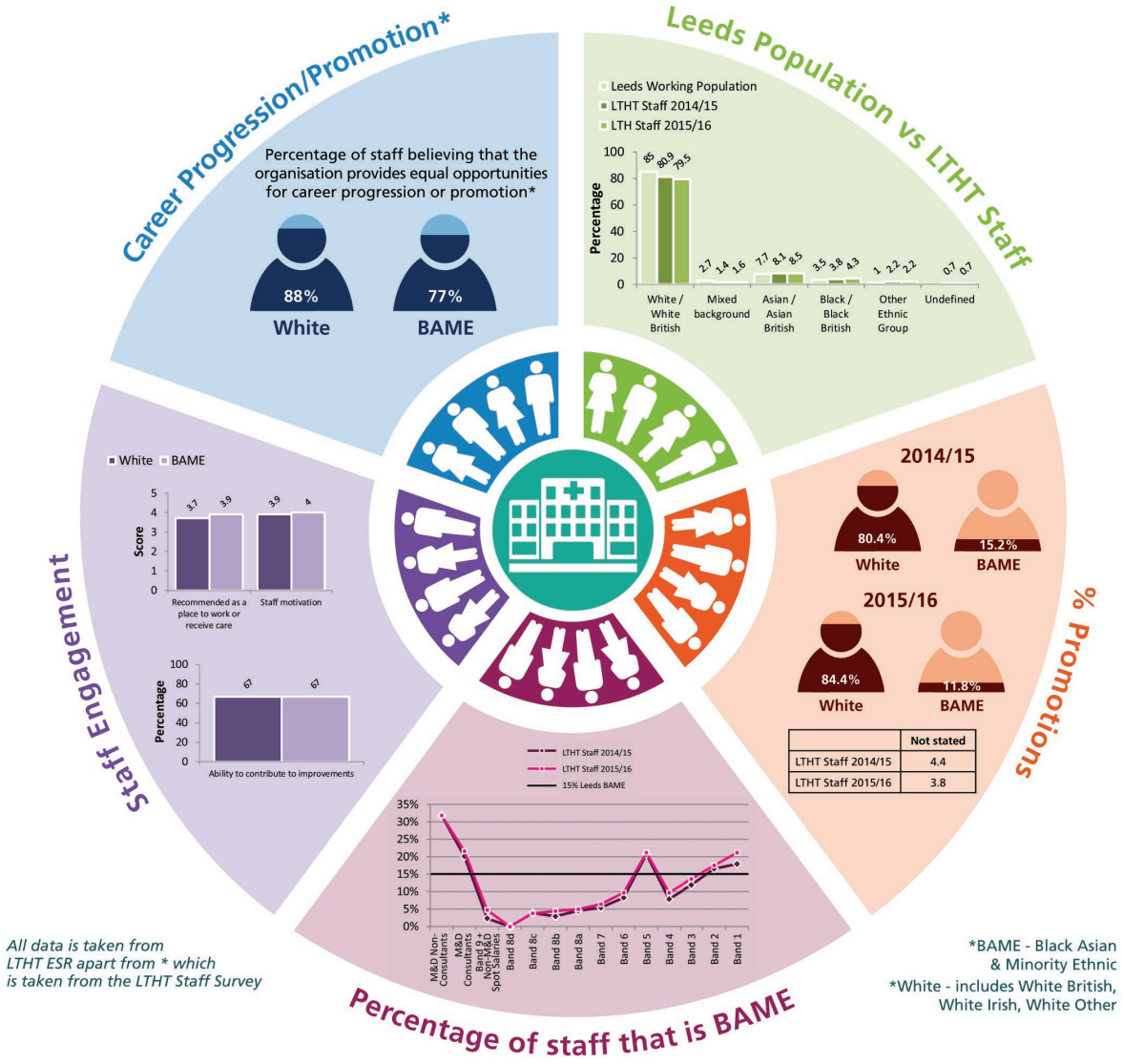
LTHT Staff Engagement Score



Understanding our people

We are proud to be one of the most diverse employers in Leeds, employing people aross all protected groups. We will continue to foster a supportive, equitable environment where staff are recognised and rewarded for their knowledge and skills. Further information on the ethnicity and gender of our people, and their representation at the Trust is shown in the graphics on the following pages.

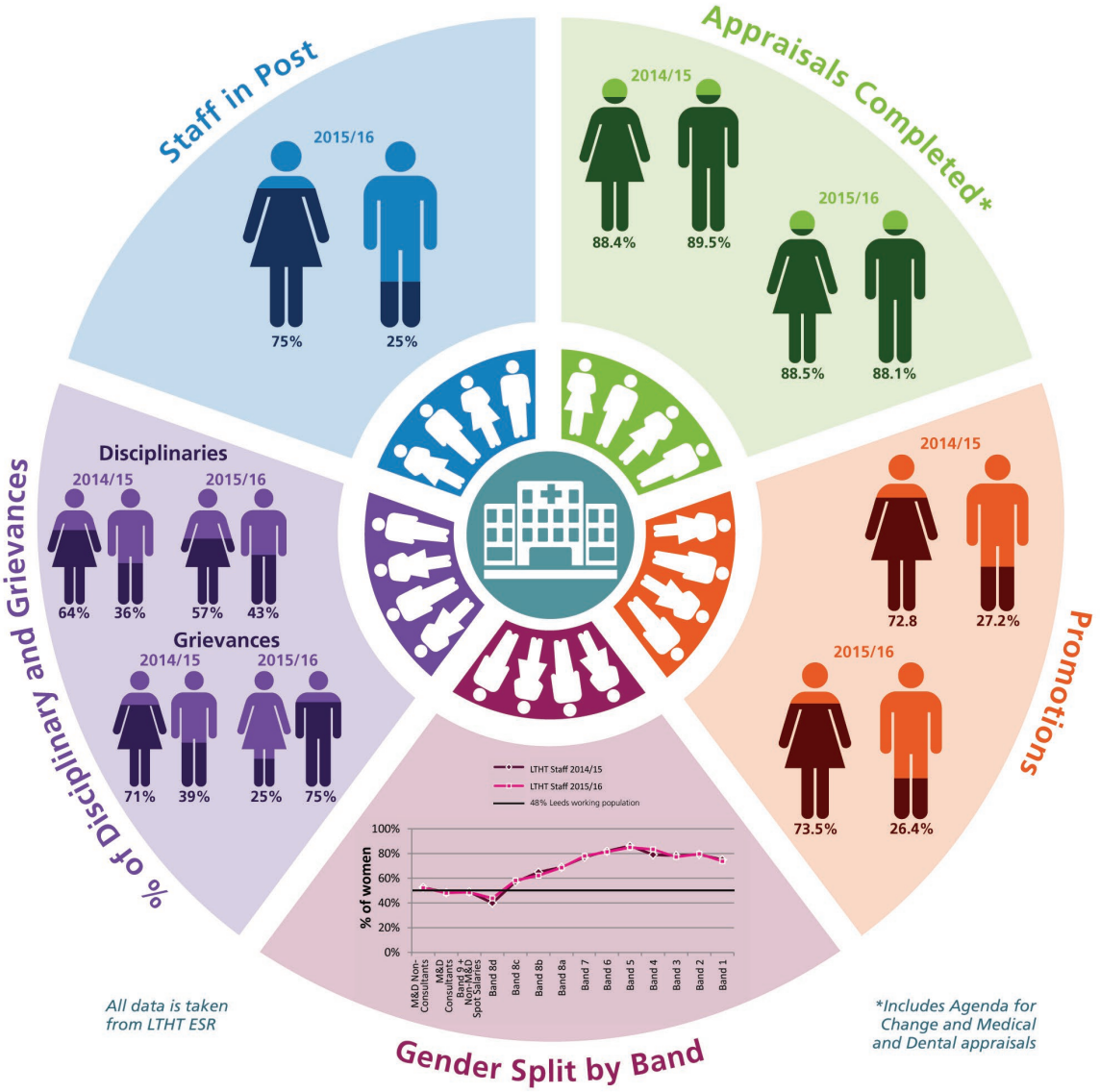
Ethnicity@LTHT



*All data is taken from LTHT ESR apart from * which is taken from the LTHT Staff Survey*

*BAME - Black Asian & Minority Ethnic
*White - includes White British, White Irish, White Other

Gender@LTHT



*Data taken from latest figures published January 2017.

Section 3
Patient Care and Experience

Patient Care and Experience

The involvement of patients, carers and the public in the Trust's work is central to our aim to deliver quality care and access to services. Over the past year, we have continued to listen to patients and learn from their feedback to improve the care we provide.

3.1 Involving patients and the public

Patient reference group and other initiatives

During 2016, one of the Trust's key aims was to make it easier to hear the patient voice. In response, the patient, carer and public involvement (PCPI) team developed a patient reference group so Trust staff can work with patients and members of the public to develop Trust-wide strategies and projects to improve patient services.

In November 2016, the PCPI team held a 'Big Event' to encourage members of the public to take part in this exciting initiative. Thirty-four people attended and in January 2017, we held our first patient reference group meeting. To date, the group has met three times and is currently working on supporting the Trust to develop a strategy to improve the patient experience. In the coming year, the PCPI team aims to build on this encouraging start and involve more Trust services and departments in working with the patient reference group to support their ambitions.

In 2016, we also began to work with colleagues at Leeds West CCG to deliver a patient leader programme. Patient leaders are individuals who want to represent the patient voice and influence decision making in the Trust. The programme assists people who are, or who wish to be a patient leader in the hospital to access development opportunities that will support them in their role. We have provided training on how the Trust is organised and manages its day-to-day activity in providing healthcare. Further sessions are planned for the coming year, which will focus on how the Trust uses patient and public feedback.

Patients who have used Trust services and members of the public are often willing to support our hospitals but don't always have a great deal of time to commit. Over the past year, we have successfully developed remote consultation via e-mail, seeking feedback on a number of topics from individuals specially selected from our database of around 6,500 people who are willing to be contacted by the Trust.

Since September 2016, we have run 11 separate consultations using this method on topics including medicines, discharge and dental care. More consultations are planned in areas such as heart disease, Parkinson's disease and ophthalmology. Feedback suggests many people are pleased to be able to contribute in this way, as it fits into their lives and enables them to feel they are 'giving something back'. We value this contribution to our services and hope to build on this success in the coming year.

In 2016 the PCPI team began a project to support existing patient groups in the Trust. These groups are usually based in specialty areas and this work assesses whether the groups have any particular development or training requirements and how they can be supported to meet their objectives and share the work they are doing with others. This work is still in its infancy and will continue to be developed in 2017/18.

3.2 Improving patient experience

Friends and Family Test

We relaunched our Friends and Family Test (FFT) in December 2016. Our new contract provider, Healthcare Communications enables us to offer patients different options for giving their feedback. This includes electronic hand held tablets on inpatient wards, an online feedback button available on the Trust internet pages,

text messaging feedback services in some areas and the introduction of an instant voice messaging service for patients who don't have a mobile phone. These changes are expected to not only increase the number of patients responding to our request for feedback but will also allow our CSUs to use feedback more effectively and identify more solutions to improve patient experience in the future.

Following the successful relaunch, tablet devices are now operational across six inpatient wards at Leeds Teaching Hospitals, and should be fully implemented in all adult inpatient areas by the end of 2017. In addition text services have been rolled out across all day case and outpatient areas and emergency departments.

To ensure all patients are able to give feedback in a format they are comfortable with, paper feedback opportunities remain available and have been redesigned to be much more patient-friendly. In addition there are easy-read versions for patients with learning disabilities and a children and young person's card has been developed. Artwork depicting the Trust's FFT mascot 'Fred' is now in use on patient feedback cards, department posters and on business cards that will be used to market online facilities. 'Fred' was introduced to the Trust following patient and staff consultation carried out during December 2016.

We not only want to collect more feedback, but also to use the feedback we receive to shape the care we provide in the future. An additional function made available to the Trust by our new provider is an online electronic feedback portal known as Envoy. All Trust staff have access to this portal and feedback can now be reviewed by department, individual comment or by themes.

In addition, comments are grouped – negative or positive - allowing for information to be scrutinised much more rigorously than previously. As a result of the new system, Trust staff can access electronic patient feedback within two hours of its submission. This means we can respond to patients' comments and make improvements to their experience and environment much more quickly.

During 2016/17, feedback gathered from the FFT has been used to make positive changes to patient experience. Some examples of these include:

- some inpatient areas have seen an increase in staffing levels after reports of delays in receiving basic care.
- protected meal times are now in operation across all inpatient areas.
- supper rounds are now carried out every evening on the Oncology wards, offering hot drinks and snacks.
- improved signage in Children's department areas signposts the facilities available.
- improvements have been made to reception areas in intensive care units which have included the installation of televisions and comfortable chairs.

Below are some examples of positive patient feedback through the FFT Envoy portal:

"Very friendly and caring.
Very well looked after and clean."

"Kind, caring and professional people, who made me feel everything would be OK."

"Nothing to be improved. Staff were all very caring and brilliant. Keep up the good work."

National Patient surveys

We believe it is important to listen and respond to the feedback we receive from patients. Their comments and opinions are collected in many different ways, including through the FFT and via NHS Choices / Patient Opinion websites. Alongside this, and in conjunction with the Picker Institute Europe, the Trust takes part in a number of national patient surveys that are mandated by the Care Quality Commission (CQC). These comprise an annual Inpatient Survey and biannually, surveys for Maternity services, the

Emergency Department and Children and Young People's services. These surveys enable us to check what patients think about their experiences in our hospitals. They 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 2016

The Inpatient Survey asks patients specific questions about their admission to hospital, what to expect after procedures and about their experience of discharge. The results of the 2016 survey were published in March 2017. In our 2015 survey we didn't perform as well other Trusts nationally or compared to our performance in 2014 on the issue of patients feeling that we do not seek their views on the care we provide and that they are not informed about how to complain. As a result of this feedback we did some focused work to improve patients' experience in this area during 2015/16 and this has resulted in a much-improved performance against these questions.

There has also been a significant reduction in the number of respondents reporting that doctors talked in front of them as though they were not there.

The results of the 2016 inpatient survey are summarised below.

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

Areas in which we signifcantly improved since last year (survey question)	2015	2016	National Trust Average
Doctors: talked in front of patients as if they were not there	26%	19%	22%
Overall: not treated with respect or dignity	21%	17%	16%
Overall: not asked to give views on quality of care	71%	68%	70%
Overall: did not receive any information explaining how to complain	61%	56%	60%
Area in which we face challenges (survey question)			
A&E Department: not given enough privacy when being examined or treated	19%	27%	23%
Discharge: did not always get enough support from health or social care professionals	43%	51%	46%

Emergency Department survey 2016

The 2016 national mandatory Emergency Department survey was published in March 2017. This survey demonstrated significant improvements in two areas since the previous survey in 2014, and highlights two areas where we need to do better. The results have been shared with Urgent Care colleagues and Estates and Facilities and an action plan is being developed to address these areas.

The areas of significant improvement and areas where we face challenges are outlined in the table below.

Emergency Department Survey: significant changes since 2014 survey (lower scores are better)

Areas in which we signifcantly improved since the last survey (survey question)	2015	2016	National Trust Average
Care: wanted to be more involved in decisions	44%	33%	33%
Tests: results not fully explained	21%	17%	16%
Area in which we face challenges (survey question)			
Waiting: waited more than 15 minutes before speaking to doctor or nurse	56%	68%	61%
Hospital: emergency department not very or not at all clean	1%	4%	4%

In 2017/18, we will be repeating the National Inpatient survey and conducting the Maternity and Children and Young People's surveys.

Patient stories

One of the best ways for us to improve the care we give to people is by listening to the stories of patients and families we care for. We continue to have been helped this year by many people who have given up their time to tell us about their experiences. We share this information in a variety of ways, including inviting people to forums and events to talk to staff and also through the use of videos.

In 2016/17, patients shared their experiences on a wide range of topics. In a film subtitled in Makaton, we followed the journey of a young person with a learning disability through Adult Cardiac Outpatients. As well as being shown at Trust Board, this video is being used to inform young people transitioning from children's to adults outpatients about what to expect. Other videos have highlighted a patient's experience of our Endoscopy services and the impact of administration errors during the outpatient journey. We have also produced two short videos featuring a wide range of staff groups who explain what brings them in to work in the morning and how they meet the challenges of caring on the front line.

All the videos produced by Patient Experience are shared with relevant teams to encourage improvement as well as being shown at the beginning of Trust Boards and other senior management meetings.

Some examples of improvement from patient feedback:

Our bereavement service heard from local Jewish and Muslim communities that they were experiencing issues meeting the requirement for timely release of deceased relatives. The bereavement service has worked with Trust staff to raise awareness of the process for early release of relatives' bodies for cultural reasons and of the availability of community registrar volunteers who can assist with expediting the process. Two separate information resources have been created for the Jewish community and the Muslim community to detail the process to be followed when an urgent release is required. These have been developed jointly with local community groups who will also support the circulation of this resource.

These initiatives have resulted in a reduction in the average time of release for cultural reasons from 22 hours in 2014 to six hours in 2016.

In March 2016 we received an e-mail from a patient who had used our Patient Advice and Liaison (PALS) service to raise her frustration that her regular appointments to receive infusions of a cancer treatment were taking a whole day out of every month. Her dissatisfaction with the service had led her to consider stopping the treatment. The PALS team shared the feedback with the Haematology day unit, whose staff talked to the patient about her concerns. Following this, the unit manager looked at ways to ensure that the necessary processes ran more smoothly and that all relevant information was available at the start of the appointment. This resulted in a vastly improved service, not only for the patient who had contacted PALS, but also for a significant number of patients undergoing the same treatment. In her e-mail the patient reported that her previous appointment had lasted less than an hour and that at her most recent visit she had been dealt with and on her way home 10 minutes before her scheduled appointment time. She ended by saying that she felt the team responsible had 'put the patient - instead of process - back at the heart of Patient Experience'.

3.3 Improving information for patients and carers

Providing good quality information for patients and carers is an essential part of the high standard of care we aim to provide across the

Trust. During 2016/17, the Patient Information Forum continued to work with representatives from a number of Trust departments. The group welcomed two new members who are patient representatives interested in working with the Trust on improving information processes. The work of the group this year has focused on making it easier for patients to access information and improving the quality of information provided.

A key achievement this year has been the creation of a Trust A-Z internet page, which is intended to provide patients and staff with access to the information resources available across the Trust. Work has begun to populate this and is expected to continue during the coming year.

3.4 Resolving complaints

Being a responsive organisation is important to the Trust and we value all patient feedback. We strive to ensure we act on the issues that are raised with us to improve the treatment and care we provide and the experience of patients, families and carers.

Complaints are a source of valuable information showing what it feels like to be cared for in our organisation and we aim to use this feedback to help us make changes where they are required.

In 2016/17 we continued to improve the process for those who make a complaint, either for themselves or on behalf of someone else. NHS Benchmarking externally surveyed complainants who lodged complaints with the Trust between February 2016 and January 2017 and provided quarterly reports to the Trust's complaints department, giving us valuable information about what people experience when they make a complaint. This has led to changes in how caseloads are managed within the complaints team and has increased our focus on improving team working to ensure complainants do not suffer delays during busy periods within the service. We recognise that the relationship between the complainant and complaint handler is key to ensuring people feel supported when making a complaint. This will continue to be our focus for the coming year and will be supported by a new Trust complainant survey that will be developed to ensure we remain responsive to feedback.

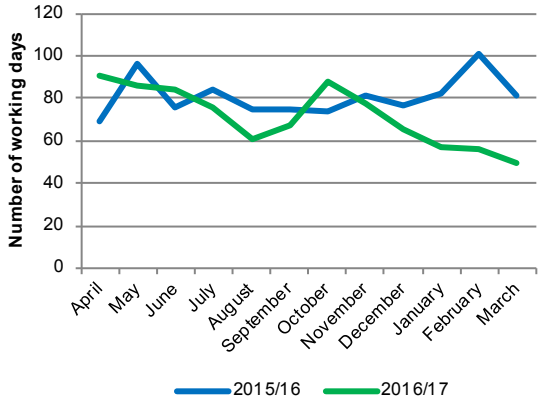
It is now common practice for our CSUs to meet with complainants face to face to resolve their concerns. Internal monitoring of this process is carried out regularly and has shown that face to face meetings lead to a higher satisfaction rate from complainants. This approach has shown a significant reduction in re-opened complaints for those cases where a meeting has taken place.

In 2016, the availability of recorded meetings was rolled out across the Trust following a trial period in one of the Trust's larger CSUs. Recorded meetings allow complainants to receive an accurate permanent record of discussions that took place and also reduce the length of time it takes to respond after the meeting. The complaints team received a 'highly commended' award at the Trust's Time to Shine Awards in March 2017 for its work to introduce recorded meetings. In the coming year, it intends to support more CSUs to use this method to improve the experience of complainants.

In November 2016, we reviewed our 'Speak to Sister, Message to Matron' initiative, which had been running for almost a year. Posters displayed in public areas had intended to inform patients and relatives that speaking with departmental managers can often result in an effective and speedy resolution of their concerns. Feedback from staff and patient groups revealed that patients felt the posters did not adequately explain how to raise concerns at a local level. In response, new posters have been developed which now have a much clearer message. Over the coming year, a further patient satisfaction survey will be carried out to ensure this initiative is meeting the needs of patients and relatives.

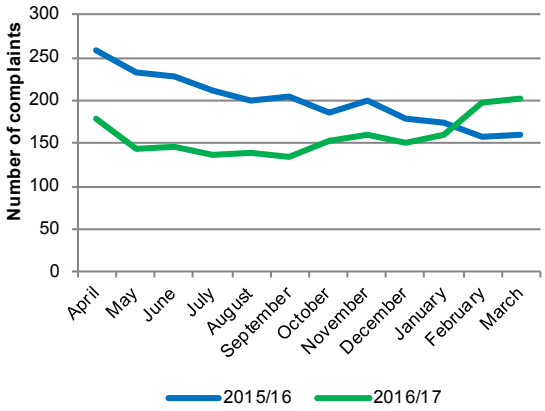
In 2016/17 we successfully reduced the time taken to respond to complaints, as shown in the graph below. To build on this work, the complaints team has developed new ways of sharing key messages held within our data, for example in a bulletin that goes out across the Trust. This will help our CSUs to understand where they should concentrate their efforts to make further improvements in 2017/18.

Average complaint response time



During 2016/17, the number of complaints open in the Trust overall were at lower levels than those received in 2015/16. There has been a slight increase in open complaints since January 2017.

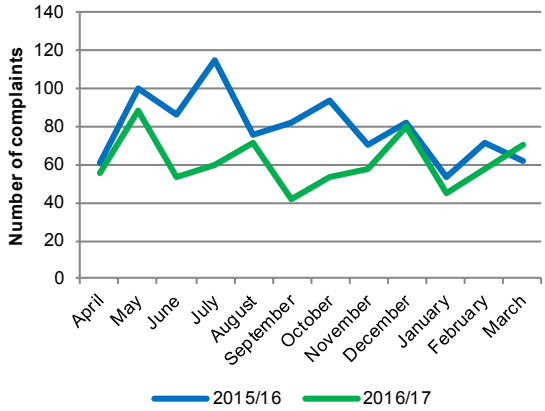
Open complaints



Service changes in response to complaints

In 2016/17 fewer complaints were closed compared to the same period in 2015/16. Higher numbers of complaints per CSU and operational pressures are thought to have contributed to this picture.

Closed complaints

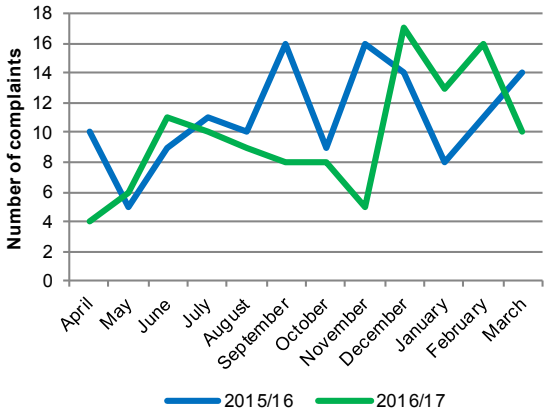


We have maintained our commitment to the quality of our written complaint responses and have continued to see a reduction in the number of complaints that are reopened, with

some peaks throughout the year. Initial analysis suggests this reduction is due to the increase in face to face meetings - only three of the reopened complaints in 2016/17 are attributed to cases where meetings have taken place.

Following a review of the Trust Quality Assurance process, the complaints team has designed a master class training session to support letter-writing skills for all levels of Trust staff. In the coming year, we will work to understand why complaints are reopened at peak times and develop solutions where possible.

Reopened complaints



Every complaint we receive may contain a number of themes and it is important for the Trust to understand what these themes tell us about patient experiences.

The complaints team is conducting further analysis of complaint themes and sharing its learning across the Trust. We are also working with areas in the Trust that have shown an improvement in their service following complaints on a particular theme, to understand how they achieved this. We will share our findings Trust-wide.

The main themes of complaints received during 2016/17 are shown below:

Most common themes raised in complaints 2016/17

3.5 Working with partners

We have continued to build relationships with local stakeholders, including advocacy groups, community forums and involvement groups and their input into our work is extremely valuable.

Working closely with colleagues at Leeds City Council Register Office, we have a Registrar based at the hospital so families are able to manage the paperwork associated with a death in one location and at the same time. Feedback via letters and thank you cards indicates that bereaved friends and relatives rate the opportunity for a 'one stop' process very highly.

In 2016, the Trust's chaplaincy, equality and diversity and patient experience teams were very fortunate to be able to work with local trans organisations, Trans Positive and Trans Mission to hold a Trans Day of Remembrance. This took place on 20 November 2016 in the LGI and was an opportunity for the trans community and their supporters to remember those who have died. The event was attended by partners from across Leeds, including the Yorkshire Ambulance Service and West Yorkshire Police.

We have continued to support Healthwatch Leeds in making visits to our hospitals. During visits, the Healthwatch team independently surveys patients, families and carers which provides 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.

In 2016/17 the Healthwatch team concentrated on reviewing our outpatient services and visited the following areas:

- Opthalmology outpatients
- Main outpatient department at Seacroft Hospital
- Lincoln Wing outpatients
- Gynaecology outpatients
- Endocrinology clinic
- Cardiology clinic

We have welcomed this support from Healthwatch Leeds and will continue to work with them in 2017/18.

The Trust is also involved in working with partners across Leeds through a complaints group supported by Healthwatch. This group enables organisations in Leeds to work together to find ways that 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 established by Healthwatch Leeds in 2014/15. This forum creates 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

In 2016/17 we supported the launch of John's Campaign in the Trust. This is a national campaign led by two carers who are calling for families and carers of people with dementia to be allowed to remain with them in hospital for as many hours as they are needed and are able to give. At Leeds Teaching Hospitals we have extended this commitment to families and carers of all our patients, not only those with dementia.

In addition to the launch of John's Campaign, the Trust has become an active member of the Leeds Carers Partnership group (LCPG), which aims to improve the lives of carers across Leeds. This year, the LCPG has been working on developing the 'Leeds Commitment to Carers' which asks organisations to sign up to make real changes which will have a positive effect. For 2017/18, the Trust has signed up to deliver three objectives through this commitment. These are:

- support the improved identification of carers and the delivery of better information to meet their needs

- ensure 'John's Campaign' has been successfully embedded across all Trust departments and is accessible to all carers
- work with staff side partners to develop a procedure to support employees who are carers and running a campaign to promote the support which is available

Volunteers

Volunteers are a valued part of our workforce at the Trust and we recognise the significant contribution they make in delivering the best possible care and experience for patients.

In 2016, we developed a new service-led model for the recruitment of volunteers that gives CSUs the opportunity to design volunteering roles that meet the needs of their departments.

Voluntary Services now work in partnership with clinical teams to provide a bespoke recruitment experience and invite the teams wishing to recruit volunteers to be involved in their selection process. This promotes local management of volunteers and ensures volunteers are able to apply for roles most suited to their skills, experience or interest. The initiative has been a success with numerous new roles being developed and more exciting opportunities in the pipeline for 2017/18.

We currently have around 400 volunteers who work in a wide variety of roles, including:

- providing support at mealtimes for elderly patients
- providing dementia friendly activities in our elderly wards
- providing family support to relatives in our intensive care units
- providing play, support and respite for parents and children on our Children's wards
- being a friendly face at reception desks to help make sure patients and visitors find their way around the hospital

In the coming year more exciting new roles are being developed, for example;

- a sibling group, 'supersibs'. This group will provide childcare support for siblings of newborns when parents are visiting their babies on our neonatal units
- bedtime story tellers in both our staff nursery and Children's departments, where volunteers will provide quiet reading time for children
- patient experience volunteers in our outpatient departments, who will provide information, company and direct patients around our busy outpatient clinics

As part of our People Strategy, we are committed to increasing the number of volunteers working with us so that we can improve the experience of our patients. In 2016, we improved our recruitment processes to make them as efficient as possible whilst ensuring all necessary safeguarding requirements were met. Part of this new approach involves making better use of technology, and those interested in volunteering for us 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 also continued to work with partners to support community projects and promote volunteering across the region. In 2016, the Voluntary Services team collaborated with the Co-op Academy, Notre Dame College and participated in a scheme to support refugees to gain volunteering opportunities. We want to increase community participation over the coming year and will work with partners to ensure our volunteers reflect the diverse community we serve.

We launched volunteer focus groups, a new initiative resulting from volunteer feedback highlighting that some of our volunteers wanted a forum for meeting other people who supported the Trust. These take place every

three months, allowing volunteers to mix with their peers and providing a valuable opportunity for the Voluntary Services team to 'check-in' with volunteers, hear about their experiences and continue to make improvements.

At the focus group meeting in October 2016, volunteers told us that they would like more communication and support from both the Voluntary Services team and the departments they work with. As a direct result of this feedback we are developing a newsletter in the coming year that will be sent to all Trust volunteers in 2017/18. We will also provide more opportunities for volunteer training. These will include a new corporate welcome session that volunteers will attend before they start in their new role and online training videos and short courses that can be accessed from home.

We are keen to make sure our volunteers feel supported at the Trust and that they are part of the wider team. In June 2016, we held a celebration event to recognise their contribution, which was supported by the Executive team. We also asked for feedback on events for volunteers at one of our focus groups and following our discussion planned a number of small events to coincide with National Volunteers Week in June 2017. In addition, we will also arrange a special year-end celebration event in December 2017, which will again be supported by our Executive team.

We would like to take this opportunity to thank every one of our volunteers for the continued, significant contribution they make to Leeds Teaching Hospitals and our patients.

Involving our members

In 2016/17, we continued to grow our membership and it has increased to 26,324 compared to just over 25,000 members 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 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 31 March	
	2016	2017
Leeds	19,881	20,753
Yorkshire & Humber	4,614	4,993
Rest of England	548	519
Total	25,043	26,324

Our membership magazine, Connect, was circulated twice in 2016 and is packed with informative articles on the fantastic work taking place in our hospitals. It also provides details of our Medicine for Members' programmes of talks held exclusively for Trust members.

These sessions are chaired by members of the Trust Board or senior management team. This year, we hosted 25 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 Genomic Research, Advances in the treatment of Heart Disease, Osteoarthritis and interactive Medical Education sessions. The programmes saw over almost 900 attendances.

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

Chaplaincy

The Trust's chaplains are supported by a dedicated group of chaplaincy volunteers drawn from the local community. Following special training these volunteers more than double the contact chaplaincy can have with patients and staff. It is an invaluable part of our service, which brings comfort and encouragement to countless patients every year. It also allows wider participation from those of different beliefs, ranging from Hindu to Humanist volunteers.

Fostering a culture where spiritual needs are respected and supported is a key feature of chaplaincy. In Bexley Wing at St James's we hold quarterly memorial events so that staff can spend a few moments to remember patients they have cared for on the wards. This is followed by an informal opportunity to share the letters and cards of appreciation that come from families. Understanding the impact of good care is a way to strengthen and affirm the values of The Leeds Way.

Responding to feedback from those who use the Bexley Wing 'Faith Centre' we installed a monitor in the foyer to welcome people. On the hour throughout the day, and activated by a motion sensor at other times, an audio-visual presentation features chaplains of many different faiths and beliefs. The provision of the monitor and software was made possible by the support of the Leeds Hospital Charitable Foundation.

During the year we appointed two new assistant chaplains to lead Friday Prayers at St James's and the LGI. This addition has helped chaplaincy to support Muslim staff, patients and visitors and enables people to fulfil their religious commitments during busy days. It also means that we have part-time Muslim chaplains on site five days a week enabling urgent pastoral situations to be addressed more promptly.

Raising funds

The Charitable Foundation is responsible for the administration of the Leeds Teaching Hospitals NHS Trust 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 HOSPITAL Charitable Foundation
REGISTERED CHARITY NUMBER 1170369

We are fortunate to have a substantial number of donors and individuals who contribute time and charitable funds so that we can financially support the enhancement of equipment and environment throughout Leeds Teaching Hospitals.

It is this support that enables us to provide the Trust with additional funds to enhance and develop the highest quality treatment and services, improving the hospital environment and promoting the wellbeing of our patients. The Charitable Foundation Board of Trustees is extremely thankful to them all.

We are now regulated solely by the Charity Commission, following new policy and guidance on charities that support hospitals by the Department of Health. We also have a small name change, and are now known as The Leeds Hospital Charitable Foundation. We believe that this move will enable us to maximise the impact we can make on supporting patients in Leeds.

Throughout 2016/17, Mr Edward Ziff as Chairman of the Charitable Foundation Board has overseen the work of the Charity. The Board of the Charitable Foundation consists of six lay trustees and one NHS link Trustee.

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. These groups identify projects that enhance the hospital environment for patients and provide additional equipment over and above that funded by the NHS.

The Charitable Foundation continued for its tenth year to fund the Annual Nursing, Midwifery and Allied Health Professionals conference. This year's theme was Caring The Leeds Way - Celebrating Inspirational Patient Care. The morning agenda included three sessions covering Research, Compassion in Practice and Collaborative Practice, which were

attended by 350 delegates from all professional groups working at Leeds Teaching Hospitals. This was a valuable forum for sharing best practice and the values of The Leeds Way.

The Trustees are also committed to encouraging high quality, ethical research and innovation. During 2016/17, The Foundation awarded £600,000 towards the development of a Clinical Research Facility at St James's to bring together the key disciplines in Musculoskeletal Disease, Haematology and Oncology research, expanding early phase and translational research led from Leeds. This expanded to include cardiovascular disease and oral and dental health, with paediatrics added in April 2017.

Support has also continued for a further year for Leeds Children's Hospital TV (LCHTV) - www.lchtv.com. Leeds Children's Hospital is the first in the UK to develop such an initiative, which gives children, young people and families accessible and friendly information about the hospital and what it's like to be a patient. Some of the specially-made films have been put together with staff on the wards, while others were made by children, young people and their families themselves. The project won a Nursing Times award in 2016 for Child and Adolescent Services.

All of this is made possible by our generous donors. Leeds Teaching Hospitals Charitable Foundation, our staff and patients value their support immensely and 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 at Leeds Teaching Hospitals. 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 seen periods of industrial action by our junior doctor workforce, held two significant exercises and experienced an outage of our Telepath Pathology IT system. 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 Jenny

To ensure that we have robust arrangements in place to deliver care to patients affected by a major contamination incident we held a live exercise on 16 July 2016 at the LGI. Named *Operation Jenny*, this was the Trust's fourth live decontamination exercise undertaken in close collaboration with the blue light emergency services and with the help of a number of excellent volunteers who acted as contaminated casualties.

This was a 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.

Telepath Pathology IT system incident

Our hospitals have business continuity plans in place to maintain key services in the event of unexpected disruption. In September 2016 our Telepath Pathology IT system failed, resulting in a significant business continuity incident.

Incident management arrangements were quickly implemented in order to manage the Trust's response to the situation, with a strong focus on ensuring patient safety.

Many valuable lessons have been identified from this incident and these will be developed to further enhance our business continuity arrangements across the Trust.

Exercise Spiral

On 9 November 2016, we hosted an exercise to test the regional response to an incident involving mass casualties.

In collaboration with partner agencies, Exercise Spiral aimed to test the response across all West Yorkshire acute hospitals to an incident involving mass casualties with traumatic injuries. The exercise involved representatives from acute hospitals across West Yorkshire and examined the command and control arrangements within each Trust and also the communication and coordination required across those Trusts in order to manage the regional response.

Regional plans and procedures for the management of mass casualties are now being further developed and refined following the lessons identified from this exercise.

3.7 Equality and Diversity

Leeds Teaching Hospitals is committed to challenging discrimination and promoting equality and diversity both as an employer and a major provider of health care services. We aim to make sure that equality and diversity is at the centre of its 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 / Deputy Chief Executive, 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 based in Human Resources who works closely with the Patient Experience department.

Our Equality and Diversity Strategy 2015 to 2020

The Equality and Diversity Strategy was developed in 2015 to bring together the various parts of the equality agenda in a way that clearly articulates the commitment of the Trust with targeted ambitions and key priorities. These same ambitions and priorities help deliver on the Trust's overarching equality objectives, which were brought in line with the key goals of the NHS Equality and Diversity Delivery System in 2015.

The following are the equality objectives of the Trust, which 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 2016/17 the following actions were achieved:

Equality objective	Equality and Diversity Strategy Targeted Ambitions	Action Achieved 2016 to 2017
1	We will ensure the rate of outpatient Did Not Attends, readmissions, RTT breaches and ED breaches are broadly representative of the patients we serve in relation to BAME, Age and Religion or Belief	Began improvement projects to reduce outpatient did not attends, including updating patient letters and leaflets to ensure they are easy to understand. Implemented plans so that patients with complex needs are seen as efficiently as possible within the Emergency Department. Ensured robust and safe discharge and admission of older patients through intensive collaborative work between the Trust's Multi-Disciplinary Team and Adult Social Services. Developed the Emergency Department Patient Reference Group, continually monitoring and working towards it being representative of the different protected groups.
2	We will ensure ready access to hospital services and information We will improve patient survey results of older inpatients, young patients using maternity services, Lesbian, Gay and Bisexual patients accessing ED and BAME outpatients We will improve the experience of Trans staff, patients and carers We will improve the experience of Lesbian, Gay and Bisexual (LGB) patients and carers We will improve the experience of patients who do not have a religion or belief	Set up and rolled out a new process through which disability-related information and communication support needs of all patients and carers are regularly and consistently requested, recorded and met. Produced and launched a new Translation and Interpreting Policy and accompanying guidance. Increased awareness of the Patient Advice and Liaison Service (PALS) within different communities to gain greater insight into areas for improvement including LGB and Religion or Belief. Renewed and improved way in which CSUs can access and understand equality-related results taken from the Friends and Family Test feedback, including in relation to age, disability, ethnicity, religion or belief and sex. Developed and rolled out a package of support to CSUs to ensure meaningful engagement and involvement of patients and carers, including a patient reference group that is working towards being fully inclusive of all our communities and access to a bank of over 3000 Trust members representative of the communities we serve. Delivery against all objectives of the Trans Equality Pledge, including hosting of Trans Day of Remembrance in Leeds. Development of Lesbian Gay Bisexual Trans (LGBT) Patient Survey and links with LGBT Hub in Leeds as part of LGBT History Month. Developed Religion and Belief Training, scheduled to take place in May, June and November 2017 in conjunction with NHS Equalities and Human Rights Week, Interfaith Week and Interfaith Day. Provided bi-monthly staff updates on religious and cultural events to raise awareness and encourage involvement.

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	Further analysis of outcomes from the Public Sector Equality Duty data with a focus on recruitment and selection, disciplinary and grievance cases, dismissals and pay audit. Delivered a comprehensive package of staff training to underpin day-to-day due regard to equality across all protected characteristics, including LGB Awareness, Trans Awareness and Unconscious Bias. Identified Equality and Diversity Key Performance Indicators for employability schemes. Staff feedback monitored and reviewed in respect of experience at work (against protected characteristics) including staff survey feedback. Signed up to the NHS Employers Diversity and Inclusion Alumni Programme. Held a number of events centred on women being effective leaders in their roles as part of The Leeds Female Leaders Network. Information reviewed and published in respect of the NHS Workforce Race Equality Standard. Established a BAME staff network with a focus on career progression and talent management. Set up process to ensure talent management opportunities accessed by BAME staff of all levels. Developed staff support and activities as part of sign up to the Mindful Employer Charter. Achieved Level 1: Disability Confident Committed and submitted for Level 2: Disability Confident Employer. Work on visualising job descriptions underway and collaborative work with local academies as part of sign up to the NHS Learning Disability Pledge. Incorporated employee health and wellbeing as part of the appraisal process in further ensuring reasonable adjustments for disabled staff are provided.
4	All	Collaborative working with local NHS organisations, Forum Central, Healthwatch Leeds, Leeds Involving People and Voluntary Action Leeds on inclusive, third sector engagement on organisational delivery against the NHS Equality Delivery System. Bi-monthly meeting of Equality and Diversity Strategic Group Chaired by the Chief Nurse/Deputy Chief Executive and Deputy Chaired by the Director of Human Resources and Organisational Development. Development of Equality and Diversity Communications Plan wrapped around key national cultural events to underpin delivery on the Trust's Equality and Diversity Targeted Ambitions. Became a Stonewall Diversity Champion with regard to sexual orientation equality. Continue to consciously consider the impact of all policies and service changes on differing groups of people through equality impact assessment processes.

Publishing of equality information

Leeds Teaching Hospitals NHS Trust publishes information in January each year to show the extent at which equality is placed at the heart of everything we do. 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 key findings and actions identified in January 2017:

	Key Findings for 2015 to 2016	Key Findings for 2016 to 2017
All **people** can access the Trust's services and experience the best possible clinical outcomes every time.	BAME patients remain more likely than White (White British, White Irish, White Other) to not attend an outpatient appointment, but the % gap has closed by approximately 25% over the last 12 months. White patients remain more likely than BAME to not be treated within 4 hours by the Emergency Department, but the % gap has closed by approximately 30% over the last 12 months. Older patients remain more likely to be treated within an 18-week period from the point of referral. The % gap has grown by approximately 50% in the last 12 months. The older the patient the less likely they are to be treated within 4 hours by the ED. The % gap has grown by approximately 80% in the last 12 months. Muslims, No Religion or Belief and Sikh remain more likely than other religions not to be treated within 18 weeks from the point of referral. The % gap has increased by 25% in the last 12 months. Christians and Jews remain more likely than other religions to not be treated within 4 hours by the Emergency Department. The % gap has increased by approximately 50% in the last 12 months.	Further implementation of NHS Accessible Information Standard and improvement projects within Outpatients CSU, including fit-for-purpose patient leaflets, appointment letters and text reminders, to ensure information and communication support needs of all patients are met and people are in a position to attend outpatient appointments. Provide assurance that the process behind treatment of patients in the ED is not biased and the patient experience is positive Carry out further analysis of ED intelligence to identify the different patient journeys by protected group. Ensure robust and safe discharge and admission of older patients by working closely with the Trust's multi-disciplinary team and Adult Social Services and implement plans to meet the needs of patients with complex needs within the ED. Further roll out of the Patient Advice and Liaison Service within the different communities, including the different age, ethnic and religion/ belief groups, to ensure all concerns are raised and addressed as far as reasonably possible. Consider Friends and Family Test (FFT) feedback with the support of the new FFT system, including ensuring it is representative of all protected groups and equality-related themes are identified and addressed. Reduce 'Not Known' and improve data quality through staff training on the purpose of capturing the data.

All **employees** are supported, representative of the local community and led to deliver on equality.	BAME staff employed at LTHT broadly reflect the local population with a higher proportion in the medical and dental workforce. However, there is not the level of consistency in the spread of BAME staff across Agenda for Change grades. Our BAME staff report that in our staff engagement measures, their experiences are the same or better than our White staff. The number of staff declaring their Religion or Belief has increased from 8% in 2011/12 to 55% in 2015/16. Women make up 75% of our workforce, but continue to be under represented equally in senior posts with numbers in our most senior posts remaining constant year on year. Men were more likely to have been involved in a disciplinary or grievance than women and the percentage of men involved in a disciplinary has increased from 34% in 2014/15 to 43% in 2015/16. We employ a larger proportion of staff over the age of 50 than are in the working population. However, our workforce is under represented compared to the Leeds working population for staff under the age of 20	Work with the BAME staff network to develop and promote learning opportunities to support BAME staff to progress in the organisation. Continue to improve the information we hold about our staff through the roll out of the electronic staff record self-service module. The employee on boarding system will improve the capture of staff information for new starters Include a request to update personal details as part of HR and staff records training. Continue the Trust's talent management programme, Talent@Leeds, and use the Female Leaders programme to encourage women to step into leadership roles. In 2017 the Trust will review the gender split in our workforce in line with the new gender pay reporting requirements. Programme of schools engagement, work experience and apprenticeships to be in place for 2017 to highlight and provide opportunities in healthcare to young people.

* 2015/16 findings published January 2017

Section 4
Quality Account

Quality Account

4.1 Chief Executive's Statement from the Board

4.1.1 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 our EDs and 1,050,000 in our outpatient departments, across seven 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 770,000 and regional specialist care for up to 5.4 million people.

Our patients are at the heart of everything we do. We employ almost 17,000 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.

4.1.2 Development of the Quality Account

Our Quality Account for 2016/17 has been developed with our staff, stakeholders and partner organisations, including clinicians and senior managers, commissioners at NHS Leeds West Clinical Commissioning Group (CCG), and Healthwatch Leeds. It has been approved by the Trust Board.

4.1.3 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 2016/17.

We had much to be proud of in our achievements through 2016/17. We have continued to make improvements in quality and safety whilst facing a significant financial challenge. We have also continued to experience pressures relating to emergency admissions and capacity within our hospitals throughout the year, which has affected all NHS trusts. We have worked with our partners in health and social care to improve the flow of patients and facilitate timely discharge, opening two new wards at Wharfedale hospital to help with this, supported by Villa Care.

In May 2016 the Care Quality Commission (CQC) returned to do a follow-up inspection; they undertook their first comprehensive inspection of our hospitals in March 2014 and judged the Trust as "Requires Improvement". We were therefore delighted to be rated "Good" in the most recent inspection, reflecting the significant progress we have made in improving our culture of quality and safety across the Trust.

Leeds Teaching Hospitals NHS Trust was chosen to be one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known locally as the Leeds Improvement Method, providing a framework

for improving quality and efficiency across the organisation. It has brought together staff with a range of skills and experience to review how they work to improve the experience of patients in our care and staff who work in our hospitals. This work began in Elective Orthopaedics at Chapel Allerton Hospital and we have introduced new workstreams in our surgical services, critical care and outpatients. We have trained a wide range of staff in lean methodology and this continues to be embedded in our safety culture.

We were delighted with the results of the 2016 NHS Staff Survey. Not only are we performing well compared to the national average but we are also performing well year on year; this year we have seen improvement in 21 of the 32 key findings, including effective communication with managers and appraisal. This shows the impact the Leeds Way continues to have in the Trust and is testament to the hard work of all our staff in creating a positive culture where staff feel engaged.

We have worked with our clinicians, managers and local partners at Leeds West Clinical Commissioning Group and Healthwatch Leeds to identify the priorities set out in our Quality Account for 2016/17. I hope you enjoy reading this summary of our achievements in 2016/17 and the work we have to done improve quality and safety in our hospitals.

Signed

30 June 2017

Julian Hartley, Chief Executive

Signed for, and on behalf of the Trust Board

4.2 Our priority improvement areas for 2017/18

The following improvement priorities for the Trust have been identified for particular focus in 2017/18. The overarching principle for all these work streams is their importance for patient experience: they have been grouped under the section headings below purely for the purpose of this Quality Account document.

Patient Safety

To continue our Patient Safety and Harm Free Care Improvement Programme which includes: acute kidney injury, sepsis, pressure ulcers, antimicrobial stewardship, falls, deteriorating patient, safety huddles and Parkinson's Disease.

Clinical Effectiveness

Leeds Improvement Method Value Streams

- Chapel Allerton Orthopaedic Centre - total hip and knee replacement patients
- Discharge - Abdominal Medicine & Surgery, specifically focusing on prostate surgery patients
- Critical Care - step down
- Outpatient Services
- Acute Medicine

Patient Experience

- Demonstrating patient and public feedback is used to support service and Trust developments.
- Learning from what patients and families tell us - implementing
- 'Always Events'.

4.2.1 Quality Improvement Strategy and Programme

We published our first Quality Improvement Strategy in 2014, and in less than three years we have taken huge steps in improving the quality of care we provide to our patients. We are proud of the ambitions we set and the achievements our staff have made so far, and we have now set out our commitment that together we can go even further. We have updated our Strategy for 2017-2020, which was approved by our Trust Board in March 2017.

In our 2017 Quality Improvement Strategy we reflect on the progress we have made and set our ambitions for the next three years, including areas we wish to improve even further, as well as setting new priority areas. This strategy is shaped by:

- Working with our staff and patient representatives at our Quality Ambitions workshop in April 2016
- Our current work with the Virginia Mason Institute and partner organisations
- Our collaborative quality improvement work, supported by partners, including the Improvement Academy

4.2.2 Summary of Leeds Improvement Method

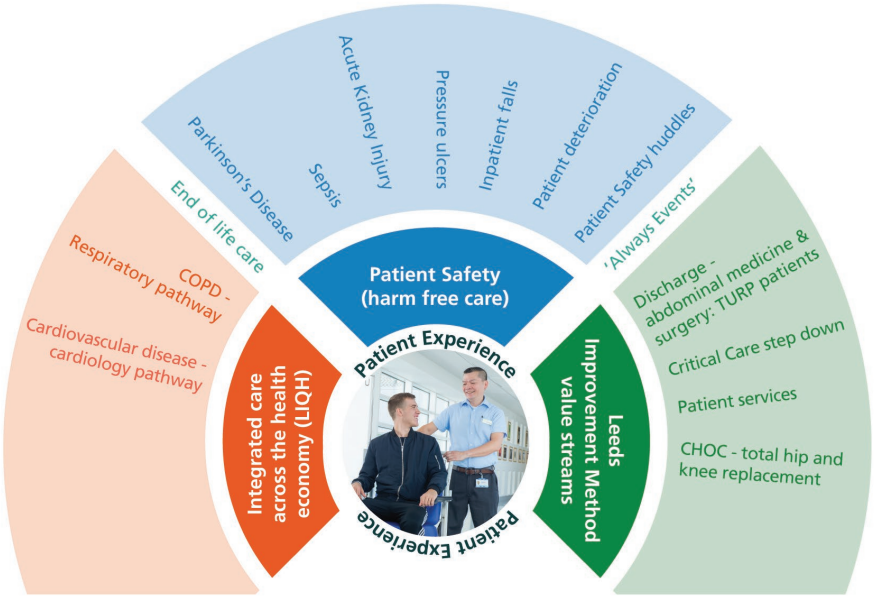
LTHT is one of only five trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known at the Trust as the Leeds Improvement Method (LIM).

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

The programme involves formal training and certification in lean methodology that will provide the Trust with the opportunity to bring about sustainable and lasting culture change. Over the next three 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 methodology and continuous improvement successfully in a healthcare setting.

Launched in Elective Orthopaedics in Chapel Allerton Hospital in 2015, it has brought

Figure 1: Trust-wide Quality Improvement Programmes 2017/18



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 times and theatre setup times.

In 2016 we launched in Abdominal Medicine and Surgery with multidisciplinary teams working to clearly define a 23 hour pathway for transurethral resection of the prostate (TURP) patients. Criteria were also agreed for a six hour pathway, which has been achieved for a small group of relevant patients in 2016/17.

We also launched in two new areas: Ophthalmology Outpatients (a collaboration between Outpatients CSU and Head and Neck CSU), and Critical Care Step-Down (a collaboration between Critical Care CSU and Neurosciences CSU), who will be planning and running improvement events in 2017/18.

A fifth and final workstream has been agreed for launch in 2017/18 in the Acute Medicine CSU.

In summary, the Leeds Improvement Method:

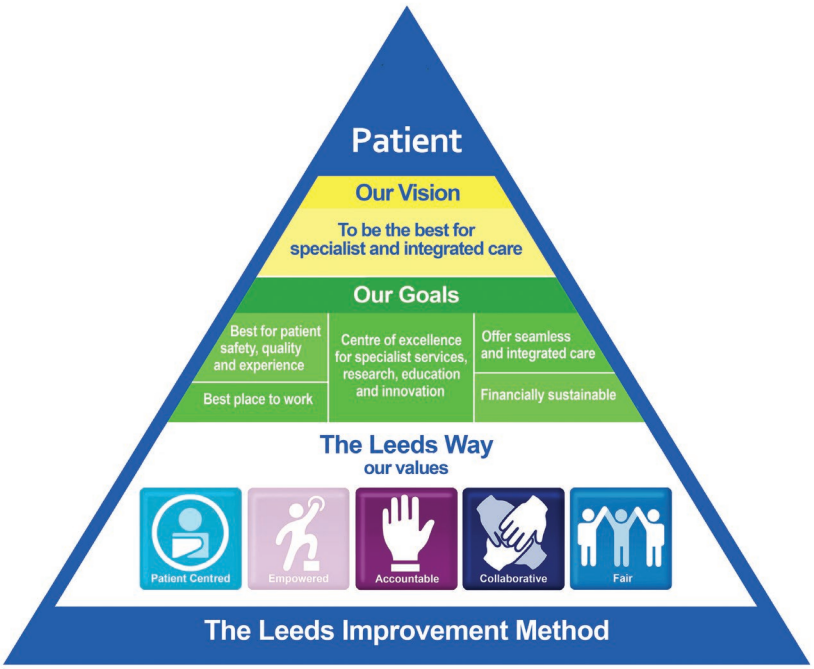
- Is patient focused.
- Is the application of observation and data analysis tools, to describe how patients experience our services.
- Supports staff to systematically remove waste.
- Promotes zero defects and zero harm for patients.
- Uses a disciplined timeframe.
- Encourages participation and respect 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 work here at Leeds Teaching Hospitals can be found here:

www.leedsth.nhs.uk/assets/Uploads/NHS-Leeds-VMI-Final2.mp4

Figure 2: LIM Underpinning the Leeds Way



4.3 Progress against our Quality Goals 2016/17

The following improvement priorities for the Trust were identified for particular focus in 2016/17:

Patient Safety

- Improvement in the care of patients with acute kidney injury (see section 4.5.1)
- Improvement in the care of patients with Sepsis (see section 4.5.2)
- Reduction in number of hospital acquired pressure ulcers and the incidence of category 3 and category 4 pressure ulcers (see section 4.5.5)
- Best use of antibiotic medicines (antimicrobial stewardship) (see section 4.5.12)

Clinical Effectiveness

Leeds Improvement Method Value Streams (see section 4.7)

- Chapel Allerton Orthopedic Centre - total hip and knee replacement patients
- Discharge - Abdominal Medicine & Surgery, specifically focusing on prostate surgery patients
- Critical Care step down
- Outpatient Services

Patient Experience

- Making it easier to hear the patient voice - establishing a Patient Reference Group and Patient Leader Programme (see section 4.4.2)
- Improving understanding of our feedback - improving monitoring of Friends and Family Test (FFT) percentage recommended, by ward area (see section 4.4.5)
- Learning and improving from what patients and families tell us:
  - Implementing method of capturing actions arising from FFT data and Patient Advice & Liaison Service (PALS) concerns (see sections 4.4.4 and 4.4.11)
  - Responding to patient feedback in Outpatients through delivery of programmes to address concerns (see section 4.4.7)

These remain part of our overall Quality Improvement Programme and span more than one year.

4.4 Patient Experience

4.4.1 Introduction

Last year we recognised that we had more work to do to be better at hearing what patients tell us and responding to that information. We have outlined later in this section the great work that has taken place this year to help improve the way we do this and the care we provide as a result.

Our aims for 2017/18

This year, we have identified the need to build on the work that we have started, to ensure that we can show how we work with patients and their feedback to support a greater number of real changes in the things that matter to patients. Consequently, our key workstreams for 2017/18 are concentrating on:

Demonstrating patient and public feedback is used to support service and Trust developments.

Work that began in 2016/17 to ensure tools are available in the Trust to capture the patient and public voice will be continued, so that these are embedded in the Trust.

Our aim is to support hospital teams to work with patients and to capture data to evidence this.

Learning from what patients and families tell us through the implementation of 'Always Events'.

'Always Events' were first introduced into the United States by The Institute for Healthcare Improvement and the Picker Institute, and focus on ensuring events that matter to patients happen every time for every patient.

Our aim is to develop, in consultation with patients, a series of 'Always Events' that demonstrate learning from what the Trust does well and focus on the elements of care that patients value most.

Members of the Patient Experience Team attending a National Conference to learn about 'Always Events'

4.4.2 Making it easier to hear the patient voice

One of our aims last year was to make it easier to hear the patient voice. We focussed on the delivery of a Trust Patient Reference Group (PRG) and Patient Leader Programme.

What we did in 2016/17

A 'Big Event' was held on 25 November 2016 with the objective of encouraging the public to sign up to become members of a new Trust Patient Reference Group. The aim of the Reference Group is to provide a mechanism for Trust-wide strategy, services, and projects, to have access to the patient voice, in their development.

The first meeting of the Group was held in January 2017 and generated much interest and enthusiasm. The Group agreed to support the development of a Trust Patient Experience Strategy as one of their first pieces of work. Much of the second PRG meeting held in March 2017 was spent in hearing the Group's ideas and views about the form and content of that strategy.

The Trust has also signed up to working alongside Leeds West CCG in the delivery of educational and peer support sessions, as part of a Leeds-wide patient leader's programme. The programme helps people who are, or wish to become, patient leaders within the hospital to access development opportunities which will assist them in their role.

Sessions have been provided on how the Trust is organised and on the systems and processes in place to make sure care is monitored and of a high standard. A session is also planned to explain how patient feedback is used in the Trust to improve services. This year, patient leaders have attended key Trust forums, including the Patient Experience Sub Group, and have supported the delivery of the Leeds Improvement Method programme and research projects within the Trust.

Members of the Patient Experience Team attending a National Conference to learn about 'Always Events'

Our Ongoing Aim

We aim to continue to raise the profile of the Patient Reference Group within the Trust, and to encourage services and departments to take the opportunity to access the Group to support the development of their work and ambitions. Additionally, we aim to increase the number of patient leaders working in key roles in the Trust.

4.4.3 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. All staff are invited to participate in quarters 1, 2 and 4. The results of Q2 2016/17 are shown below.

Comparison of Friends and Family Test Results May 2014-September 2016

	Quarter 1	Quarter 2	Quarter 4	Quarter 1	Quarter 2	Quarter 4	Quarter 1	Quarter 2
	May 2014	Sep 2014	Mar 2015	Jun 2015	Sep 2015	Mar 2016	Jun 2016	Sep 2016
Response Rate (numbers of staff, students and volunteers)	750	1507	1514	1644	1671	1546	1053*	1976
How likely are you to recommend LTHT to Family and Friends if they needed care or treatment?	72.7%	81%	84%	86%	84%	82%	86%	87%
How likely are you to recommend LTHT to Family and Friends as a place to work?	56.90%	65%	68%	68%	67%	66%	73%	73%

*Technical issues resulted in a drop in numbers.

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

The results from the National Staff Survey for the equivalent question in 2016 are shown in the table below.

Percentage of staff who would recommend the Trust as a provider of care to their family or friends

Question	Reporting period	Trust performance	National average
Percentage of staff who would recommend the Trust as a provider of care to their family or friends	2012	47%	62%
	2013	58%	64%
	2014	63%	65%
	2015	69%	70%
	2016	74%	71%

Over the last five years the Trust's performance on the National Staff Survey for "Percentage of staff who would recommend the Trust as a provider of care to their family or friends" has improved significantly. For the first time in 2016, the trust is now performing better than the national average.

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

	LTHT score 2014	LTHT score 2015	LTHT score 2016	National Average for acute trusts
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	86%	87%	86%	87%

The score for this key finding shows us in line with the national average.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

	LTHT score 2014	LTHT score 2015	LTHT score 2016	National Average for acute trusts
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	26%	26%	23%	25%

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.

4.4.4 Friends and Family Test

The Friends and Family Test (FFT) process at LTHT was re-launched in 2016. In addition, the Trust began to work with a new contract provider, Healthcare Communications. This was a very exciting time, as it opened up wider opportunities for a new approach for collecting friends and family feedback which would give patients and relatives more choice. Feedback can now be provided through a variety of methods, including electronic tablets, text messaging and instant voice messaging. It is anticipated that these new methods will not only increase the number of patients responding to our request for feedback, but will also allow for services to use their feedback more effectively and to find sustainable solutions to improve patient experience in the future.

Following a successful re-launch event in December 2016 the new process is now fully operational across the Trust.

What we did in 2016/17

Leeds Teaching Hospitals Friends and Family test cards have been updated with new and improved artwork. The FFT team has introduced a new mascot - FFT 'Fred'.

The team also implemented a new feedback portal, 'ENVOY', for Trust staff. This electronic platform allows staff to have quick access to their feedback and to therefore act quickly when issues are identified.

Our ongoing aims

We aim to:

- Offer more patients a variety of methods to provide feedback using options such as:
  - Tablets
  - Text messaging
  - Instant voice messaging
  - Paper feedback cards
  - On-line FFT links
- Support clinical service units to make FFT accessible to all patients.
- Support clinical services to let patients know what actions have been taken when issues are identified through the FFT process.

Julian Hartley, Chief Executive and Suzanne Hinchliffe, Chief Nurse, at the re-launch of FFT with FFT Team and staff from J21

4.4.5 Friends and Family Test early warning system

One of our aims last year was to improve understanding of our feedback, by monitoring the Friends and Family Test recommended rate by ward area. We focussed on improving the monitoring of the data we receive into the Trust from our patients, associated with the Friends and Family Test (FFT).

We wanted to find a way to continuously analyse data, so that we could deliver a quick response in clinical areas when a number of patients identified concerns.

The appointment of a data analyst into the Patient Experience Team this year provided us with an opportunity to take forward this piece of work.

What we did

We developed an early warning system (EWS), which analyses FFT data every two weeks to see if there are areas in the Trust where patients are particularly reporting concerns. Where wards/departments are identified, the data analyst in the Patient Experience Team will review the comments patients have made through the FFT process and also any concerns that may have been raised with the PALS team. Wards/departments will then be contacted, alerting them that a number of patient concerns have been raised and identifying any themes that have arisen.

Although teams do already see their feedback, this may not happen until a few weeks after it has been provided and this system will enable wards / departments to be much more responsive to changes that need to be made. The system was introduced in March 2017.

The Friends and Family team

Our ongoing aim

Our aim is that wards/departments will respond quickly to the feedback they receive and will be able to demonstrate this through the use of 'You said - We did' communication in their areas.

Teams will also be able to draw on the expertise of the various patient experience departments in the hospital to assist them in planning the actions that they would wish to take forward.

4.4.6 National patient surveys

We believe it is important that we listen and respond to the feedback that we receive from patients. The Trust takes part in a number of National Patient Surveys so we can check what patients think about their experiences with us to allow us to see whether actions we have put in place in response to previous surveys are having the desired effect and improving our services.

What we did

In the 2015 National Inpatient survey we scored poorly on questions relating to patients being asked to give views on the quality of care and on receiving information about how to complain. The Patient Experience Team undertook an audit of inpatient areas to ensure that posters and current leaflets were available to advise patients on how to provide feedback, raise concerns or complain. The 2016 survey demonstrated that we had improved in both these areas.

National Inpatient survey 2016

We take part in the National Inpatient Survey annually and the results of the 2016 survey were published in May 2017. It asks patients specific questions about their admission to hospital, how they felt about their stay with us, 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)

	2015	2016	National Trust Average
Areas in which we have got significantly better since last year (survey question)			
Doctors: talked in front of patients as if they were not there	26%	19%	22%
Overall: not treated with respect or dignity	21%	17%	16%
Overall: not asked to give views on quality of care	71%	68%	70%
Overall: did not receive any information explaining how to complain	61%	56%	60%

Areas in which we have got significantly worse since last year (survey question)			
Emergency Department: not given enough privacy when being examined or treated	19%	27%	23%
Discharge: did not always get enough support from health or social care professionals	43%	51%	46%
Care: not always enough emotional support from hospital staff	45%	51%	43%
Care: staff did not always work well together	22%	27%	22%

Our aim

We have shared the results of the Inpatient survey widely and will be working with clinical staff to develop local action plans to address areas in which we are not doing so well. A Trust-wide initiative is planned to ensure that our patients feel that they are receiving the emotional support they need, and will be looking at the best way to provide this.

Emergency Department survey 2016

The 2016 bi-annual National Emergency Department survey was published in May 2016. This survey demonstrated significant improvements in patients' experiences of the doctors and nurses involved in their care since the 2014 survey.

Emergency Department Survey: significant changes since 2014 survey (lower scores are better)

	2014	**2016**	**National Trust Average**
Areas in which we have got significantly better since last survey (survey question)			
Care: wanted to be more involved in decisions	44%	33%	33%
Tests: results not fully explained	31%	19%	20%
Doctors / nurses did not fully explain condition and treatment	39%	32%	30%
Doctors / nurses did not fully discuss patient anxieties or fears	46%	40%	41%
Doctors / nurses did not have complete confidence and trust	26%	21%	21%
Areas in which we have got significantly worse since last survey (survey question)			
Waiting: waited more than 15 minutes before speaking to a doctor or nurse	56%	68%	61%
Hospital: emergency department not very or not at all clean	1%	4%	4%

Our aim

Staff from Urgent Care will continue to work with their Patient and Staff forum, which meets quarterly, to maintain and monitor progress on their action plan in response to the latest survey results.

4.4.7 Learning from what patients tell us

One of our aims last year was to learn and improve from what patients and families tell us. We recognised it was important for us to address consistent patient feedback received via complaints and PALS, which showed patients have concerns about Trust administrative functions, particularly in the outpatient setting.

What we did in 2016/17

A project looking at standardised booking pathways, which aimed to improve patient choice in the booking of appointments. Patient representatives have been involved in reviewing letters and providing feedback, which has been taken into account in the changes that have been made.

The PALS team who hear the concerns our patients have about our services

The new systems have been piloted in Gastroenterology services. Before commencing the project, only 39% of patients were offered a choice of appointment. This has increased to 75% as the project has evolved, and has resulted in reduced patient cancellations and non-attendance rates; within Gastroenterology, the DNA rate has fallen from approximately. 9.6% to 6.1% and the patient cancellation rates have reduced from 14.2% to 11.4%. In addition to this, waiting times are decreasing and the follow-up backlog has been significantly reduced. Also, Referral and Booking Service staff are checking to make sure that all appropriate tests have been completed before patients attend for appointments, which was previously a common cause of patient concerns.

A separate project has taken place in the outpatient setting to address patient feedback in relation to patient letters. The aim has been to reduce the number of letters patients receive, to make sure they contain the information that patients really need and to produce an outpatient leaflet which provides general information. The team has received direct patient feedback which has been taken into account in the changes that have been made. Plans are in place for the outpatient leaflet, which has been well received, to be translated into the most common languages used by patients in the Trust.

Our ongoing aim

We aim to continue improving the experience of our patients and their families by identifying other improvements we can make in the outpatient setting. Our work with Healthwatch, who are currently obtaining feedback from patients in our outpatient areas, will help us do this.

4.4.8 Patient Experience Toolkit

Two of our clinical areas have been hard at work this year taking part in a research project, led by the Bradford Institute of Health Research (BIHR), with the aim of developing a patient experience toolkit. The research aims to find the best way to support clinical areas to make use of the feedback they receive and to use it to make positive changes that improve the experience of patients.

What we did

One of our hospital wards, J21, and the St James's Emergency Department have been participants.

During 2016/17, a number of workshops took place across West Yorkshire which were attended by staff from these areas, the Head of Patient Experience, and patient representatives supporting the Trust. The workshops were used to identify the key elements that would be important to include in a patient experience toolkit, and to build a prototype to be tested in practice.

Teams from ward J21 & SJUH Emergency Department with patient representative, Philip Elphick, and Head of Patient Experience, Krystina Kozlowska, working on the project

The second phase of this work has now begun, working with the teams within their clinical areas to apply and test the prototype and to identify support needs required to ensure success.

A patient representative supporting Ward J21 through this initiative has agreed to undertake a patient survey to ascertain what patients feel would make the biggest difference to improving their stay in the area. The results of this work will be available in May 2017.

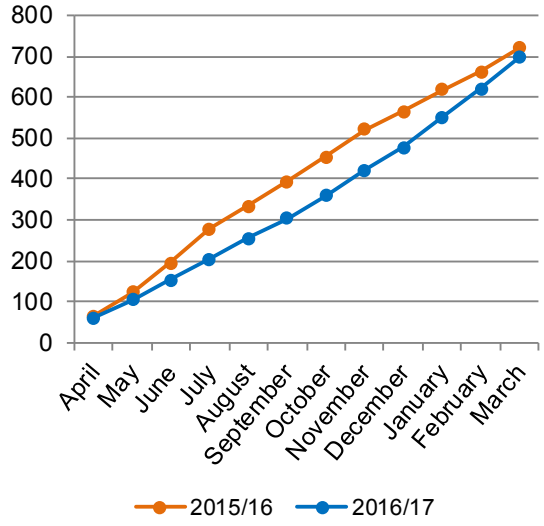
Our aim

We will continue to work with BIHR to progress the patient experience toolkit. This provides us with an opportunity to learn what support is needed for our clinical teams to assist them in systematically acting on feedback and delivering the improvements patients identify as important to them, in a long term and sustainable way.

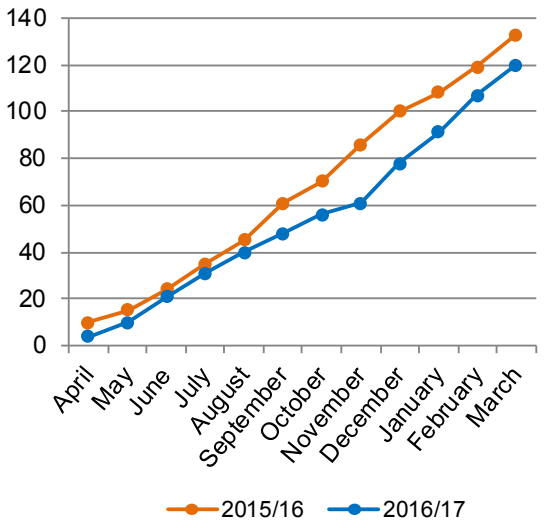
4.4.9 Complaints

In 2016/17, the Trust sustained improvements in the handling of complaints across Leeds Teaching Hospitals, which was demonstrated by the reduction in complaint numbers across the year. In addition, the Complaints Team introduced a number of new initiatives to support staff in managing complaints.

Number of complaints received in Trust (cumulative) 2015/16 and 2016/17



Number of reopened Trust complaints (cumulative) 2015/16 and 2016/17



What we did

We rolled out a process for audio recording of complaint meetings which has improved the experience for complainants across the Trust.

In 2016/17, the Complaints Team at Leeds Teaching Hospitals received a 'Highly Commended' award for the recorded complaint meeting initiative, as part of the Trust 'Time to Shine Awards';

- The Complaints Team developed a more detailed coding process to ensure themes arising in complaints were easily identified.
- Improved key performance indicators were developed to ensure services are monitored on their management of complaints more effectively.
- Complaints master classes supported by the Complaints Team now run monthly and are available to all Trust staff.

Our ongoing aim

- To improve how the learning from complaints is shared across the Trust
- To improve the time it takes for us to respond to complaints
- To ensure all Trust staff are knowledgeable in the complaints handling process.

4.4.10 Speak to Sister Initiative

In 2016, a new initiative was implemented aiming to support patients at LTHT to raise concerns at a local level rather than allowing minor concerns to escalate into formal complaints.

What we did

A poster asking patients to 'Speak to Sister' or to get a 'Message to Matron' was designed and trialled in one of the larger Trust services. The trial was a success and the poster was rolled out across the Trust. In November 2016, a review was carried out by surveying all Trust senior nursing staff and a selection of patients to check how well the poster was working.

Following the review, revised posters were created that are clearer in informing patients how to raise concerns at ward level to ensure they are managed swiftly.

Example of a Speak to Sister poster

Our aims

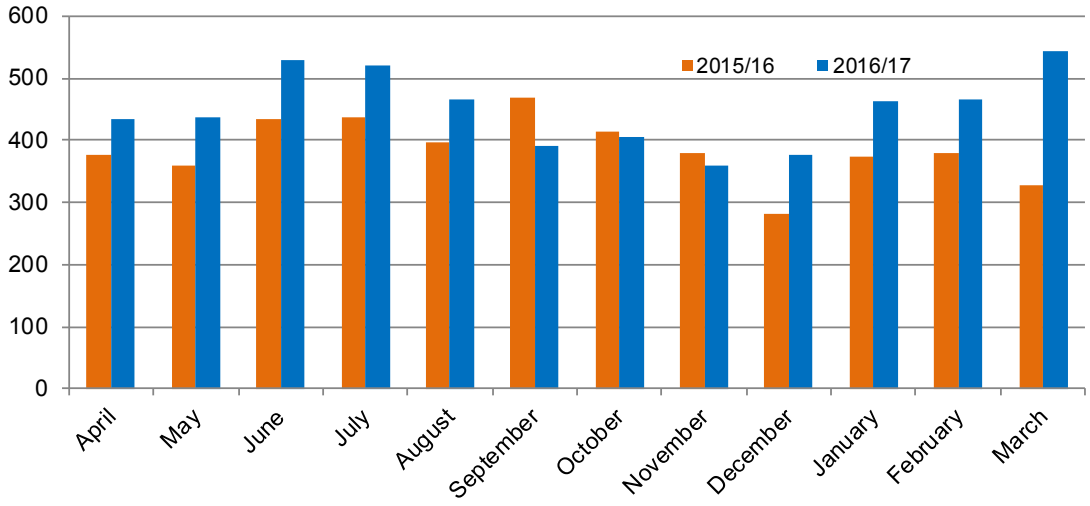
In 2017/18 we aim to:

- Provide information for patients that make it easy to understand how to raise concerns with ward staff.
- Roll-out the new posters to all departments.
- Ensure patients can identify when information is relevant to them.
- Ensure the process is embedded by surveying patients and staff once the new posters are in place across the whole Trust.

4.4.11 PALS

During 2016/17, the Trust PALS service saw an increase in the number of PALS concerns received. We believe this increase is because we have become better at supporting patients and families to understand how to raise the concerns they have so they can be resolved quickly by local teams.

Number of PALS received 2015/16 and 2016/17



What we did

We developed ways to provide better information about how to raise concerns and concentrated on spreading this message to communities that traditionally raise less concerns.

We introduced our 'Speak to Sister' initiative and increased availability of PALS leaflets, business cards and posters. This meant that more issues were resolved at department level before concerns become so serious that they required formal investigation. The number of formal complaints received into the Trust during this period showed a month on month decrease, which would suggest these initiatives worked well.

The PALS team also continued their programme of community outreach to local groups and community hubs in order to ensure that community groups are aware of the PALS service and how it can help them, and also to hear individual concerns which are then logged and progressed via the PALS process. PALS officers have attended more than 20 different community groups since April 2016 and are planning many more visits in 2017/18.

PALS Staff Visiting the Gipton Community Hub

Our aim

We aim to continue to ensure that all our patients are aware of how to raise a concern and have the opportunity to discuss the best way of doing that with a Senior Nurse or our PALS Team. We will be checking all our wards and departments to ensure that up to date leaflets and posters are visible and accessible. In addition, we will continue our outreach programme to local groups and communities throughout 2017/18.

4.4.12 Carers

During 2016/17, we built on the work we had commenced the year before to improve the life of carers who look after our patients, by implementing John's Campaign and by getting involved in work taking place across Leeds to look at this important aspect of care.

What we did in 2016/17

We distributed posters and leaflets to all wards, alerting carers that the Trust is a supporter of 'John's Campaign'.

This is a national campaign that has been led by two ladies who had relatives with Alzheimer's, and the campaign has been based on their experience of hospital care. They are calling for the families and carers of people with dementia to have the same rights as parents of sick children, and be allowed to remain with them in hospital for as many hours as they are needed, and as they are able to give. At Leeds Teaching Hospitals we have extended this commitment to families and carers of all our patients, not only those with dementia.

The Trust became an active member of the Leeds Carers Partnership group and has contributed to the development of the Leeds Commitment to Carers. This document calls for organisations across Leeds to sign up to improving the life of carers by committing to the delivery of objectives that will improve experience.

The Trust has agreed two objectives to date:

- Supporting improved identification of carers and the delivery of better information to meet their needs.
- Undertaking a piece of work to ensure John's Campaign has been successfully embedded across all departments and is accessible to all carers.

A third objective is currently being developed and will focus on supporting Trust staff who are also carers.

PALS John's Campaign Poster

Our aim

We aim to deliver the objectives we have signed up to as part of the Leeds Commitment to Carers and, through this, to take positive steps towards recognising the support provided to our patients by unpaid carers, and meet their needs.

4.4.13 Learning Disability

2016/17 has seen more improvements in supporting patients with a learning disability at Leeds Teaching Hospitals. The Get Me Better Champion programme has been further developed: this involves a team of 15 volunteers at the Trust, delivering learning disability and reasonable adjustment awareness training to Trust staff.

The Champions and the Learning Disability Team have been such a success they won The Yorkshire Evening Post's Healthcare Team of the Year in December 2016. The Team are

continuing with their great work to ensure all patients who require reasonable adjustments receive support and to ensure that Leeds Teaching Hospitals provides fair access to all.

What we did in 2016/17

A training day for staff champions across adult and children's services took place in September 2016.

A Learning Disability / Autism purple file has been introduced into all inpatient areas to provide information to support staff to ensure reasonable adjustments are made for patients who require them.

A Changing Place has been developed in Clarendon Wing Reception at Leeds General Infirmary. The space was formally opened in September 2016 and provides appropriate facilities for patients and visitors with a learning disability.

A flag is now available on Trust admissions on-line system which identifies patients with additional access needs.

Our aims

- Introduce staff champions for learning disabilities across every department.
- Increase the number of facilities available for patients and visitors with a learning disability.
- Ensure all patients with additional access needs are identifiable to Trust staff on admission.
- Work in partnership with carer organisations and forums to improve the support for carers of patients with learning disabilities.
- Continue to identify the best ways for Trust staff groups to access training relating to reasonable adjustments.

Get Me Better Champions receiving Team of Year Awards at Yorkshire Evening Post Healthcare Team of the Year 2016

4.4.14 Calm at Night

The 2015 Inpatient Survey identified that the Trust scored significantly worse than other Trusts surveyed by Picker Institute Europe for the question "Were you bothered by noise at night from hospital staff?". At LTHT, 24% of our patients answered yes to this question compared to a national average of 20%. The Patient Experience Team identified improving the hospital environment at night as a priority action and began its Calm at Night campaign.

What we did

We surveyed over 400 inpatients and 35 members of staff to find out what they thought about our hospital environment at night. 45% of patients surveyed said they slept badly or very badly. The results indicated that some improvements could be made not only in terms of noise, but also in terms of activity, environmental temperature, and excessive light.

A member of the Patient Experience Team observed the ward environment first hand at night on the SJUH and LGI sites. Some immediate actions were taken as a result of these observations, including recommending the repair or maintenance of noisy doors and equipment, and adjusting the timings of stock deliveries to delivery bays on the LGI site.

Our aims

We aim to continue to work with our colleagues on the wards and within support services to identify potential solutions to the issues identified through the Inpatient Survey, local surveys and direct observation, and to share good practice. We will also work with our patients to understand their information needs in relation to tips to aid restful sleep, relaxation techniques and how to respect other patients who are trying to sleep.

4.4.15 Neonatal Survey

In 2015, a neonatal survey was carried out across 72 NHS Trusts and 88 Neonatal Units in England. The survey was supported by the neonatal charity, BLISS. In January 2016, the results were reviewed by the Children's Hospital and an action plan developed. In 2016 good progress has been made in progressing the action plan and changing the way the department works, to ensure a positive experience for this patient group and their families.

What we did in 2016/17

We implemented a Family Integrated Care project at St. James's University Hospital. A discharge co-ordinator for the Children's Hospital has now been introduced as a result, to ensure successful discharge of babies from the neonatal units. The project overall has resulted in increased breast feeding rates and reduced lengths of stay on the unit.

We changed our process so that parents are routinely encouraged to attend daily ward rounds with Consultants and Senior Nursing Teams.

We continued our Neonatal Nursing Programme which is now in its second year and available to all Neonatal staff to support staff education and encourage staff retention.

We developed a leaflet titled 'Keeping Your Baby Safe' which has now been put in place and is accessible to all families. This provides families with appropriate information about risks and safety issues to support them in caring for their babies.

The Neonatal Team at Leeds General Infirmary

Our aim in 2017/18

- We will implement the model of Family Integrated Care in the Transitional Care Unit at the Leeds General Infirmary. This will also be rolled out to the Neonatal Intensive Care Unit (NICU) and the Neonatal High Dependency Unit at LGI.
- We will also support the Neonatal Unit's development of its information pages on the Trust internet site. In addition, we will ensure patient stories are filmed and made available through the Leeds Children's Hospital TV Channel. This work will ensure families have access to information and advice through a number of different sources.

4.4.16 Bereavement Service

During 2016/17, the LTHT Bereavement Service team has continued to work hard to improve the experience of bereaved families and friends of our patients. We have been working with the Muslim and Jewish communities to ensure that the requirement for timely release of their deceased relatives is met. In addition, the Bereavement Service has worked with our new hospital funeral provider, and with our Chaplaincy Team to ensure that patients who die without close families, or in cases of hardship, receive a high quality personalised funeral service.

What we did in 2016/17

Through close working with local faith communities, improvements have been made

in the process and information relating to the release of patients who die in hospital and require an urgent burial. We have been able to improve release time of a body following death from an average of around 24 hours, to six hours. Members of the Patient Experience Team attended a celebratory event at the Leeds Islamic Centre with other partners to share successes and to build strong links that will influence improvements.

Significant improvements have been made with the introduction of a new funeral services provider. On occasions, the Trust is required to provide funerals for patients who die in hospital and have no relatives able to make arrangements. Along with improving the funeral service itself, we have been able to improve the way in which cremated remains are returned to parents following the sad loss of a child or baby. Below is an exampleof a child's ashes scatter tube from a recent 'teddy bear' themed funeral undertaken by Co-op Funeralcare on our behalf. Our ability to support families in this personal way has helped make these difficult experiences a little easier.

Example of a child's ashes scatter tube

We have also worked with colleagues at Leeds City Council Register Office, who now provide a registrar based at the hospital. This increases the amount of appointments available to bereaved families so that they are able to deal with the paperwork associated with a death in one location, which reduces the burden on them in dealing with legal arrangements after death.

Our aim for 2017/18

Our aim is to build on the strong relationships with public bodies, local charitable organisations, and others who support us, which we have formed during 2016/17. Continuing to work with partners and local communities to shape our services will result in worthwhile improvements for the bereaved.

Head of Patient Experience, and Bereavement Services Manager, with the Lord Mayor Councillor, Gerry Harper, at the Leeds Islamic Centre

4.4.17 Interpreting Services

Delivering a quality interpreting service for patients at Leeds Teaching Hospitals was a key focus for the Patient Experience Team in 2016/17. The Trust was particularly keen to appropriately support provision of British Sign Language Services and Guide Communicators for the community of Leeds with those specific access needs, as the existing contract with Leeds Society for Deaf and Blind People came to an end.

What we did

In December 2016, the Patient Experience Team undertook a period of consultation with community members. The community told us of the difficulties they would experience if we moved to a different provider of services. Following this consultation, the Leeds Deaf and Blind Society successfully retained their contract to provide interpreting services at the Trust.

This has enabled our local patients to continue to receive services they are familiar with; delivered by people they have existing relationships with.

Our ongoing aim

- To continue to provide patients of Leeds Teaching Hospital high quality access to healthcare through the provision of appropriate interpreters.
- To ensure patients receive the most appropriate access support they need at the right time, and in the right place.
- Continue to monitor service provision and check user feedback to ensure our service meets the needs of our patients.

4.4.18 Volunteering

The Voluntary Services Team has been through a period of review in 2016 with a new management structure now in place. Since August 2016, a full review of Trust processes for the attraction, recruitment, selection and allocation of volunteers at LTHT has taken place and new ways of working have been developed.

The new Voluntary Services Team

What we did in 2016/17

Since September 2016, 126 volunteers have been recruited to a variety of existing and new roles designed to meet the needs of the patients we care for. A greater focus on collaboration with clinical colleagues has been adopted, which the Voluntary Services Team hope will increase the number of volunteers in the Trust over the coming years.

We trialled the collaborative model of working in Children's Services, Neurosciences and the Liver Unit. This has produced three schemes so far:

- Bedside buddies (Children's Services). These volunteers read stories to children.
- Peer Support Volunteers (Neurosciences). These volunteers have previously experienced a stroke and support patients with this condition.
- Infection Control Support (Liver Unit). These volunteers support and promote hand hygiene on the unit.

We also developed a focus group where volunteers are asked to feedback their experience of working in the Trust to drive future improvements. This takes place every three months.

Finally, we organised a celebration event for our volunteers in June 2016 that was attended by Trust Chair Linda Pollard and Chief Nurse Suzanne Hinchliffe.

Our ongoing aims

To continue to support recruitment that provides volunteer roles which add value to the needs of our patients and the Trust.

To engage with our volunteers to encourage more people to join the service and to help us to understand what we should do to support our volunteers to stay with us.

To show volunteers our appreciation for their commitment and dedication to the Trust and its patients.

4.4.19 Engaging with our Members

In 2016/17, the Trust continued to engage with Trust Members, now totalling over 26,000.

Members receive two member magazines per year, called Connect, which provide information on Trust developments and Patient and Public Involvement activities.

To date, the Trust has collected just over 7,600 responses to the Public and Patient Involvement (PPI) Questionnaire. The PPI Questionnaire

identifies members who have had experiences within services at LTHT within the last two years. Responses are stored on a database and can be viewed and selected, using search criteria, so the information can be used for improvement projects.

In the latter part of 2016, the Patient Experience Team began using this feedback for a small number of projects and also extended the use to CSUs through a workshop in December. Feedback provided by members was used to influence service changes and improvements in a range of areas, including Theatres & Anaesthetics, Outpatient discharge letters and the rebranding of the Leeds Cancer Centre. The Research and Innovation Team also sent a communication to members who had registered an interest in becoming part of a patient forum, in an attempt to recruit 10 Patient Research Ambassadors. This advertisement received over 130 member responses.

Connect also gives information regarding Leeds Teaching Hospitals NHS Trust (LTHT) Membership events, Medicine for Members. In 2016, the Trust held 22 sessions, inviting members to learn about the exciting and innovative work undertaken at LTHT. The events are presented mainly by clinical staff giving an overview of their professional area of expertise. Almost 900 members attended the 2016 programmes overall, which is an increase of around 300 more members than the sessions presented in 2015. The Osteoarthritis session, held on 3rd October 2016, was one of the most popular events, with 82 members attending the session. The CQC Inspection Event in April 2016 was also very well attended, with 122 members attending.

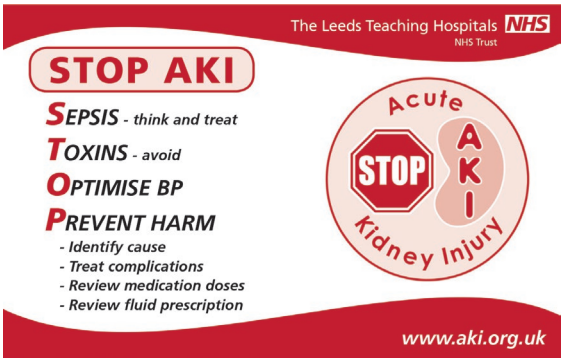
4.5 Patient Safety

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

Background

Acute Kidney Injury (AKI) is a major cause of harm, with half a million people sustaining AKI in England every year. It has a major impact on patients, including increased length of stay in hospital, the risk of progression into chronic kidney disease, and an increased risk of dying. It is estimated that AKI could be preventable in 20-30% of cases, so making improvements in the detection and treatment of AKI can make a big difference for our patients.

The Tackling Acute Kidney Injury (AKI) project was launched in April 2016 as part of a Health Foundation 'Scaling up Improvement Programme', across five NHS Trusts. Improvements will be achieved through awareness, education, an electronic alert, and use of the STOP AKI care bundle.



Key achievements in 2016/17

- The AKI electronic alert and care bundle has been successfully piloted across eight wards within the Trust.
- The AKI alert is now visible on all wards within the Trust, allowing staff from all areas to complete the care bundle when the patient is identified as having AKI.

- The Trust observation charts have been updated to improve the awareness of AKI.
- There have been a number of targeted AKI education sessions for medical and nursing teams.
- The AKI staging is included on the Electronic Discharge Advice Notice (EDAN).
- Patient information leaflets have been developed to increase patient awareness.
- There is continued shared learning with other organisations in the project through peer assist events.

Aim for 2017/18

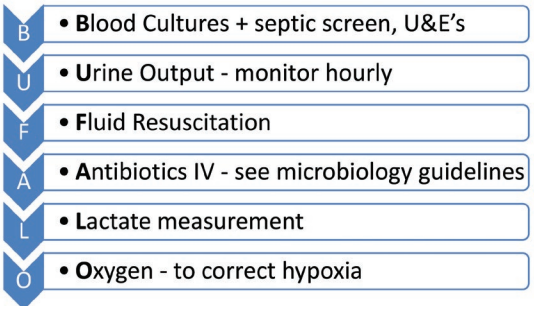
Our ambition is to continue to implement the AKI STOP care bundle across all our wards. Education and training will be a key focus in 2017/18 to ensure that all staff are aware of AKI diagnoses and management, and the importance of including information on the EDAN: this will ensure continuity of care and treatment throughout the patient pathway.

4.5.2 Improvement in the care of patients with Sepsis

Background

NHS hospitals treat around 150,000 cases of severe Sepsis each year and many more with uncomplicated Sepsis. It is one of the biggest causes of death in the UK but with early recognition and treatment, it is thought that mortality can be cut significantly.

BUFALO – Sepsis Intervention Tool



In 2015 we tested and developed an intervention package for clinical areas to provide reliable and effective Sepsis care: this consists of a screening tool and the interventions, collectively known as 'BUFALO'.

Key achievements in 2016/17

The Emergency Departments (EDs) and admission areas have implemented the Sepsis protocols and are now embedding the use of the Sepsis screening tool and BUFALO interventions.

Sepsis has also been incorporated into an e-learning package as part of our Acute Kidney Injury programme, which is coordinated by the Sepsis Operational Group.

The Sepsis Screening Tool has been introduced to pilot wards at both SJUH and LGI. We have seen consistent improvements in the proportion of patients attending the ED with Red Flag Sepsis features receiving appropriate antimicrobial therapy within one hour. We continue to have a low mortality in this group of patients for acute admissions through the ED (approx 10%) in line with published data for this group of patients. We have successfully achieved the targets agreed with the CCG for completion of the 2016/17 Sepsis CQUIN.

In order to further support staff education regarding sepsis, a training video has been produced that followed a patient admitted with sepsis through from ED to the ward, to HDU and successfully back to the ward after treatment.

A Paediatric Sepsis group has been formed to adapt the current NICE Sepsis Guidelines and Fever in Child guidelines into a safe and workable policy within LTHT that will apply across all areas of Leeds Children's Hospital. An adapted screening tool is currently being piloted in the Children's Assessment & Treatment Unit (CAT) and Paediatric ED.

Aim for 2017/18

Our ambition is to improve the identification of high risk sepsis patients, across LTHT, and reduce delays to their management.

In 2017/18 we aim to build on the foundations of the pilot wards, and implement the Sepsis Screening Tool and BUFALO interventions Trust-wide (including Leeds Children's Hospital). Scale-up will commence in April 2017, ensuring timely identification and treatment for Sepsis in all acute inpatient settings.

We are integrating the sepsis work with other key projects across LTHT, such as the deteriorating patient work, AKI project, and the roll out of e-Obs and eMeds.

4.5.3 Deteriorating patients - improvement in the care of patients when their condition deteriorates on our wards

We want to continually improve the treatment and care of our patients when they deteriorate on our wards, to ensure they receive safe, timely and effective treatment and care, and better end of life care.

In July 2014 we started a breakthrough series improvement collaborative with 14 wards trialling small scale tests of change, to reduce avoidable deterioration, including escalation of care stickers to alert clinical teams to deterioration and a brief guide for staff for recording observations. Following testing, an intervention bundle of the most successful changes was created, and tested across all pilot wards, from June 2015, before beginning to scale up to other Trust areas.

Achievements in 2016/17

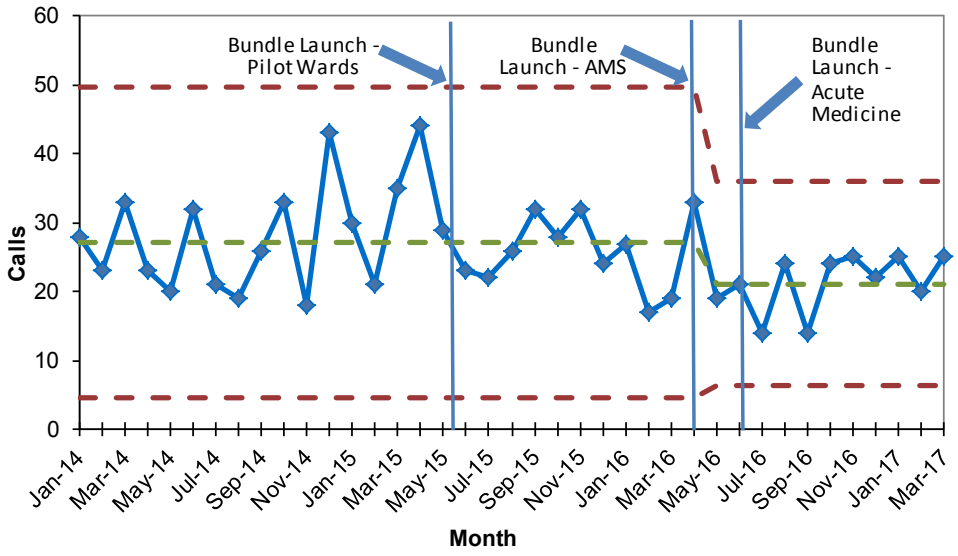
Scale up of the intervention bundle began in three full CSUs in 2016/17; Acute Medicine, Abdominal Medicine and Surgery, and Cardio-Respiratory.

In July 2016 the pilot wards achieved their aim of a 50% reduction in cardiac arrest calls and following scale up to the Abdominal Medicine & Surgery, and Acute Medicine CSUs, there has been a Trust-wide step reduction in cardiac arrest calls, of over 25%.

Aims for 2017/18

There are plans for the Trauma and Related Services CSU to begin further scale up later in 2017, followed by the Centre for Neurosciences, Oncology, and Women's CSUs.

Trust-wide Cardiac Arrest Calls January 2014 - March 2017



4.5.4 Reducing patient falls

Background

The most common patient safety incident causing harm reported by NHS Trusts relates to patients who fall whilst in hospital.

In July 2014, LTHT started a breakthrough series collaborative improvement programme with 14 pilot wards, and our aim was to reduce inpatient falls by 50%. A Falls Intervention Bundle was created and successful changes were then tested across all pilot wards.

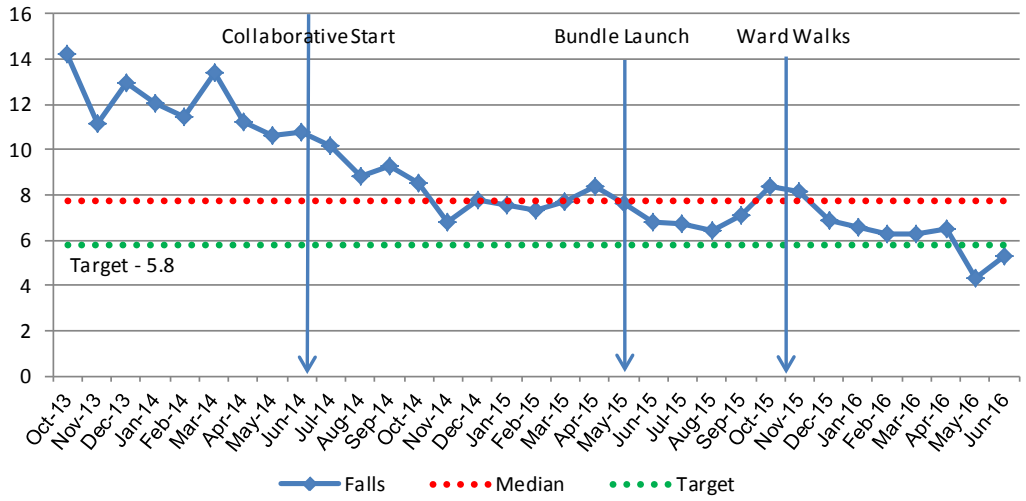
Key achievements in 2016/17

There has been a sustained decrease in the number of patients suffering a fall for the fourth year in a row, and by March 2017 the number of falls per 1,000 bed days had decreased by 18.1% when comparing the inpatient fall rate to date in 2016/17 (3.86) to the previous financial year (4.72).

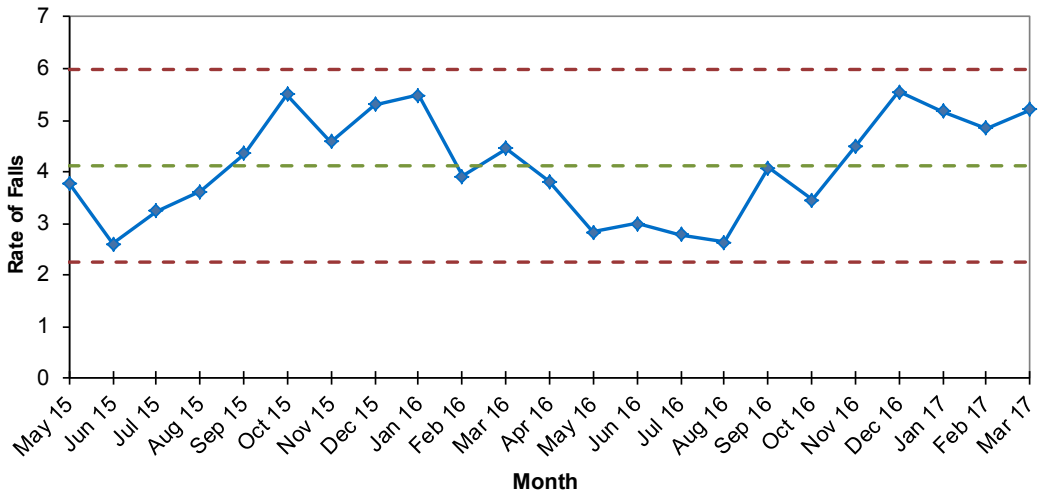
May 2016 saw the 14 pilot wards involved in the collaborative project reach their aim of 50% falls reduction compared to the start of the programme.

The intervention bundle has already been scaled up across four clinical service units (CSUs); Abdominal Medicine & Surgery (AMS) and Oncology have organised their own learning and celebration events to analyse their falls data and share learning between wards. The AMS CSU has been working on learning from the incidents that have occurred, as well as improving staff training. Between April 2016 and the end of March 2017 it has seen a 9.3% reduction in the total number of falls compared to the same time period in the previous financial year, and seen an 8.3% reduction in their falls rate per 1,000 bed days compared to the previous year.

Falls Per 1,000 Bed Days on Pilot wards Oct 2013 - Jul 2016

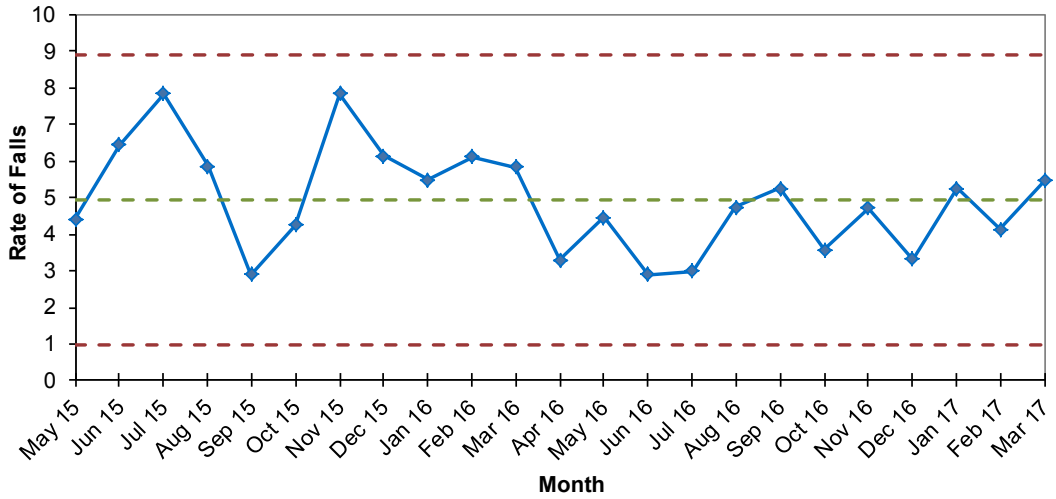


Falls Per 1,000 Bed Days in AMS, April 2015 - March 2017



The Oncology CSU has also improved its nursing staff's falls prevention competency training by running twice weekly training sessions. Safety huddles are now embedded in all wards and the CSU is using the Falls Intervention Bundle. It noticed that a number of the falls on its wards were suffered by patients who did not wish to bother the nursing staff. This led to the development of a sticker which the nurses have started to wear that says "Don't risk a FALL, give us a CALL", as well as using patient stories on the wards. This is a great example of a CSU responding to the themes of their own incidents and developing their own intervention. They have seen a 17% reduction in the total number of falls in 2016/17 compared to the previous financial year.

Falls Per 1,000 Bed Days in Oncology, April 2015 - March 2017



Aim for 2017/18

Our ambition for 2017/18 is to scale up further the implementation of the Falls Intervention Bundle across all wards in the Trust and achieve and sustain a further reduction in the number of falls Trust-wide. The Trust Inpatient Falls Prevention group will oversee the improvement work across the CSUs and help to spread good practice and lessons learnt from falls that result in serious harm.

4.5.5 Reduction in the number of hospital acquired pressure ulcers, and the incidence of Category 3 and Category 4 pressure ulcers

Pressure ulcers can be painful, affect quality of life, lengthen hospital stay, and may even be life threatening. It is estimated that 80-95% of all pressure ulcers are avoidable.

Our commitment is to reduce by 50% all avoidable pressure ulcers through the Trusts QI programme launched in November 2015, based around the 'Stop the Pressure' initiative from Midlands & East Region. As part of this initiative we are testing a range of interventions that sit under a SSKIN acronym:

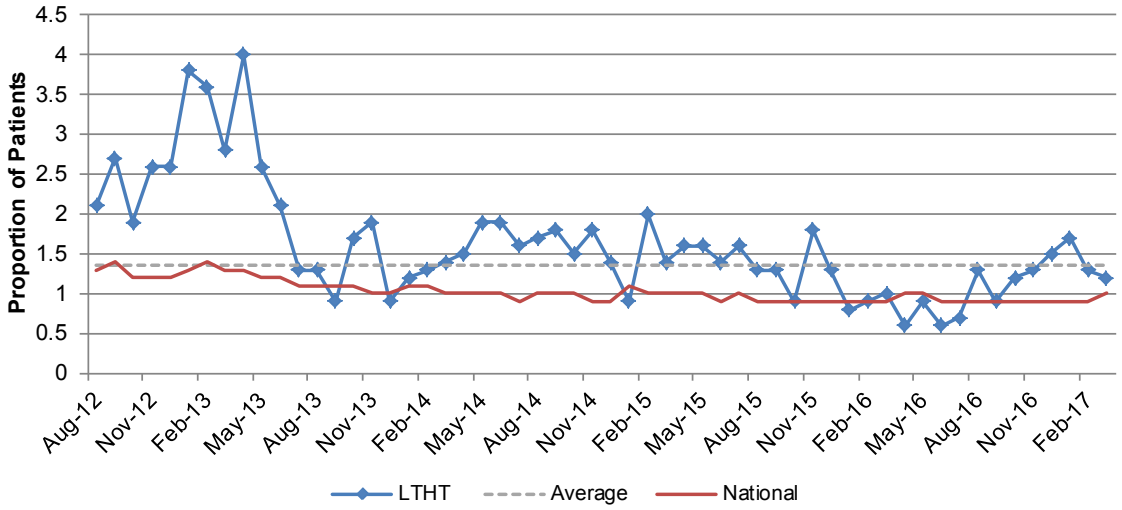
Surface - appropriate mattress/cushion
Skin Inspection
Keep Moving
Incontinence/Moisture
Nutrition/Hydration

This framework has been widely tested and implemented in a range of acute hospitals.

Key achievements in 2016/17

- Following successful testing of the SSKIN Bundle within a number of CSUs, scale up started in 2016 and is currently focussed in the Abdominal Medicine & Surgery, and Trauma & Related Services CSUs, supported by the Tissue Viability Team and a Clinical Leadership Fellow for Nursing.
- There has been a reduction in the incidence of all hospital acquired pressure ulcers (PU) by 4% over the year 2016/17.
- Incidence of all hospital acquired PUs per 1,000 bed days has reduced by 5%.
- Category 3 hospital acquired PUs have decreased by 13% in 2016/7.

Number of New Pressure Ulcers



Aim for 2017/18

- Our ambition in the first instance is to reduce by 50% all avoidable hospital acquired Pressure Ulcers by April 2018 through scale up and spread of the SSKIN interventions across the Trust.
- Our longer term ambition is to have no category 3 or 4 avoidable hospital acquired pressure ulcers.

4.5.6 Scaling up improvement: reducing harm and improving patient safety culture by integrating daily patient safety huddles on wards

Background

Ward led Safety Huddles were first tested on four wards at LTHT in 2013, with evidence of reduction in patient harm, and improved teamwork and safety culture. Our Trust was one of four acute trusts awarded a 'Scaling up Improvement' grant, worth £500,000 from the Health Foundation in 2014.

Safety Huddles are a ward patient safety meeting focused on one or more agreed patient harm. They follow 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. Patient and public engagement events have been held where safety huddles are demonstrated. Suggestions from attendees as to how patient and carer views and concerns can brought into the daily huddle are currently being tested on several wards.

Key achievements in 2016/17

So far, huddles have been adapted and embedded to 63% of wards at LTHT, and 81% of wards are using huddles. This has been associated with reductions in harm including falls, pressure ulcers, cardiac arrests, and improvements in safety culture. As a result many other organisations nationally are taking an interest in our learning and improvement.

Aim for 2017/18

Our ambition is to embed safety huddles on all our wards by the end of 2017.

4.5.7 Improving care for patients with Parkinson's

Safety Huddles are focused on one or more agreed patient harms (identified by the team) such as falls, pressure ulcers, or avoidable deterioration.

'Safety Huddles' are a short (5-10 min), daily, MDT ward patient safety meeting involving all members of the team.

Background

There are approximately 1,500 patients with Parkinson's in the Leeds Teaching Hospitals Trust catchment area, and around 30-40 inpatients in the Trust with Parkinson's at any time. In August 2016 we launched our improvement collaborative, with 16 clinical areas from across the Trust, to improve the care of patients with Parkinson's. This was in response to feedback from patients' families and, in this collaborative, patients and carers are actively involved. Our ward areas are testing small scale tests of change, using the breakthrough series collaborative model, with the support of a multi-disciplinary team, including a patient representative.

Our aim is that all patients with Parkinson's receive timely administration of medication and holistic care by;

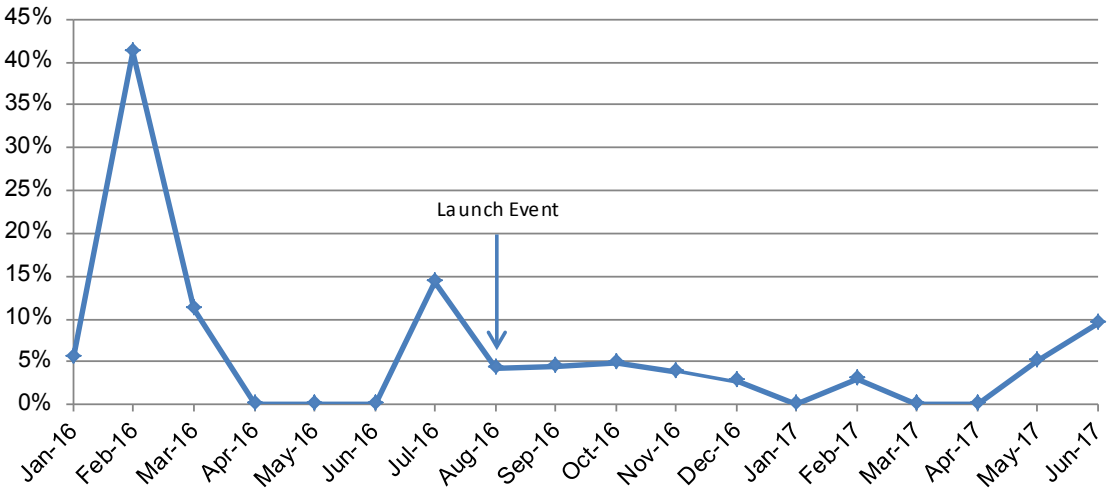
- Identifying and promptly administering Parkinson's medications.
- Improving culture, teamwork, and accountability.
- Identifying and promptly managing patients with swallowing difficulties.

Key achievements in 2016/17

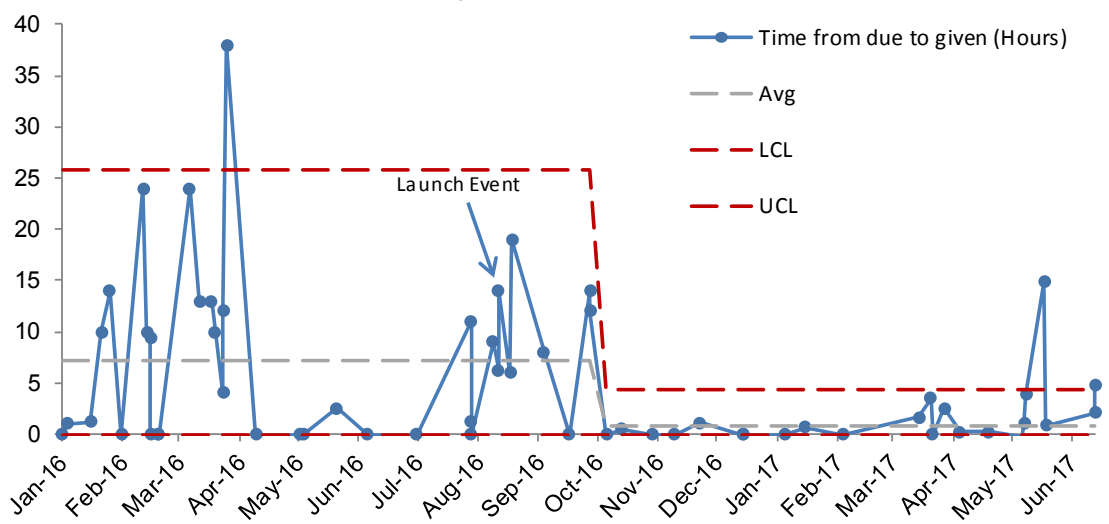
Working with carers, our faculty and front line teams have already:

- Raised awareness across the wards and through a launch event and Parkinson's Masterclasses for staff
- Created a real time list of current inpatients with Parkinson's Disease
- Developed educational material
- Developed tools to support collection of data to highlight good practice and areas for improvement
- Seen a reduction in omitted Parkinson's medications, and a reduction in the delay in patients receiving their first dose of medication after admission

Parkinson's Medications Omitted in 24 Hours, January 2016 - April 2017



Delay in first dose of Parkinson's Medication after admission, January 2016 - April 2017



Aim for 2017/18

Our ambition is that all our patients in pilot areas with Parkinson's receive timely administration of medication and holistic care by June 2017. We aim to further involve our patients and carers, to work in partnership with us to improve the quality of care we provide.

4.5.8 Maternity care - reduction in harm

The publication of the Maternity Strategy in 2015 provided a focus for the top priorities for the service over a five year period, and is aligned closely with the National Maternity Review "Better Births - Improving outcomes of maternity services in England" 2016. Within the Maternity Service in Leeds we have identified several key work streams to progress this work further including:

Safety huddles

Safety Huddles have been introduced on the postnatal ward to review high risk women i.e. readmissions, women on IV antibiotics and medication for blood pressure, or women who a midwife is concerned about. The safety huddle consists of a consultant obstetrician, junior doctors, midwives, and maternity support workers. It ensures that women are reviewed by senior members of staff, and placed on the appropriate treatment, required investigations are requested, and discharge is safe and timely.

EROS (Enhanced Recovery in Obstetric Surgery)

The Service has introduced EROS on both sites. This approach is a bundle of the best evidence based practices delivered by a multidisciplinary team with the intention of helping patients to recover faster after surgery.

Sepsis

Through national audit, Sepsis has been identified as one of the leading causes of maternal morbidity and mortality. Within the Maternity service we have taken steps to address this by including a Sepsis module in the new electronic patient record system that is to be introduced in 2017/18 - the aim being to improve the identification of women at risk of developing Sepsis so that treatment can be commenced in a timely manner.

Stillbirths

In 2016 NHS England published the Saving Babies' Lives Care Bundle - designed to tackle stillbirths by bringing four elements of care together, namely by;

1. Reducing smoking in pregnancy - Carbon Monoxide monitoring of all pregnant women has been introduced across the antenatal care pathway and targeted support for women who smoke to be referred to stop smoking services. Women who continue to smoke during pregnancy are offered additional growth scans.

2. Risk assessment and surveillance for fetal growth restriction - six midwives have been trained to undertake 3rd trimester ultrasound scanning, including fetal growth assessment.

3. Raising awareness of reduced fetal movement - Staff have been trained to discuss with women the monitoring of fetal movements in pregnancy and clear referral pathways have been introduced.

4. Effective fetal monitoring in labour - An enhanced multidisciplinary training package has been introduced which incorporates human factors and situational awareness training in relation to fetal monitoring in labour. In addition, the purchase of new cardiotocograph fetal monitoring machines has improved the quality of recordings obtained.

We are working closely with other units in the Yorkshire region to develop a consistent regional process for stillbirth review and sharing learning to reduce harm.

Training

The maternity service has recently been awarded £80,000 to spend on training for staff; the focus of this will be around developing further training in relation to recognising the role of human factors in incidents, the development of the labour ward teams, and resilience training.

4.5.9 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 17,200 in December 2016.

The right number of staff is an essential precondition to great care but is not enough on its own. We are embedding our values through The Leeds Way to drive staff engagement and use a number of different approaches to build engagement. From the 2016 Staff Survey we are proud to see that we are best performing Trust in England in terms of the number of staff having an appraisal. In 2016 the Trust also launched an Employee Assistance Programme which provides a range of confidential support services to our staff.

In 2015 we were the most improved Trust on the national staff survey, improving our results in 17 key result areas and the 2016 Staff Survey shows further improvements: we now have results in the top 20% of Trusts and 25 of our 32 key findings are average or above. In 2016 we have seen improvement in 21 of the 32 key findings and maintained performance in the other 11.

We have continued to expand our opportunities for apprentices and have recruited around 400 people since April 2015 across a range of disciplines, including nursing, business administration and other clinical areas. We are proud that our programmes have won a range of awards over the past 12 months and we have been recognised as the West Yorkshire Centre of Excellence in collaboration with Bradford District Care Trust, by Skills for Health.

Nurse staffing

In 2014 the Trust committed to investing £14 million in additional nursing staff enabling clinical teams to increase their establishments. In 2016/17 we continued to recruit across the registered and unregistered workforce to maximise this investment. The Trust has also changed the provider of the internal Bank to increase financial efficiency and optimise staffing levels.

Ward rosters are now fully electronic to reduce variation, increase transparency and to ensure the effective deployment of substantive and temporary staff.

Ward establishment reviews have been completed for all CSUs to explore opportunities to modernise the workforce. This includes changing the workforce model to increase senior nursing numbers (to attract experienced staff) or a shift in skill mix to better reflect the range of skills and roles now available to deliver high quality care.

Recruitment: registered staff - nurses, midwives and operating department practitioners (ODPs)

In 2016/17, we attended four national recruitment fairs, the Royal College of Nursing Congress and a number of university events across the country. These are now attended in conjunction with our city partners, promoting Leeds as a first class place to pursue a career in nursing and as a place to live. Internally, a number of CSU or site-specific recruitment campaigns and events have taken place, for example LGI-site specific, the Children's Hospital and the Acute Medicine CSU.

The Trust continues to work with the local universities and healthcare partners to attract graduating nurses, midwives and ODPs, and in 2016/17 over 200 newly qualified staff joined the Trust through this process. In 2016/17, 566 new Band 5 nursing staff started in the Trust.

Recruitment: support staff - clinical support workers, assistant practitioners and nursing associates.

The Trust has now got a full range of developmental opportunities for support staff, enhancing career progression and, hopefully, retention.

Clinical Support Workers are now primarily recruited and trained through the Trust's apprenticeship initiative.

Recruitment Fairs

In 2016/17 over 250 apprentices joined the Trust to commence training to become CSWs. The programme will continue to recruit up to 30 apprentices in each of 10 cohorts in 2017/18. A second apprenticeship programme has been established to train Senior CSWs, providing a Level 3 qualification.

The Assistant Practitioner Training Programme, supported by Health Education Yorkshire & Humber, has continued with a further cohort starting in September 2016. The programme moved to a Foundation Degree award, taught over two years with the first group of 15 qualifying in July 2017.

The Trust, as part of a West Yorkshire Pilot Partnership across Leeds, Bradford and Airedale, succeeded in becoming one of only eleven pilot sites for the training of Nursing Associates. This new role will bridge the gap between registered and unregistered nursing staff, with responsibility for all elements of care.

The trainees are employed by and work in the Trust whilst studying at local universities and attending placements. The Trust has 29 trainees, mainly recruited internally, who will work towards a Foundation Degree and access placements across the whole health economy.

Recruitment: advanced practice

In 2016/17, Health Education Yorkshire & Humber funded 25 advanced practice trainees and continued to support academic programmes for advanced practice. The number of trainees and completed practitioners in the Trust is now over 80, with interest for widespread development of the role across the CSUs.

Temporary staff

Bank and agency staff continue to provide an essential component of the workforce. In 2016/17 further pay rate caps were introduced for agency staff to try to reduce agency expenditure overall. The Trust has seen a reduction in agency spend, and work continues to improve Bank recruitment to reduce reliance on agency workers.

In October 2016, the bank provider moved from NHS Professionals to LTHT Staff Bank, supplied by Reed. Shift fill rates continue to improve since implementation despite some delays to recruitment to the service.

4.5.10 Ward Healthcheck

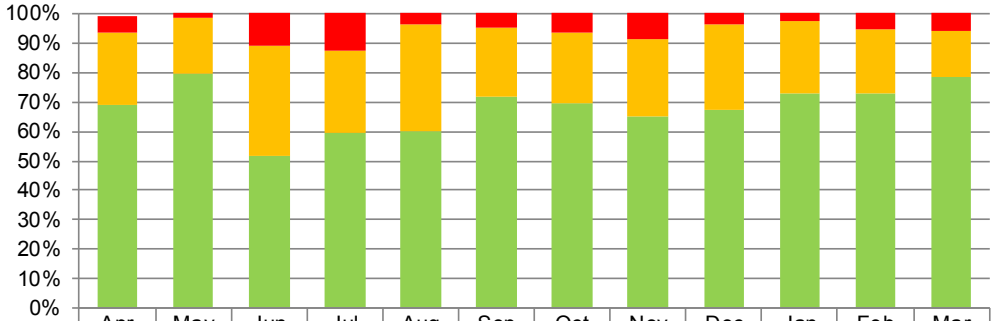
Background

The Ward Healthcheck and metric programme has been in place since December 2013 for all adult wards, March 2014 for maternity and paediatric wards, and September 2014 for the Emergency Departments (ED), Theatres and Outpatients.

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. The individual standard scores are collated to give an overall score which is RAG rated; 79.9% or below is Red, 80-89.9% is Amber and 90% and above is Green.

The chart below sets out by percentage the number of areas that are Red, Amber and Green. 85% of wards were Green by the end of 2016/17, and this has been achieved with only 5% of wards rated red. This is as a result of all the focused hard work clinical areas have delivered.

RAG Rated % of Cinical Areas Relating to Metrics Scores



	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017
Red	5%	2%	11%	13%	4%	5%	6%	9%	4%	2%	5%	6%
Amber	25%	19%	38%	28%	36%	23%	24%	26%	29%	25%	22%	16%
Green	69%	80%	52%	59%	60%	72%	70%	65%	67%	73%	73%	79%

Ward Metric results (March 2016 and March 2017)

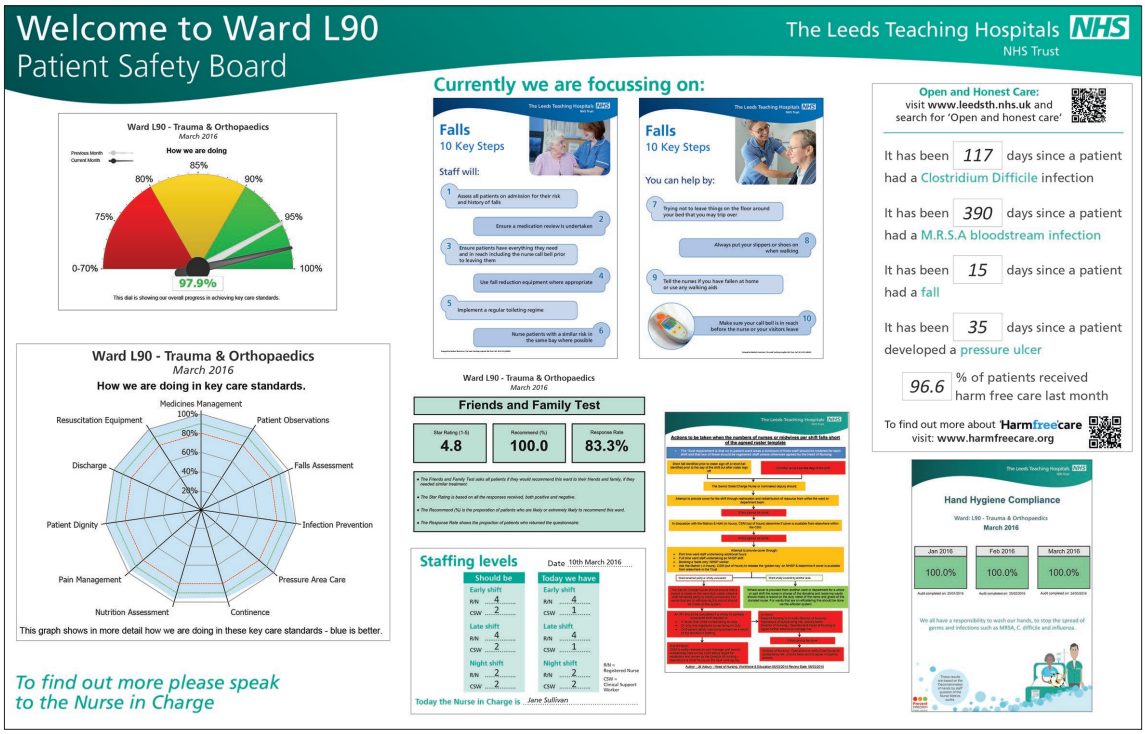
Question Group	Total Mar '16	Total Mar '17
Medicines Management	91.50%	96.10%
Patient Observations	91.10%	93.50%
Falls Assessment	94.50%	91.70%
Infection Prevention	85.90%	91.30%
Pressure Area Care	90.40%	90.30%
Continence	95.90%	96.00%
Nutrition Assessment	92.90%	93.90%
Pain Management	96.60%	97.00%
Patient Dignity	97.50%	97.80%
Discharge	87.00%	91.70%
Documentation		90.50%
Resuscitation Equipment	87.80%	93.50%
Total	**92.80%**	**93.60%**

The information generated from the Ward Healthcheck 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.

Aim for 2017/18

Following on from the progress that has been made, we will continue to develop the ward metrics and pilot its use in specialist assessment and day case areas, the Dental Institute and renal satellite units, and review and further develop the outpatients metrics. We will progress the work on the ward accreditation programme and will start to test this with our high achieving wards as a means to recognise their success.

Patient Safety Board

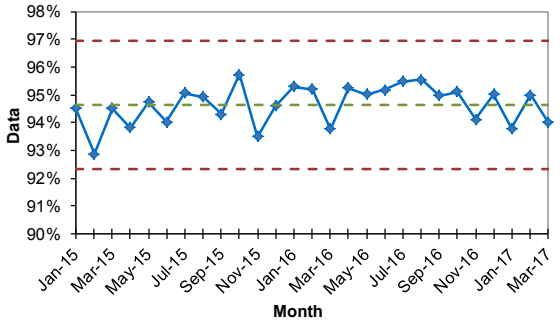


4.5.11 NHS Safety Thermometer

The NHS Safety Thermometer Classic provides a 'temperature check' on harms associated with falls, pressure ulcer, catheter associated urine infections (CAUTIs) and venous thromboembolism (VTE). Data is collected nationally on one Wednesday every month. Results are published on the NHS safety thermometer website. This gives a snap shot view of patients in the bed base at the time of the audit.

Harm free care performance for LTHT is shown in the chart below. Since April 2016 this has been above 95% for eight months. The improvements in our performance over time are due to reduction of falls with harm and new VTE, both of which are following a downward trend.

Harm Free Care Data, Sept 2014-March 2017



4.5.12 Reducing rates of healthcare associated infections (HCAI)

Preventing avoidable hospital acquired infection is a key priority for the Trust. Although this has remained challenging in 2016/17, we have seen a number of improvements, noticeably the substantial reduction in the number of patients who developed Clostridium difficile infections (CDI) whilst in our care.

The key objectives achieved in 2016/17 included:

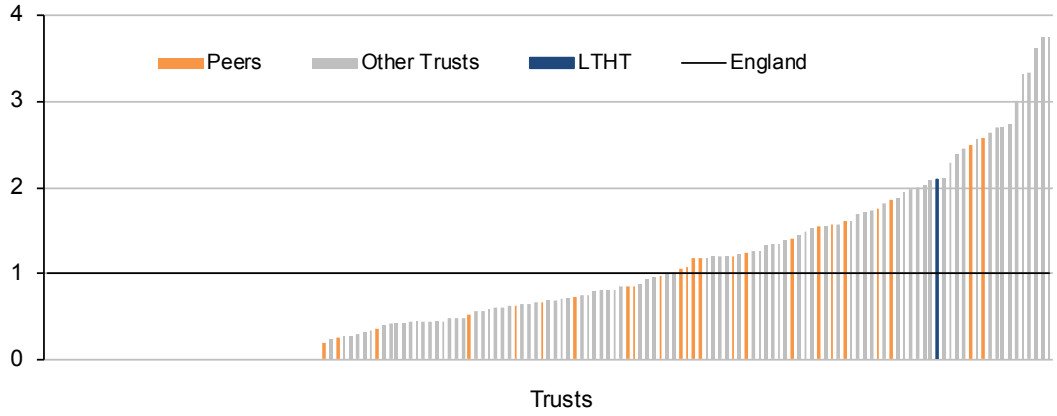
- Providing a robust approach to MRSA screening, to ensure all high risk patients received the appropriate antibiotic treatment prior to surgery.
- Review of all patients with CDI daily, to provide specialist advice and optimise treatment.
- Review of key antimicrobial guidelines, to promote the use of antibiotics which have been shown to be less likely to be associated with CDI, and reduce the use of very broad-spectrum antimicrobials, where clinically appropriate.
- Further promoting the use of safe working practices for all our staff by integration of lessons learnt from inoculation injuries throughout the Trust.
- Introduction of a vessel health and preservation group to develop pathways for safe placement of vascular devices.
- Participation in the 2016 national point prevalence survey on HCAI and antimicrobial usage, for Critical Care, and Abdominal Medicine & Surgery.

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 2016/17, 11 patients developed an MRSA bacteraemia whilst in our care, plus one where the MRSA isolate was a sample contaminant. This total is an absolute rise on the number that we had last year (7), and nationally each NHS Acute Trust continues to have an MRSA bacteraemia annual target set at zero, which a handful of our peers have achieved. The circumstances of each event were thoroughly reviewed. The patients involved had a number of medical co-morbidities, necessitating complex medical and nursing care. In the light of lessons learnt, the LTHT guidance for preventing and controlling MRSA has been refreshed and will be implemented in 2017/18 along with the HCAI Collaborative as outlined below. However, whilst the absolute total has risen, we are not currently a significant outlier nationally.

MRSA Bacteraemia cases March 2016 - March 2017



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, and the condition can usually be treated with another course of different antibiotics.

In 2016/17, 110 patients developed CDI in our hospitals compared to the nationally-set trajectory of 119 for the Trust, which is a significant reduction compared to last year when 139 patients were diagnosed with CDI whilst in our care. The CDI rate per 100,000 bed days has fallen for 2016/17 as illustrated below; and our recent performance in the setting of all England acute trusts is demonstrated in Table 6, courtesy of Public Health England.

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 Committee met with most of the bed-holding CSUs in 2016/17 to review and support their work. This has helped to deliver the four elements of the Antimicrobial Stewardship CQUIN on reducing antibiotic consumption compared to the baseline from 2013/14 and improving the review of "best-guess/empiric" antibiotics within the first three days.

We have built our antibiotic treatment guidelines into the electronic prescribing system that is being rolled out across the Trust. It has been set up to drive day 3 review. We have reviewed our Antimicrobial Stewardship systems against the NICE guidance and quality standards on systems and processes for effective antimicrobial use (NG15 & QS121) and NICE drug allergy quality standards QS97. Our monthly audit programme is now reported on the Trust Ward Healthcheck dashboard.

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+)	2016/17	19.3	14.4	0.0 to 81.6
	2015/16	24.8	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

Aims for 2017/18

The targets we have been set for 2017/18 are:

- Zero "avoidable" MRSA bacteraemias
- No more than 119 cases of CDI.

During 2017/18 we will launch a Collaborative for HCAI as part of the quality improvement programme to address the question 'How can we prevent HCAI blood stream infections?'. The Collaborative will utilise the Model for Improvement as a framework for testing new interventions and making changes to their areas. Ward teams will identify small tests of change that they believe will lead to improvements. Our ambition is to go at least 200 days without an MRSA bacteraemia. The efforts of the Collaborative should also help prevent blood-stream infections with other organisms, including Escherichia coli and other Gram-negative bacteria; which will be addressed as a whole health care economy approach in accordance with the drive for reduced rates nationally.

The challenge is to deliver this continuous improvement, whist ensuring that the actions already implemented to achieve the overall reductions witnessed to date are sustained.

4.5.13 Reducing harm from preventable venous thromboembolism (VTE)

Venous thromboembolism (VTE) or blood clots can be caused by being in hospital so reducing the risk of these occurring is an important part of patient care. Assessing adult patients on admission to hospital for their risk of developing blood clots or their risk of bleeding helps us decide how best to care for each patient.

Key achievements in 2016/17

In 2016/17 quarters 1 - 3 the Trust continued to achieve the target of ensuring that at least 95% of adult patients admitted to the Trust are risk assessed for VTE rapidly within 24 hours of admission. Unfortunately the implementation of eMeds had a negative effect on risk assessment rates in quarter 4 and we failed to achieve the 95% target. The Trust is currently looking into this and deciding on an action plan.

The table below shows the percentage of patients who have had a VTE risk assessment in 2016/17.

Since April 2013 we have completed an investigation into all patients' care if they develop a VTE during or within 90 days of their hospital admission. We are committed to learning how we can try to prevent VTEs and so continue to make sure we complete an investigation for 100% of all such events.

We have been incorporating what we have learnt from our investigations into the training we regularly provide to staff. On World Thrombosis Day in October 2016 we organised a Trust-wide study session which was extremely well attended by LTHT healthcare professionals who wanted to increase their knowledge and awareness of VTE, and what they can do to help our patients reduce their risk.

We want to make sure all patients receive general information about what they can do to help reduce the likelihood of developing a VTE, both as an inpatient and when they leave the hospital. This year, to help increase our patients and carers awareness of VTE prevention we have developed more detailed leaflets about VTE prevention for pregnant patients and for patients with cancer.

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 2016/17	94.7%	98.5%	63.0% - 100%
	Q3 2016/17	96.0%	98.2%	76.5% - 100%
	Q2 2016/17	96.0%	97.7%	72.1% - 100%
	Q1 2016/17	96.2%	95.6%	80.6% - 100%

1Excludes independent sector providers

Aims for 2017/18

Our plans for the coming year are to develop a new e-learning package to support staff to learn more about VTE prevention in Leeds.

4.5.14 Preventing harm from misplaced nasogastric tubes

Feeding through a misplaced nasogastric (NG) feeding tube is defined by NHS England as a Never Event. In 2016/17 we have seen further improvements within our hospitals to improve standards and safety for those who require nasogastric tubes for feeding (NGTs). These include;

- Revising NG care plans to improve safety aspects such as assessing risk of patients feeding overnight.
- Radiographers empowered to highlight any problems they observe and take action, enabling focused training/feedback to be given to individuals or clinical areas.
- Review of all incidents related to NG tubes every two months at the Enteral and Parenteral Guidelines group meeting, with actions taken.

In the most recent NG tube audit, NG care plans were used for 96% of patients, with pH used first line in 93% of cases (the gold standard method to check safe placement). X-ray was used as the first line check of safe placement in only one case, reflecting the good progress that has been made.

4.5.15 Safeguarding vulnerable people

The Trust is committed to safeguarding all children, young people and adults at risk of abuse, and we believe that everyone has an equal right to protection from abuse, regardless of their age, race, religion, gender, ability, background or sexual identity.

Leeds Teaching Hospitals NHS Trust continues to work to enhance safeguarding practice and standards across the whole organisation to safeguard our most vulnerable patients and to continue to develop and embed a culture that puts safeguarding at the centre of care delivery.

Key achievements in 2016/17

- In November 2016 the Trust participated in the Safer Leeds and National White Ribbon Campaign raising awareness about domestic violence.
- Leeds Teaching Hospitals Trust continues to embed the "Think Family" agenda to improve outcomes for children and families.
- In December 2016 our Children's Hospital, and Safeguarding Team successfully launched the 'Alternatives to Physical Chastisement' Campaign.

Head of Safeguarding Karen Sykes, with Chief Executive Julian Hartley and Executive Director Dean Royles

Safeguarding Team with patients and staff from the Children's Hospital

In our response to valuing mental health equally with physical health or "Parity of Esteem", the Trust has undertaken collaborative work with all our partners and stakeholders to:

- Roll out a robust procedure and risk tool to better support patients presenting with mental health needs when they need safe transfer to a psychiatric setting.
- Implement an improved suite of procedures focussed on patients who require enhanced levels of care and supervision. This helps front line staff to identify patients early in their admission and to identify person centred responses to keep people safe and still engaged in meaningful interactions with staff providing one to one care.

One of our mental health pledges

4.5.16 Serious incidents

We are committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence: 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 Assurance Committee, led by the Chief Medical Officer: this 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 reduction in the total number of serious incidents reported. There has been a reduction in reporting of Category 3 pressure ulcers, because all Category 3 pressure ulcers are now reviewed locally to consider whether each one was avoidable and led to longer-term or permanent harm. This was introduced following the recommendation made in the revised Serious Incident Framework by NHS England in 2015.

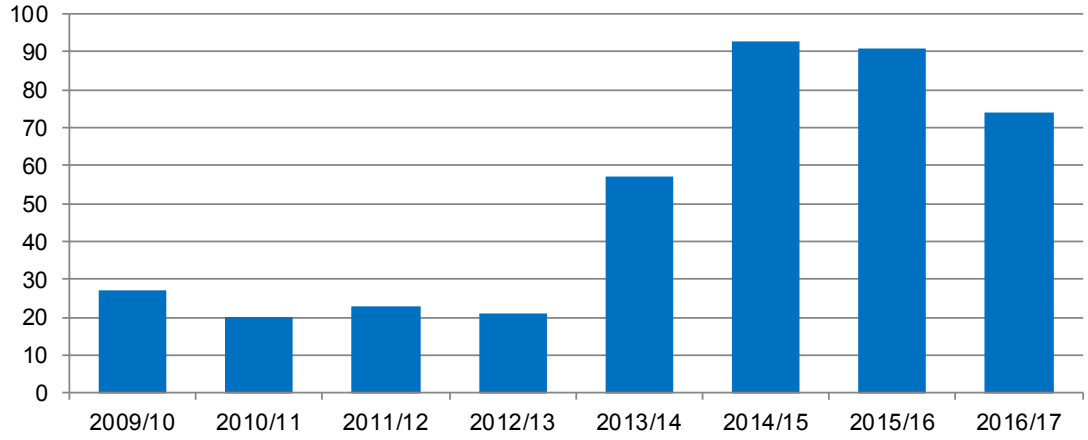
Learning from incidents

The Lessons Learned Group, established in 2014/15, continues to increase the effectiveness of learning lessons from serious incidents. Six learning points bulletins have been produced Trust-wide during 2016/17 covering various topics. Videos continue to be made by the Clinical Service Units and uploaded onto the Lessons Learned YouTube Channel. The Group are in the process of developing a Lessons Learned App for Android/Smart phones for staff to download and instantly receive lessons learned from incidents.

The LTHT intranet site has been updated with a Lessons Learned page where all staff can access all the learning points bulletins, videos and resources to assist with learning.

The Trust has continued to publish fortnightly safety briefings for staff, called 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. Topics included in 2016/17 are shown opposite.

Number of serious incidents reported (by year)



Patient safety Incidents (NRLS) October 2015 - March 2016

Indicator	Trust Performance	Average all Acute Hospitals Performance	All Acute Hospitals Range
Rate of patient safety incidents (per 1000 bed days)	40.89	39.31	14.77-75.91
Number of patient safety incidents that resulted in severe harm	12	Not specified	0-85
Number of patient safety incidents that resulted in death	8	Not specified	0-37
Percentage of patient safety incidents that resulted in severe harm	0.1%	0.3%	0.1%-1.7%
Percentage of patient safety incidents that resulted in death	0.1%	0.1%	0%-1.1%

Quality and Safety Matters Briefing Topics

Assessing Mental Capacity	Omission of medicines	Transferring patients with mental health needs
McKinley T34 syringe pump	Incident Reporting	Antimicrobial review
Use of restraint	Preventing incidents involving medicines and allergies	Prescribing strong opioids to adult palliative care patients
Pre-operative fasting guidelines	Mental Health Act Detention - Sectioning	Investigation and management of VTE
Patient Blood Management	Stop the Pressure	Stop before you block
Keeping patient information safe	Insulin	Acute Kidney Injury (AKI) management

LIST (Leeds Incident Support Team)

September 2016 saw the Trust-wide launch of the Leeds Incident Support Team (LIST). The LIST is a voluntary group of LTHT staff who have previously been involved in serious incidents. They have made a commitment to be available to talk to other staff who may become involved in a similar type of incident. They will talk through the process of an investigation and should be able to answer any questions a staff member may have. The 'buddies' on the LIST have received training for their role which has just expanded to include supporting staff involved in PALS and Complaints.

Never events

NHS England revised the list of Never Events in 2015/2016, reducing the number from 25 to 14.

The Never Events list provides an opportunity for commissioners, working in conjunction with trusts, to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur. Nationally the most commonly reported Never Events relate to retained surgical items, wrong site surgery, and wrong implants.

We have reported four Never Events during 2016/17 under the following categories:

- Wrong tooth extraction x 1
- Wrong site surgery x 2
- Wrong site block 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. They have also been reviewed with the clinical teams to ensure immediate action has been taken to reduce the risk of recurrence, that Duty of Candour regulations have been followed, and that they have been 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 incidents that result in moderate harm, severe harm and death, using the National Reporting and Learning System (NRLS) categories for incident reporting.

Every week the Risk Management Department monitors the Datix web incident reporting system to ensure that where incidents have led to moderate harm, severe harm or death the Duty of Candour process has been followed, including offering an apology and an explanation that an investigation will be done to help us understand the cause of the incident so that we can learn from this.

We have supported clinical teams and staff to ensure the Duty of Candour regulation is complied with. We have published an electronic learning tool for staff and Quality & Safety matters bulletins, which have been shared with clinical teams across the Trust.

4.5.17 Scan 4 Safety

LTHT is one of six demonstrator sites for a project that utilises scanning technology to associate: patient, product, place and process.

Scan for Safety Standards

This brings with it significant safety and efficiency benefits including:

- Tracking product use, eg tracking those used for a surgical procedure in an operating theatre.
- Tracking patients in each location they go to in our hospitals, including which bed they are in on which ward.
- Rapid identification of the location of products that have been recalled.
- Recording which staff are involved in procedures.
- Managing stock more efficiently, reducing stock stored and ensuring all stock is in date.

We are 14 months into a 24 month project and are on schedule to meet all the milestones agreed. We are working to integrate all the information gathered by different systems into our Electronic Patient Record, and link to electronic scanning and documentation using mobile devices at the bedside.

4.5.18 Guardians of Safe Working

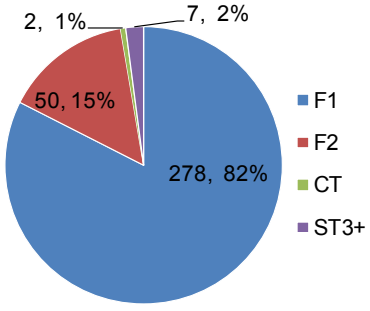
As part of the May 2016 junior doctors' contract, Guardians have been appointed in NHS Trusts to ensure fair and safe delivery of the new contract. The Trust appointed two Guardians to take up this role, who are consultants in Emergency Medicine and Renal Medicine.

The Guardians' role is to oversee the work schedule review process for junior doctors:-

- To address concerns relating to hours worked and access to training opportunities.
- To support safe care for patients by ensuring doctors do not work excessive hours.
- To use powers to impose financial penalties when safe working hours are breached.

Trainees on the new contract who work over and above their contracted hours, or are unable to take adequate rest, or attend education and training are required to complete an Exception Report (ER), which are reviewed by the Guardians every morning. It is encouraging to note that there have been very few patient safety concerns included in ERs. Robust systems have been put in place to escalate serious concerns to senior colleagues in CSUs, following the daily reviews.

Overview of Exception Report Data (7 December 2016 - 31 March 2017)



Specific interventions have been made as a direct result of the feedback received from Exception Reports, including:

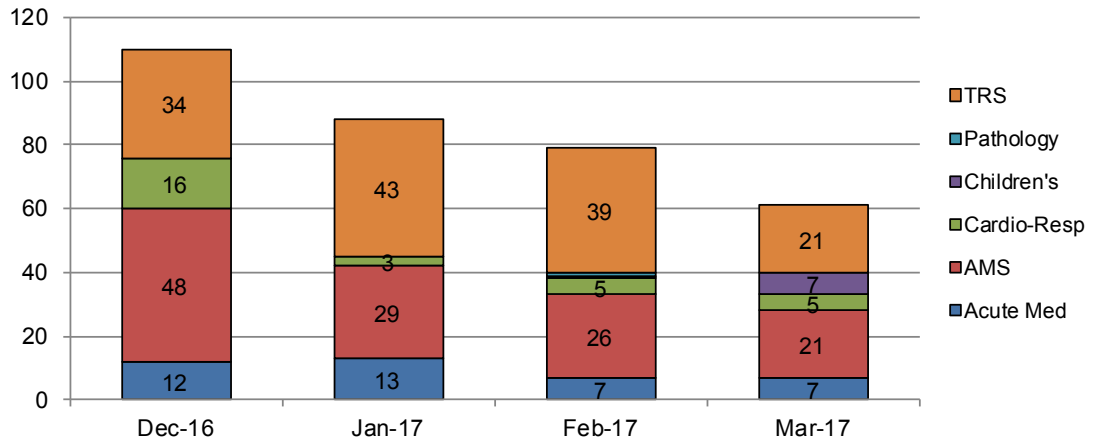
- Review and updating of rotas in Vascular Surgery.
- A senior doctor now being present at the late afternoon handover in Trauma & Orthopaedics, potentially facilitating juniors leaving on time.
- Work in General Surgery to review the medical and clinical workforce ahead of the August rotation, to create a longer-term solution to the problems of late working.
- Work with the Rostering Team to redesign rotas to accommodate gaps in the Paediatric Intensive Care Unit (PICU) rota.

The Guardians updated the Trust Board in November 2016, and reported to the Research, Education & Training (RET) Committee in March and May 2017. In the latest report, they focused on the lessons learned, and what they are doing alongside colleagues in Human Resources and the Medical Education Team to improve rotas, and better engage with trainees.

The review processes are working effectively and so far the roll-out of the contract is going well. We have noted a significant reduction in the number of reports coming in over this period, particularly from our most junior (FY1) trainees. Where problems have been identified the Guardians are working collaboratively with colleagues across the Trust to deal with them.

The Corporate Medical Directorate is leading a programme of work to improve communication, engagement and morale amongst junior doctors, supported by the appointment of a Chief Registrar, the work of the Junior Doctor Body, and plans to create a Professional Support Unit, which is key to safe working.

Exception reports submitted by month



4.6 Clinical Effectiveness

4.6.1 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 NHS Digital.
- 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 a 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 October 2015 to September 2016, 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 Oct 15 - Sept 16

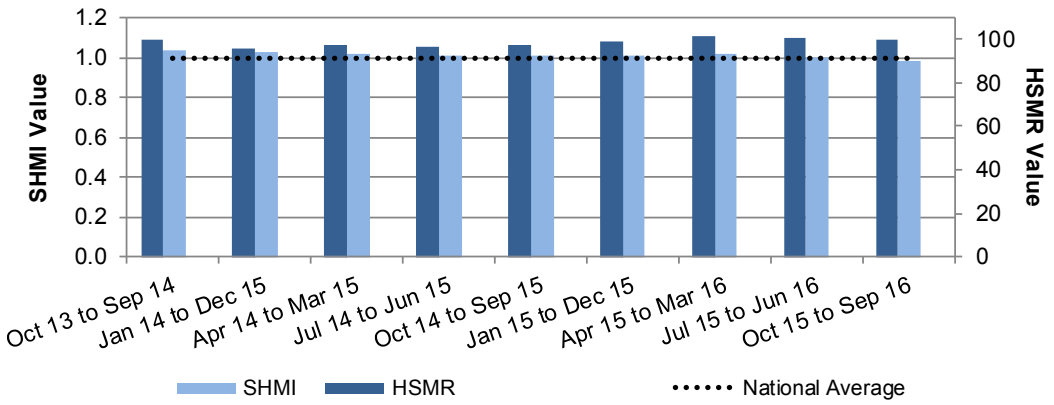
Trust level mortality, Oct 15 - Sept 16	Spells	Value	Observed deaths	Expected deaths	95% Confidence Interval
SHMI	134,133	0.9836	4,130	4,199	0.894-1.119
HSMR	62,449	100.28	2,556	2,549	96.43-104.24

Higher than expected	As expected	Lower than expected

SHMI Indicator by rolling 12 month reporting period

Indicator	Reporting Period	Trust Rate	National Average	National Range
SHMI	Oct 15 to Sep 16	0.98	1.00	0.690 - 1.164
	Jul 15 to Jun 16	1.00	1.00	0.694 - 1.171
	Apr 15 to Mar 16	1.02	1.00	0.678 - 1.178
	Jan 15 to Dec 15	1.01	1.00	0.669 - 1.173
	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

Trust level SHMI and HSMR (basket of 56 diagnoses) by rolling 12 month reporting period



The Trust SHMI and HSMR rates have consistently fallen within the expected range.

The Trust uses tools provided by Dr Foster to review more current mortality rates, as 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 Feb-16 to Jan-17

February 2016 to January 2017	HSMR (basket of 56 diagnoses)	HSMR (all diagnoses)
Observed deaths	2,621	3,132
Expected Deaths	2,645	3,216
HSMR	99.1	97.4

For the reporting period October 2015 to September 2016 LTHT had a crude death rate of 28.2% of deaths reported in the SHMI with a palliative care coding. This figure is less than the National average of 29.7%, and within the National range of 0.4% to 53.3%.

Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust

Reporting Period	Trust Percentage	National Average	National Range
Oct 15 to Sep 16	28.2%	29.7%	0.4% - 53.3%
Jul 15 to Jun 16	26.0%	29.2%	0.6% - 54.8%
Apr 15 to Mar 16	24.2%	28.5%	0.6% - 54.6%
Jan 15 to Dec 15	23.6%	27.6%	0.2% - 54.7%
Oct 14 to Sep 15	22.4%	26.6%	0.2% - 53.5%

LTHT investigation into intracranial linjury mortality outlier alert

In June 2016 the Trust received a letter from the Dr Foster Unit at Imperial College containing analysis which highlighted a higher than average mortality rate for intracranial injury. This analysis was also shared with the Care Quality Commission. A Trust investigation into the mortality outlier alert was conducted in four parts;

i. An analysis of outcome and activity data, sourced from Dr Foster, NHS Digital, Trauma Audit & Research Network (TARN) and Intensive Care National Audit & Research Centre (ICNARC). Data was reviewed at the Trust Mortality Improvement Group, including clinician representation from related services.

ii. An audit of clinical coding in 45 cases across five services (Neurosurgery, Stroke, Acute Medicine, Children's, and Trauma services) during the period April 15 - March 16.

iii. A combined review by the Lead Clinician in Neurosurgery and the Clinical Coding Manager of clinical documentation, covering paper case notes and electronic records.

iv. A case note review of 27 cases by senior clinicians across five services.

When compared to other Major Trauma Centres nationally, it can be demonstrated that for intracranial injury, mortality at LTHT is broadly comparable to other MTCs, and the Trust is within expected range compared with its peers.

The Trust Investigation highlighted both clinical coding training needs and clinical documentation issues, both of which are being addressed. Detailed case note reviews did not identify any cases where the death was considered avoidable, however there was valuable learning which is being shared through the Trust Mortality Improvement Group. The investigation provided assurance that there was no cause for concern regarding our level of intracranial injury related deaths.

Learning from deaths

The Trust Mortality Improvement Group has overseen work to review the NHS England's recommendations for mortality review published in December 2016: this showed the Trust to be in a good position against the guidance in terms of Trust-wide and specialty specific mortality review processes, and actions to strengthen those processes were already well underway.

Subsequent work was undertaken to review the Mazar's 2015 report into Southern Health which had found shortcomings in adequately reviewing deaths of patients with learning disabilities. In view of this, the Trust carried out an in-depth review of deaths in LTHT of patients with learning disability from February 2015 to February 2016 which demonstrated that all these patients had received appropriate care with regard to their learning disability and that their deaths were unavoidable. The Trust has subsequently become involved in the Yorkshire and Humber pilot of the National Learning Disability Mortality Review (LeDeR) established in November 2016 to support local reviews of deaths of people with learning disabilities aged 4-74 across England.

The Trust has also been actively involved in piloting the Structured Judgement Review tool, which was launched by the Royal College of Physicians in November 2016, and we currently have 167 members of staff trained in the use of this tool. Our specialties are being actively encouraged to use it as a core part of their mortality review process.

Throughout the above period the Trust has been developing an updated Mortality Review Procedure to take into account the learning from the above reviews and incorporating the Structured Judgement Review methodology. This will also take into account aspects of the national guidance was issued by the National Quality Board in March 2017.

Weekend care

The table on the next page shows the Trust HSMR for emergency patients split by weekday (Monday - Friday) and weekend (Saturday & Sunday) day of admission; both are within the expected range and there is no significant variation between the two.

Weekday and Weekend HSMR - Emergency Admissions

Trust HSMR - Emergency Admissions Dec 15 - Nov 16	Spells	Value	Observed deaths	Expected deaths	95% Confidence Interval
Weekday	27,668	97.32	1,792	1,841	92.87 - 101.94
Weekend	9,026	97.94	602	615	90.27 - 106.08

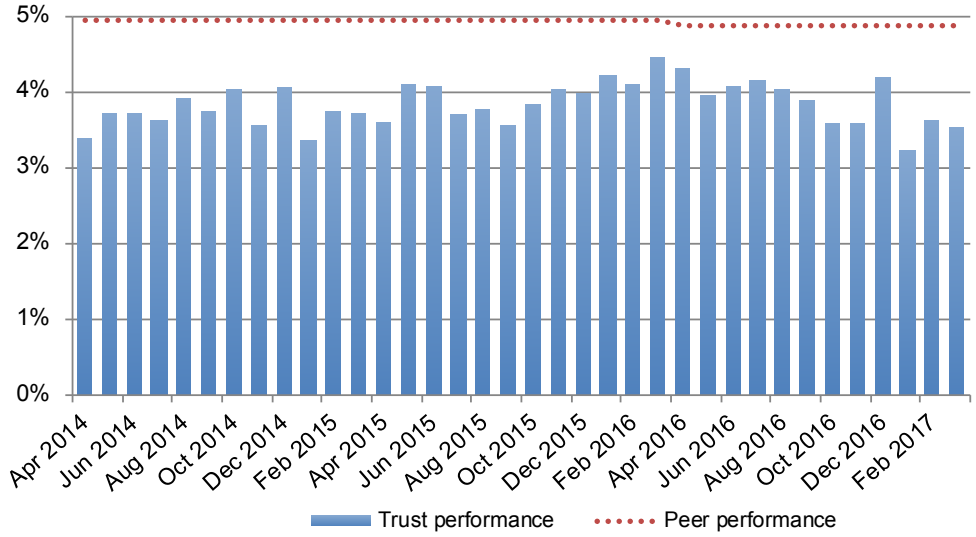
Higher than expected | As expected | Lower than expected

4.6.2 Readmissions

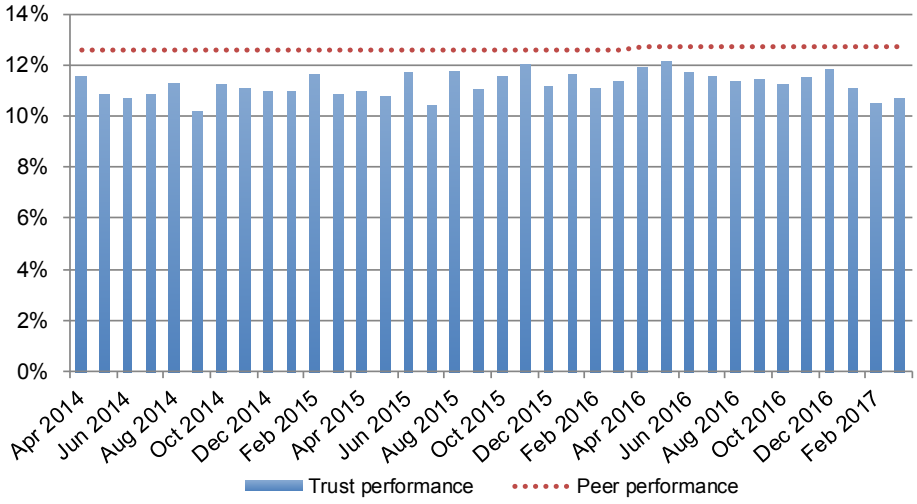
The Trust performs better than its peers with lower readmission rates following an elective or non-elective admission. Sometimes, after patients are discharged from hospital, they may need to be re-admitted again for a variety of reasons. Some readmissions are unavoidable, such as for patients returning following cancer treatment or for some cases the relevant care in the community may not be available. Nevertheless, it is important that hospitals closely monitor their readmission rates to ensure that these are as low as possible.

The graphs below show monthly 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. Our rates are consistently lower than other teaching hospitals for both categories of patients.

Readmissions to the Trust within 30 days of discharge: elective spells



Readmissions to the Trust within 30 days of discharge: non-elective spells

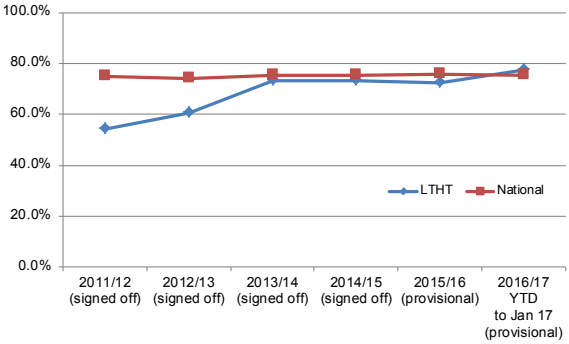


4.6.3 Patient reported outcome measures

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 chart below (please note that the 2015/16 and 2016/17 data is still provisional; the final signed-off data will not be available until Summer 2017 and Summer 2018 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: NHS Digital; 2016/17 YTD (January) as at March 2017

The following table shows the average Health Gain for each of the PROMs procedures for each of the scoring systems, for both LTHT and the England average; (note that the condition-specific systems are not applicable to certain procedures). Average Health Gain is measured by comparing the results of the pre-operative questionnaire with the post-operative questionnaire. The outcomes show that LTHT is within the expected range across the various procedures. (Note that for the Aberdeen system, the lower the score the better).

PROMS Scores - Casemix-adjusted average Health Gain - April 2016 to December 2016, provisional data

	EQ-5D Index	EQ VAS	Oxford Hip Score	Oxford Knee Score	Aberdeen Varicose Vein
Groin Hernia	0.10	1.41	N/A	N/A	N/A
England Average	*0.09*	*-0.18*	*N/A*	*N/A*	*N/A*
Varicose Vein Surgery	0.08	0.13	N/A	N/A	-10.24
England Average	*0.09*	*0.66*	*N/A*	*N/A*	*-8.61*
Hip Replacement Primary	0.44	10.24	21.18	N/A	N/A
England Average	*0.45*	*13.46*	*21.86*	*N/A*	*N/A*
Knee Replacement Surgery	0.30	7.06	N/A	16.81	N/A
England Average	*0.33*	*7.40*	*N/A*	*16.74*	*N/A*

4.6.4 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 can help patients and their carers to have a more active role in dealing with their own medicines, which can in turn help to reduce problems.

The number of patients who were offered a copy of a printed patient information sheet about their specific medicines from the tool called MaPPs - 'Medicines: a Patient Profile Summary', has increased during this year. We found that different patient groups wanted different information and also wanted to access information about medicines in different ways. We also heard from conversations with patients, their family members and carers, that all too often patients still leave consultations with unresolved medicines related issues. We have been working with a small sub-group of the Leeds Area Prescribing Committee, led by a lay patient advocate, to help develop something called a medicines communication charter. This is an approach that can support patients, carers and health professionals when they are involved in conversations about the choice and use of medicines. The medicines communication charter group has developed tools, with a consistent image, which aim to support everyday conversations about medicines - me and my medicines "It's ok to ask….".

In 2017/18 we will be using the "me + my medicines" approach in some of our hospital areas, alongside our continuing "Your Medicines-Your Health" programme of work. We will be using this to support patients with chronic conditions who wish to take responsibility for managing their own medicines whilst they are in hospital.

More patients are telling us they would like to continue to look after their medicines, just like they do at home, if they have to be in hospital and remain well enough to do this safely.

Together with our specialist heart team, Cardiology, we started a new outpatient service in 2016 which helps patients who have suffered a heart attack. After having a heart attack patients are prescribed multiple medicines: the new service offers patients support to help them get the best

out of the different medicines and gives patients time to talk about and find ways to resolve medicines related concerns or problems with medicine experts. Patients who have completed our survey about the clinic tell us this service has really helped them to understand their medicines and they feel involved in the decisions about their on-going medicines needs and preferences.

Whenever a patient is transferred from one location to another it is really important that the relevant information about the patient's medicines is shared so that everyone involved in caring for the patient has the information they need to help prevent mistakes with medicines wherever possible.

Last year we had just started implementing a new electronic medicines prescribing and administration system, and now over 50 wards are using this eMeds system.

emeds
Better Medicines Safety
Better Patient Care

Some of the benefits already seen are clearer information about medicine changes, reduced duplication and more easily produced up-to-date medicines lists which share electronically. Throughout 2017/18 we will continue to implement this electronic system, which integrates with the Leeds Care Record.

Children, and some adult patients, told us about their difficulties with swallowing tablet medicines, so this year we worked with patients in the Children's Hospital, parents, play leaders, nurses, pharmacists and doctors, to try to find out what techniques might help. We identified seven different techniques and, in our survey, everyone found that at least one of the techniques actually worked for them; for many meant that they could start using tablets or capsules instead of inconvenient bulky liquid medicines which are often also more expensive. We plan to use this tool more widely during 2017/18. Some of the things patients told us are: "I'm happier taking tablets as it's less obvious to my friends", "Liquids taste awful, tablets are much better", " I feel more grown up being able to take tablets", "Putting your head back makes you feel like there is no pill", "It's much quicker".

The parents of the children that this helped told us: "It is not a fight to take medicines any longer", "We don't have to come back to clinic as often", "It's much easier for school to manage", "My child no longer dreads taking their medicines".

Medicines optimisation improvement will continue throughout 2017/18 based on the issues our patients, their carers and our staff tell us about.

4.6.5 End of Life Care

Ensuring that we provide excellent end of life care at all times is a priority within LTHT. Our Palliative Care Team lead a large portfolio of quality improvement projects across the Trust, working collaboratively with clinical teams and city wide partners. We are committed to sharing good practice locally, regionally and nationally, thereby informing national strategy and guidance for the benefit of our patients.

Key achievements in 2016/17

- End of life care being rated "Good" by the CQC - May 2016.

- Individualised care plans for dying patients highlighted as an area of outstanding practice by the CQC - May 2016.
- One of 10 hospitals selected to be part of the National Building on the Best (BoTB) project in collaboration with NHS England (NHSE), the National Council for Palliative Care and Macmillan.
- Priority training in place for senior medical staff nurses and AHPs - highlighted as an example of good practice by NHSE.
- Rapid discharge plan (RDP) implemented within the Emergency Department to enable patients to be transferred to their preferred place of care in the final days and hours of life - Best collaborative project at the LTHT Time to Shine awards.
- Agreement with all adult CSUs to have a bespoke end of life care improvement plan in place to be monitored through their governance meetings and reporting progress to the End of Life Care Steering Group.
- Enhanced integrated city-wide working within the new Leeds Managed Clinical Network (MCN) for Palliative and End of Life Care to lead service improvements for palliative care patients in Leeds.
- Improvements made to support for relatives of dying patients - extension of free car parking permits and comfort care packs.
- Palliative care patient information resources promoting choice accessible and visible across adult wards - Best educational / promotional campaign at the LTHT Time to Shine awards.
- Comprehensive opioid guidance implemented Trust wide.
- Successful collaborative projects with the Deteriorating Patient Group, and Liver and Respiratory teams to improve future care planning for palliative care patients.

Aims for 2017/18

- Working within the MCN, to streamline processes to facilitate timely transfer of care for patients from the Trust to the Hospices.
- Promoting wider use of RDP to enable patients to be discharged to their preferred place of care at the end of life.
- Improving the quality of prescribing palliative care drugs with a focus on reducing waste and streamlining practice across Leeds.
- Rolling out the end of life / advance care plan in PPM+ to enable sharing and recording of patient preferences with health care professionals across all providers.
- Building on the individual CSU improvement plans to ensure service improvements continue at a local level, and embedding ownership and accountability of end of life care provision with clinical teams.
- Rolling out new care of the dying person care plans across all adult wards.
- Supporting the implementation of the RESPECT documentation and approach.
- Further rolling out and evaluation of the BoTB project workstreams: symptom management and outpatient working.
- Continuing cross city working to build a robust data reporting system that includes patient clinical outcomes.

4.6.6 Discharge

Discharge team

Improving the quality of discharge of patients and their families remains a key priority for the Trust. Building on the work started in the previous year, 2016 has seen the implementation of further improvements to the discharge process:

- Implementation of the Leeds Integrated Discharge Service
- Introduction of a discharge lounge at St James's University Hospital
- Improvements to the electronic systems
- Collaborative working with care homes

The Discharge Team

October 2016 saw the launch of the multidisciplinary Leeds Integrated Discharge Service (LIDS) in the Acute Medicine CSU. The team consists of nursing and allied health professional staff from LTHT and Leeds Community Health (LCH). The staff have specialist knowledge and understanding of the discharge process, helping to improve speed and quality of a patient's discharge from hospital. Early results show a reduction in length of stay on the acute medical wards of 0.6 days.

Improving links into the community is an important part of the discharge process; the Discharge Team is continuing to develop networks with the care homes of Leeds to build relationships and share learning to improve discharge for patients.

Discharge lounge

The Discharge lounge at St James's University Hospital was launched in October 2016. The lounge is a dedicated area in Lincoln Wing and can take up to 40 patients per day, with a team of staff who are able to visit wards to collect the patients. Since the opening, the Discharge Lounge has significantly improved the flow of our patients through the hospital, and has now seen over 1,000 patients successfully discharged from this area.

Due to the success of the project, the Discharge Lounge is being re-located to a larger area in Lincoln Wing that will enable it to accept more patients and include those patients who require a greater level of care whilst their discharge arrangements are made. This development has been supported by the West Yorkshire Accelerator Zone.

4.7 Leeds Improvement Method

In October 2015 four work areas, known as Valuestreams, were chosen for developing the Leeds Improvement Method continuing into 2017/18; a fifth Valuestream was added during late 2016 which will launch in May 2017, looking at the time to first consultant review in Acute Medicine, at St James's University Hospital.

Valuestream 1 - Total hip and knee replacement surgery patients

Since April 2016, there has been two week-long workshops called Rapid Process Improvement Workshops (RPIWs). These are specifically focussed on teams understanding the contribution and impact they have within a single work area and/or process. These two events take the total RPIWs in this Valuestream to four in total and focussed on:

RPIW3 - Elective Orthopaedic Pre Assessment

As a result of our first RPIW most patients have agreed a date for their surgery with the Consultant in their final outpatient clinic appointment. At this point patients require a surgical pre-assessment appointment to ensure they are fit and well for surgery.

Achievements - Elective Orthopaedic Pre Assessment

Before	After
114 hours to have a clinical administration pack ready for the patient's surgery	64 hours and 55 minutes, with still more work ongoing
66% of patients required a repeat pre-assessment appointment	32% of patients currently require a repeat pre-assessment appointment
Administration clerk had to ask for input to decipher consultant handwriting on a patient booking form for 45% of booking forms	Administration clerk has to ask for input to decipher consultant handwriting on a patient booking form for 7% of booking forms
0.5 WTE nurse time spent re- preassessing patients	0.13 WTE nurse time spent re- preassessing patients

RPIW4 - Early Mobilisation

Research evidence tells us that early mobilisation following a hip or knee joint replacement improves patient outcomes, however we observe variation in our ability to provide this opportunity to every patient.

Achievements - Elective Orthopaedic Early Mobilisation

Before	After
Physiotherapy staff had to walk on average 304 steps to find a patient for early mobilisation on the day of their surgery	Physiotherapy now walk on average 152 steps as patients are clearly identified as requiring early mobilisation with a green card at the end of their bed
51% of patients were not supported to mobilise at Day Zero	17% of patients were not supported to mobilise at Day Zero
Only 56% of patients were aware that they would be mobilised on the day of surgery at between 4-6 hours after their operation	80% of patients aware that they would be mobilised on the day of surgery at between 4-6 hours after their operation
0.3 wte of nursing time supported a handover between two stages of recovery	This process has been eliminated as the same nurse supports the patient through their recovery phase before being moved to the ward

Valuestream 2 - Transurethral resection of the prostate (TURPs) patients

After launching in March 2016 there have been three week-long Rapid Process Improvement Workshops (RPIWs) specifically focussing on:

RPIW1 - Clinical Checkpoints

There is significant variation in patients' experience of their TURP pathway from their arrival on the ward through to their discharge. The theatre suite in which the patient's surgery takes place, has a significant impact on their length of stay post operatively, between 19 hours to just under 40 hours.

Achievements - Clinical Checkpoints

Before	After
Patients stay post TURP Surgery up to 40 hours	Rapid discharge process with 6 hour discharge pathway and 23 hour pathway
Bladder scanner not available 75% of time	Bladder scanner available 100% of the time
11 individual forms for nurse to complete on patient arrival with no guidance on discharge.	TURP rapid discharge booklet with clinical checkpoints built in to enable a standardised process
Typical language: "Stop irrigation when the urine colour is rosé"	New irrigation chart with visual control chart

RPIW2 - Effective preparation for TURP Patients

Patients attending the Urology Outpatients who choose TURPs surgery can experience a frustrating and lengthy journey to their day of surgery.

Achievements - Preparing the Patient

Before	After
64% of patients required a second pre-assessment	7% of patients currently have a second pre-assessment
Insufficiently prepared patients for clinic appointments resulting in an average appointment time of 64 minutes	New patient information leaflet that lets a patient know they should arrive with a full bladder, and that they would have their flow rate test immediately. Average appointment time reduced to 21 minutes.
Lower urinary tract patients mixed with all other outpatients in clinic	New Lower Urinary Tract Clinic, specialising in rapid triage and consultation of patients

RPIW3 - Electronic Discharge Advice Notes (eDANs)

There is significant variation in patients being discharged in a timely way in receipt of a formal record of their care, including medications where applicable. This formal record of their care is called an Electronic Discharge Advice Note or eDAN. A patient is told on the ward round that they can go home that day but can regularly be left waiting significant periods of time before that actually happens.

Achievements - Electronic Discharge Advice Note

Before	After
Patients waited on average 349 minutes once they had been told they could go home to actually having the eDan ready for them to go	20 minutes nurse authorised discharge, with pre-prepared eDan
29% of patients left hospital without eDan being ready	0% of patients leave without an eDan
10% of patients had medication sent in a taxi after discharge	All patients leave hospital with all medication they need.
155 minutes was the average time spent preparing the eDan on the day of discharge	3 minutes on average is spent preparing the eDan on day of discharge

Next steps for 2017/18

Implementation of the Leeds Improvement Method will continue in Orthopaedics at Chapel Allerton and TURPs at St James's University Hospital.

Valuestreams 3 and 4 had their launch events during the last quarter of 2016/17 and are planning their first RPIWs during the first quarter (April to June) of 2017/18.

4.8 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.

Each Professional Leadership & Change Programme is a 13 day educational and change programme with six additional days to support embedding ideas into practice. The programme is designed for health and social care (public and 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 Trust has been actively involved in six change programme workstreams;

- Chronic Obstructive Pulmonary Disease (COPD)
- Cardiovascular Disease
- Fracture Neck of Femur
- Improving Diabetes Care
- Improving Dementia Care
- Improving Cancer Care

Our priorities moving forward will be on the following two pathways with were linked to CQUINS in 2016/17;

- Respiratory Pathway Review
- Cardiology Pathway Review

Examples

Cardiac Rehabilitation data collected as part of the LIQH Cardiovascular Disease Programme showed that over an 11 month period, 340 patients who had had a myocardial infarction had been discharged from specialties other than Cardiology; consequently the majority would not have received hospital based cardiac rehabilitation or any community based support. Work has been undertaken to promote the Cardiac Rehabilitation service using posters across the Trust, and the service strengthened with an 'in reach service' on the SJUH site, link nurses on wards, and information booklets available for patients. This initiative is already ensuring more patients receive the cardiac rehabilitation they need to improve their outcomes.

The **Fracture Neck of Femur** work stream used a multidisciplinary team approach to develop a community falls clinic for frail patients who were screened as high risk on the basis of their electronic frailty assessment score. 90% of patients who attended clinic went on to have one or more interventions to reduce their risk of falls.

4.9 Performance Against National Priority Indicators

The Trust's performance against the national priority indicators is summarised in Appendix E.

4.10 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 & Outcomes Team, and the Information Technology Training Team.

4.10.1 Review of services

During 2016/17 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 2016/17 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.

4.10.2 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 53 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% (47) of the recommended national clinical audits and 100% (5) 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 opposite.

Reasons for Non-Participation

National Clinical Audit Title	Reason for Non Participation
Inflammatory Bowel Disease (IBD) programme	The UK IBD audit transitioned to and merged with the IBD Registry, moving towards an improved system for data capture and quality improvement in IBD. The Trust is developing its IT system and database to support this transition. This work is in progress to enable the Trust to submit data to the IBD Registry in 2017/18.

The reports of 33 national clinical audits, and 677 local clinical audits, were reviewed by the Trust in 2016/17. 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 below.

Audit of Advanced Hepatitis C Therapies

Hepatitis C infection can lead to disease of the liver if left untreated. Before 2016, the treatment options available in the UK were medications that required long term weekly injections, and had severe side-effects. In February 2016, NICE approved new therapies for the hepatitis C virus (HCV), which require use for a shorter duration and do not have as severe side-effects. Other medications a patient is taking can reduce how well the new hepatitis C therapies work, or increase the risk of side-effects. An audit was carried out in LTHT to ensure patients with hepatitis C were receiving the advanced hepatitis C therapies in line with the national guidance, and that their other medications were appropriate to use alongside the therapies. The findings showed that 99% of patients audited were receiving the correct therapy for their disease type, and in line with the national recommendations. The 1st line treatment was appropriately not being used for the other 1% of patients because of other medical conditions they had. The findings also showed that 85% of the patients audited were using at least one other medication regularly; the audit findings showed the Pharmacy Team had assessed these medications in line with national guidance, and identified 18% that could have potential drug interactions with the hepatitis C medications. The Pharmacy Team had then worked with each patient's clinician to identify alternative treatments. The audit findings highlighted the importance of ensuring the right medications are used for each patient with hepatitis C: one of the recommendations following the audit was that a process should be established to ensure a patient's medication history is detailed and accurate prior to the multidisciplinary team (MDT) meeting to discuss their care. A specialist pharmacy technician working in the Hepatology Team now prepares a full documented medication history that is checked for interacting medicines prior to the MDT, allowing any concerns to be raised at the meeting so appropriate action can be taken if necessary.

Patient Property & Valuables

In 2015 the Trust updated its procedures for looking after patient's property, money and valuables when they are admitted to hospital. Some changes made as part of this update included redesigning the patient property and valuables record book, and the introduction of sealable patient valuables bags. An audit was carried out in 2015 to see how well these changes had been adopted, and was repeated in 2016 as part of the Trust's 2016/17 Clinical Audit Programme. The aim of the audit was to ensure staff were following the processes in place to keep patient's property safe. The results showed there had been improvements in the use of the patient property and valuables record book, availability of sealable valuables bags, and improvements in the storage of patient property on the wards. The audit highlighted that more wards could have bereavement bags available. The findings from the audit will be included in a newsletter, including information about how wards can make sure they have a supply of bereavement bags.

Audit of the Management of Giant Cell Arteritis (GCA)

Giant cell arteritis is an inflammatory disease of medium and large arteries, normally those in the head. Treatment for GCA involves high doses of corticosteroids, which can cause corticosteroid toxicity. A temporal artery biopsy (TAB) is therefore often used to determine whether corticosteroid treatment can be withdrawn rapidly, thereby reducing the risk of toxicity, or whether a patient needs long term treatment with corticosteroids. The TAB results become less useful the more corticosteroid therapy a patient has received, so an early biopsy is preferable to help determine the diagnosis and the course of treatment required. The British Society of Rheumatology guidelines for the management of GCA recommend i) a TAB preferably be done within 1 week of starting corticosteroids, and definitely within 2 to 6 weeks, ii) patients are reviewed by a clinical specialist within 6 weeks of starting steroids, and iii) patient information leaflets are given to patients to explain how they will be treated. An audit carried out in April and May 2016 showed TABs were not generally carried out within 1 week, patients were not always reviewed within 6 weeks of starting steroids, and patient information was not consistently given to patients. The Rheumatology Team agreed a new package of safety measures and patient education, which included a plan to centrally record all GCA referrals for TAB; the central record would be monitored by the duty rheumatology registrar and the rheumatology secretaries. The rheumatology secretaries would then ensure biopsies occur on time and follow up in clinic takes place within 4 weeks. A re-audit was carried out on patients seen following the introduction of the changes. The findings of the re-audit demonstrated significantly more temporal artery biopsies were being carried out within one week of starting steroids, and significantly more within two weeks. The findings also showed no patient was seen by a clinical specialist longer than six weeks following starting steroid treatment, and that almost 50% more patients were given patient information leaflets about their condition and treatment.

National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis

The 2016 National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (published in July 2016) looked at whether the care patients with inflammatory arthritis received was in line with the quality standard published by the National Institute for Health and Clinical Excellence (NICE). The results showed that patients of the Trust's rheumatology service had access to urgent advice, and when diagnosed were offered education about their condition, as well how to self-manage it. The results showed patients referred to the service were seen within four to six weeks; NICE's standard is that patients should be seen within 3 weeks of referral. The service has since reviewed the process for assessing referrals to ensure appointments for appropriate patients are fast-tracked, as well as establishing a dedicated fast-track clinic.

4.10.3 Information governance and data quality

Statement on relevance of Information Quality and actions to improve

Information Governance is a framework for handling information in a confidential and secure manner.

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.

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2016/17.

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 2016/17 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 2016 to March 2017 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	99.7%	0.4%
Outpatient care	99.9%	0.4%
Accident and emergency care	96.2%	-0.7%

The percentage of records in the published SUS Data Quality Dashboard for the period April 2016 to March 2017, which included a valid General Medical Practice Code can be seen in the table below:

Percentage of records in the published SUS Data Quality Dashboard which included a valid General Medical Practice Code

Type of care in the NHS	% of records	% above the national average
Admitted patient	100%	0.1%
Outpatient	99.9%	0.1%
Accident and emergency	99.9%	0.8%

Clinical coding

Ensuring that the clinical information recorded for our patients is complete, accurate and reflective of the care and treatment given is important for the management 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 CSUs to ensure a general overview of all areas.

In line with the IG Toolkit a 200FCE (finished consultant episode) Clinical Coding audit was undertaken.

The speciality areas included in the audit were:

- Elective Orthopaedics
- Ear, Nose & Throat (ENT)
- Oral Surgery
- Respiratory Medicine

In order to achieve Level 2 accreditation for the IG Toolkit, coding accuracy needs to be 90% on primary diagnosis and primary procedures, and 85% on secondary diagnosis and procedures.

The Trust has taken a number of steps in response to this year's recommendations, including:

A member of the Clinical Coding Team had achieved Clinical Coding Auditor accreditation.

All members of the Coding Team have had feedback from the audit, the individuals involved have had a separate session to go through the errors and gain a greater understanding of the issues raised.

An individual has been employed to systematically go through the clinical coding with the clinical teams to ensure accuracy and consistency.

The Trust is undertaking a review of all patient pathways and education about what the correct information on the PAS system should be. Additional reporting will be provided to closely monitor data quality issues.

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. There is sustained improvement in the timeliness of the coded information.

Clinical Coding Audit Findings

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Chapel Allerton - Elective Orthopaedics	92.17	94.00	92.66	88.62
St James's - Ear Nose Throat	88.37	94.44	96.12	93.94
St James's - Oral Surgery	91.67	94.74	81.82	85.71
St James's - Respiratory Medicine	92.00	86.18	93.33	62.16
Overall	**91.00**	**92.66**	**92.61**	**86.98**

Timeliness of Accurately Coded Data

	Jan-14	Jan-15	Jan-16	Jan-17
Month End	76.2%	86.95%	94.9%	96.2%
5th Working Day (after Month End)	89.3%	98.6%	97.6%	98.89%
Payment by Results Flex Date	95.9%	100%	98.7%	99.96%
Payment by Results Freeze Date	100%	100%	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 2016/17 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 14 (2016-2017)	0	0	29	16	45	78%	Satisfactory
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

4.10.4 Goals agreed with Commissioners (CQUINS)

The 2017/18 CQUIN scheme has been agreed; these goals have been set nationally and also by NHS England for specialist services. This is included in Appendix E.

Local quality incentive scheme CCG 2016/17

The national and local CQUIN scheme agreed with commissioners for 2016/17 is provided in the following tables, including achievement of the goals that has been signed-off by our Commissioners. The schemes included new national quality goals for improvement relating to NHS staff health and well-being, sepsis, and antimicrobial stewardship.

2016/17 CQUIN (national and local goals) summary as at 28/06/2017

	Quarter Requirements	Q1 Signed off Performance	Q2 Signed off Performance	Q3 Signed off Performance	Q4 Signed off Performance
CCG - National CQUINs					
1a	NHS Staff Health & Well-being - Initiatives re physical activity/mental health/access to physiotherapy		Not Applicable	Not Applicable	
1b	NHS Staff Health & Well-being - Healthy food for NHS staff, visitors & patients		Not Applicable	Not Applicable	
1c	NHS Staff Health & Well-being - Improving the uptake of flu vaccinations by front line staff - Target 75%	Not Applicable	Not Applicable		Not Applicable
2a 2b	Sepsis - Timely identification & treatment for Sepsis in emergency depts & Inpatient wards				
	• Screening - % of patients who met the criteria for sepsis screening & were screened				
	• Treatment and day 3 review - % of patients with severe sepsis, red flag sepsis & sepsis shock - antibiotics within 1 hour & 3 day review.				
	• Initiation of treatment and day 3 review - mean time to antibiotics.				
3a	Anti-Microbial Resistance - Reduction in antibiotic consumption by 1%. 3 parts: Total antibiotic, Total Carbapenem, Total Piperacillin-tazobactam	Not Applicable	Not Applicable	Not Applicable	
3b	Anti-Microbial Resistance Ensure empiric review of antibiotic prescriptions				
CCG - Local CQUINs					
4	Outpatients - Reducung delays & achieving better care, better value in follow-ups				
5a	Improving Care Pathways (Respiratory)				
5b	Improving Care Pathways (Cardiology)				
6	Smoking in Pregnancy - Contribute to reducing prevalence of smoking among pregnant women				
7	Acute Kidney Injury				

Further CQUIN goals agreed with NHS England Commissioners for specialist services are listed in the table below.

2016/17 CQUIN (specialist services) summary as at 28/06/2017

	Quarter Requirements	Q1 Signed off Performance	Q2 Signed off Performance	Q3 Signed off Performance	Q4 Signed off Performance
NHSE - Specialised CQUINs					
1	Local QIPP Engagement & Delivery				
2	Improving HCV Treatment Pathways through ODNs - Governance & Partnership				
	Improving HCV Treatment Pathways through ODNs - Stewardship & Nice Compliance	Not Applicable	Not Applicable	Not Applicable	
3	Clinical Utilisation Review (CUR)	Not Applicable	Reviewed in Q2	Income foregone	
4	Adult Critical Care Timely Discharge	Income foregone			
5	Enhanced Supportive Care for Advanced Cancer Patients			Not Applicable	
6	Optimal Devices - Cardiac devices	Not Applicable	Not Applicable		
7	CAMHS Screening for Paediatric Patients with Long-term conditions (LTCs).				
8	Improving Haemoglobinopathy Pathways through Operational Delivery Network (ODN).				
9	Multi-System Auto-Immune Rheumatic Diseases MDT Clinics, Data Collection & Policy Compliance.	Not Applicable			
10	Spinal Surgery: Networks, Data, MDT Oversight.				
11	Nationally Standardised Dose Banding Adult Intravenous SACT.				
12	Local Adult Critical Care Scheme				
NHSE - Dental					
1	Dental - Orthodontic Data Collection - Secondary care providers to collect the same data set as primary care providers.				
2	Dental - Day Case Audit - (Some day case procedures may be coded as 'outpatient with procedure')		Not Applicable	Not Applicable	Not Applicable
NHSE - Screening					
1	Diabetic Retinopathy				
2	Breast Screening				
3	AAA Screening				
4	Neonate Bloodspot Screening				
5	Cervical Cytology Screening				
NHSE - Armed Forces					
1	Waiting List/Access Policy Review				

Not achieved
Partial achievement
Local assessment to be signed off
Achieved

4.11 Participation in Clinical Research

The Trust has an ambitious strategy for research and innovation, aimed at harnessing the significant advances in clinical science for the benefit of Trust patients by improving access to world-leading research studies.

Research underpins excellent clinical services; for example, recent work led by Leeds researchers has confirmed that patients with colorectal cancer have better clinical outcomes in research-intensive hospitals. Therefore a strategic goal is to ensure that all our specialist services are research-intensive. Working in partnership with the University, the Trust has strengthened its research programmes in key areas of strategic strength, including;

Musculoskeletal disease

The National Institute for Health Research (NIHR) has designated the Trust as a Biomedical Research Centre (BRC) in Musculoskeletal Disease. £6.7m has been awarded for five years from April 2017. The Trust is one of only 20 NIHR Biomedical Research Centres and, although ranked 18th nationally by funding amount, the quality of the clinical science was noted as "outstanding" by the international review panel.

Cardiovascular disease

Cardiovascular imaging is a nationally recognised strength in Leeds – for example, a Leeds study has changed clinical practice in the use of scanning techniques to detect heart disease. The 3T Magnetic Resonance Imaging (MRI) system which is part of the Medical Research Council National Centre for Hyperpolarised MRI is now operational in the new Advanced Imaging Centre at the Leeds General Infirmary. The National Centre is a partnership with the University of York and is developing novel MRI tracers to improve diagnosis and monitoring of a wide range of diseases. Professor Sven Plein was appointed to a prestigious British Heart Foundation Chair in Cardiovascular MRI and Professor Jurgen Schneider, a world-leading pre-clinical MR imaging scientist from Oxford, was appointed to a Chair of Cardiovascular Imaging. The Cardiovascular Research Group also received a £2.4m doctoral training award from the British Heart Foundation and a leading group member, Professor Robert Ariens, received a prestigious Wellcome Trust Investigator award for his work on the behaviour of blood clots.

Cancer

The National Cancer Research Institute (a partnership organisation which includes Cancer Research UK) completed a benchmarking exercise for Centres of Excellence in Academic Radiotherapy. The exercise was led by two international reviewers. Leeds has been assessed overall as an "Emerging Centre of Excellence" which compares well with peers.

The Trust was a partner in a successful bid to Cancer Research UK to create a Paediatric Experimental Cancer Medicine Centre Network. The Network comprises eight Children's Hospitals and will support early phase clinical trials in children.

Significant investment (over £5m) in Leeds by Yorkshire Cancer Research to fund a series of wide-ranging research programmes has been a welcome and prominent feature of 2016.

£750k has been awarded by the NIHR for the Clinical Research Facility. The Facility comprises a hub and spoke model, with major spokes in Bexley Wing, Jubilee Wing, and the Dental Hospital. The Facility conducts early phase research with leading-edge medicines and technologies across a range of diseases, with cancer particularly prominent. Trials of new drugs for the treatment of blood cancers have been particularly successful.

The University and Trust invested significantly in cancer research, appointing four new Chairs and 10 University Academic Fellows. Leeds

receives more than £100m income for cancer research and has the second largest clinical trials cancer activity in the UK. Leeds now has five Cancer Research UK programme grants totalling over £5m, demonstrating the charity's perception of our overall scientific strength.

Precision medicine

Precision (or personalised) medicine is an approach for the treatment and prevention of disease that is informed by individual variability in genes, environment, and lifestyle. The Trust and University were designated as a Precision Medicine Centre by Innovate UK, with the aim of helping UK Life Sciences industry commercialise precision medicine technologies (for example, new tests in cancer including wider use of tumour genetic testing to select appropriate treatments), This builds on the existing Trust NIHR Diagnostic Evidence Cooperative (one of only 4 nationally). The Trust is working with the Leeds Academic Health Partnership to create a Personalised Medicine and Health System in Leeds which would span laboratory discovery to Leeds-wide adoption of precision medicine technologies. The Trust, in partnership with Sheffield Teaching Hospitals and Sheffield Children's Hospital, was successful in achieving designation as a Genomics Medicine Centre by Genomics England.

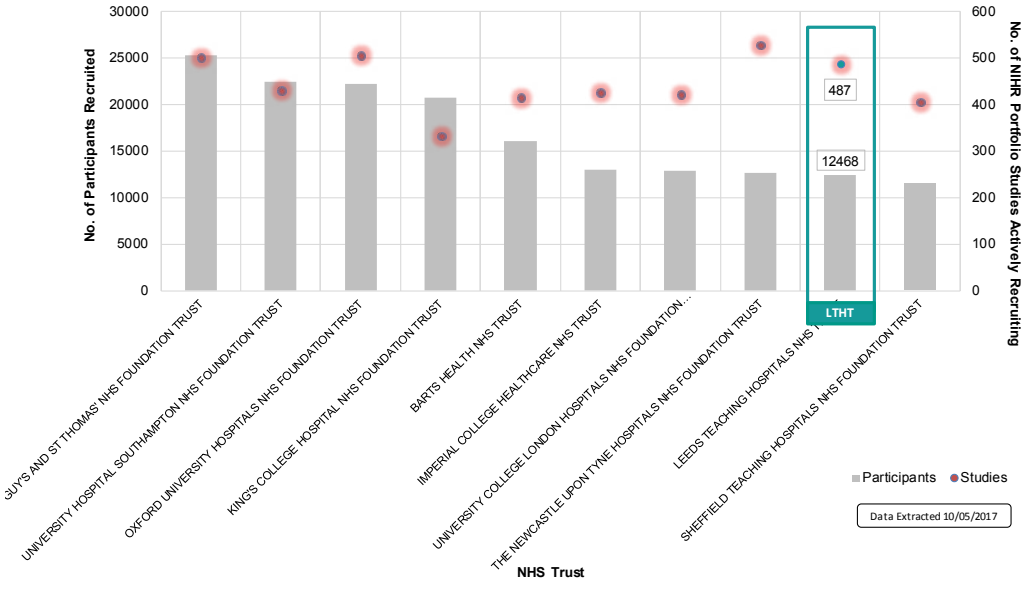
Research performance

The Trust conducts a large number of clinical trials and other research studies across all specialties. This portfolio of studies is kept under active review to ensure a balance between delivering large simple studies and the Trust's leading role in delivering complex studies which involve smaller numbers of patients.

During 2016/17, the Trust maintained its position as one of the Top 10 performing trusts in England for projects recognised by the National Institute for Health Research (NIHR), playing a leading role in recruiting patients into high quality studies. This year we have involved 12,468 patients in 487 research studies.

The Trust has maintained its performance against the NIHR initiation and delivery targets for clinical trials. This means patients continue to be recruited into trials in a fast and effective manner. During 2016, 92% of trials were started within the required 70 day timeline and 62% of commercial trials recruited the agreed number patients within the agreed recruitment period.

Top 10 Performing Trusts in England for projects recognised by NIHR



4.12 What Others Say about LTHT

4.12.1 Care Quality Commission

The Leeds Teaching Hospitals NHS Trust was required to register with the Care Quality Commission (CQC) under Section 10 of The Health and Social Care Act 2008 from 1 April 2010.

The Trust is required to be compliant with the fundamental standards of quality and safety. The Trust's current registration status is registered with the CQC without conditions (compliant).

The CQC undertook a planned inspection on 10-13 May 2016. This was a follow up visit following the comprehensive inspection that had been undertaken in March 2014. The CQC published their final reports on 27 September 2016, and we were delighted to have been rated as "Good".

Key Question		Rating
Safe		Requires Improvement
Effective		Good
Caring		Good
Responsive		Good
Well led		Good

Overall rating		**Good**

An action plan has been developed to address the recommendations from the CQC reports. A summit meeting was held on 15 November 2016 with the CQC and other stakeholders, where the action plan was formally presented and agreed. Particular discussion focused on those actions that required support from partners, including:

- Patients waiting on trolleys for an inpatient bed
- Staffing
- Patients in Critical Care
- Patients being operated on at night.

Progress on implementation of the actions is being overseen by the Quality Assurance Committee and reported to the Trust Board.

The plan is also being monitored in conjunction with our local CQC Inspection Manager through their routine engagement meetings with the Trust, and through routine quality meetings with the CCG. Implementation is being overseen by NHS Improvement.

4.13 Appendices

Appendix A

Statement of Directors' Responsibilities in Respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality 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 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

30/6/17 ..... Date

..... Chair

30/06/17 ..... Date

..... Chief Executive

Appendix B - Statements from Local Stakeholders

Joint comments from Healthwatch Leeds, and the Overview and Scrutiny Committee for Health, Public Health and Social Care in Leeds

The Trust provides clear information about how their patient and public engagement has progressed and influenced quality improvement. We have seen significant progress in the Trust-wide approach to engaging with local people and patients with work progressing every year. The use of the extensive data base and the development of the patient leaders are commendable as is the spread across good practice in engagement across the organisation. There is a clear aim to make the document more user friendly with a summary of key points planned after the formal submission.

Given that around 20% of Leeds's population includes Black and Minority Ethnic (BME) communities, it is hoped that the work to understand and adapt services to meet the needs of all communities will continue.

Letter from NHS Leeds West CCG

NHS
Leeds West
Clinical Commissioning Group

Thank you for giving the Leeds Clinical Commissioning Groups the opportunity to comment on the Quality Account for Leeds Teaching Hospitals NHS Trust 2016-17. We have reviewed this in accordance with NHS regulations and are pleased to provide the following statement:

The Leeds CCGs continue to work closely with the Trust to gain understanding of the quality of care provision and the experience of patients using its many services. We do this through meeting regularly with the hospital team to consider the systems and processes that the Trust have in place to promote safe, effective and high quality care delivery. We believe that the information published in this year's Quality Account provides a good representation of the Trust's achievements and its commitment to delivering high quality of care.

It is encouraging to read about the development of the Leeds Improvement Method as a result of the collaborative partnership with the Virginia Mason Institute, and the other many programmes of improvement work. The results of such quality improvement approaches are demonstrating some great successes in a number of clinical areas and staff clearly appreciate the opportunity to contribute directly to improving services and the work environment.

The year on year improvement in the scores of the Staff Friends and Family Test has shown that the Trust's inclusive approach to engaging with all staff members has resulted in a workforce that is proud to be part of the organisation. Implementation of a number of staff health and wellbeing measures has, no doubt contributed to this and excellent progress has been made through the national Staff Health and Wellbeing CQUIN indicator.

Whist nurse recruitment continues to be a challenge on a national level; the CCGs recognise that the Trust has taken a proactive approach in holding internal recruitment events and maximising opportunities to attract staff from elsewhere in the country. A number of additional roles for support staff with a career progression pathway have been introduced and it is good to see the Trust working with partners to promote Leeds as a city of choice in which to work.

We are pleased to hear about the progress made in developing the Patient Reference Group and a Trust Patient Experience Strategy. Involvement of patients and public in developing services will bring benefits to both the organisation and the local community. The Leeds CCGs are delighted to work in partnership with the Trust with our Patient Leader programme to support this work going forward.

The 'Get Me Better' work to support people with a Learning disability by developing Champions across the Trust is a vital contribution to reducing health inequalities and improving the experience of those using services. This builds on the excellent work referred to in the 2015 Quality Account and we are delighted to see this work continuing and being embedded in the organisation. We congratulate the Trust on their award for the Yorkshire Evening Post Healthcare Team of the Year in relation to supporting those with a learning disability.

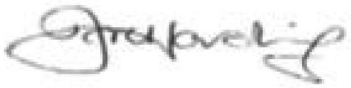
We recognise the significant progress made by the Trust in regards to the complaints process, including the feedback initiatives such as Speak to Sister. We would like to see more about how the Trust responds to feedback from the public and how this has been incorporated into service improvements.

Whilst it is disappointing that a higher number of MRSA bacteraemia cases occurred in 2016 -17, we acknowledge that the Trust have made significant achievements in reducing the levels of Clostridium difficile, progressing the antimicrobial stewardship programme and demonstrating a collaborative approach to working with partners. We look forward to seeing how the quality improvement work to reduce blood stream infections progresses over the coming year.

The implementation and roll out of Safety Huddles in the Trust has contributed significantly to a reduction in patient harms and it is pleasing to note that this work is receiving national interest. The introduction of carer and patient views into these discussions is welcomed and we will watch with interest to see how this develops.

The CCGs commends the Trust on its commitment to working with the CCGs in a collaborative and transparent manner, and we look forward to continuing to work in partnership over the coming year.

Kind regards



Jo Harding

Director of Nursing

Independent auditor's imited assurance report to the directors of The Leeds Teaching Hospitals NHS Trust on the 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 2017 ("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 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

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 2016-17; 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 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback from the Commissioners dated May 2017;
- feedback from Local Healthwatch dated May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2017;
- the latest national patient survey 2016;
- the latest national staff survey 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017;

and

- the annual governance statement dated May 2017.

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 2017:

- 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.

Gareth Davies, Partner for and on behalf of Mazars LLP

Tower Bridge House, St Katharine's Way, London, E1W 1DD

27 June 2017

Appendix C: Glossary of Terms

Acute Hospital Trust: an NHS organisation responsible for providing healthcare services.
Antimicrobial Stewardship: Antibiotic stewardship refers to a set of coordinated strategies to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs.
Board (of Trust): The role of the Trust's Board is to take corporate responsibility for the organisation's strategies and actions.
Breakthrough Series Improvement Collaborative: A model for achieving improvements in the quality of healthcare.
Care Quality Commission (CQC): the independent regulator of health and social care in England.
Clinical Commissioning Group (CCG): clinically 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.
Critical Care Step-Down: An intermediate level of care between the Intensive Care Unit (ICU) and general medical-surgical wards.
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.
eMeds: an electronic system for prescribing and administration of medicines.
e-Obs: a digital method of recording the observations of patients' vital signs.
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.

Gram-negative bacteria: a class of bacteria that includes those that can cause, amongst others, pneumonia, bloodstream infections and surgical site infections in healthcare settings. Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics.
HDU: High Dependency Unit; a level of care between intensive care and general wards.
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 (HSMR): an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Hospital Episode Statistics (HES): a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.
Information Governance Toolkit: the NHS Information Governance Toolkit ensures necessary safeguards for, and appropriate use of, patient and personal information.
In-reach Service: A service that enables safe transition of care from hospital to community by providing appropriate support at home for patients.
Lean methodology: A methodology to ensure we provide the highest quality care for patients, whilst reducing inefficiencies and getting the best value for public money.
Leeds Care Record: The Leeds Care Record gives health and social care professionals directly in charge of your care access to the most up-to-date information about you by sharing certain information from your records between health and social care services across Leeds.
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.
Methicillin Resistant Staphylococcus Aureus bacteraemia (MRSA): a bacterial infection.
Myocardial Infarction: a heart attack.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): reviews clinical practice across England and Wales, and makes recommendations for improvement.
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.
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 Leaders: A representative of the public that ensures the voice of patients and carers is considered to help influence key decisions.
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.
Quality Summit Meeting: a group of healthcare quality experts meet to discuss quality initiatives to improve health care.
RESPECT: A Recommended Summary Plan for Emergency Care and Treatment, that is agreed by a patient and their healthcare professional. It includes recommendations about the care an individual would like to receive in future emergencies if they are unable to make a choice at that time.
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.
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 NHS Digital.
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.
Trust Members: Trust Members have a say in the services the Trust offers and help us understand the needs of our patients, carers and local population, in order to improve our services. Anyone aged 16 years or over living in England or Wales can become a member.
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).
West Yorkshire Accelerator Zone: A system that has been set up for rapid implementation of improvements in urgent and emergency care delivery across the West Yorkshire & Harrogate.
WTE: Whole time equivalent; the workload of one fully employed person.

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*
Care of patients with mental health problems in acute general hospitals	92%
Non-invasive ventilation	89%
Chronic Neurodisability, focusing on cerebral palsy	Not yet available**
Young People's Mental Health, focusing on self harm	Not yet available**
Cancer in Children, Teens, and Young Adults	Not yet available**

National Audit	Participation Rate*
Acute Asthma	32%
Asthma (Paediatric & Adult) care in emergency departments	100%
Bowel Cancer (NBOCAP)	100%
Cardiac Rhythm Management	100%
Case Mix Programme	52%
Congenital Heart Disease (Paediatric Cardiac Surgery)	100%
Endocrine and Thyroid National Audit	65%
Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database	94%
Female Stress Urinary Incontinence	56%
Head and Neck Oncology Audit	100%
Learning Disability Mortality Review Programme	100%
Lung Cancer (NLCA)	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	100%
Myocardial Ischaemia National Audit Project	100%
National Audit of Dementia	99%
National Adult Cardiac Surgery Audit	100% ***
National Cardiac Arrest Audit (NCAA)	100%
National Cataract Audit	100%

National Comparative Audit of Blood Transfusion programme: Re-audit of Patient Blood Management in Scheduled Surgery	31%
National Diabetes Core Audit	99%
National Diabetes Foot Care Audit	Denominator not known
National Diabetes Inpatient Audit	100%
National Emergency Laparotomy Audit	84%
National Heart Failure Audit	73%
National Joint Registry (NJR)	Data not fully submitted****
National Neonatal Audit Programme	100%
National Neurosurgery Audit Programme	100%
National Paediatric Diabetes Audit (NPDA)	98%
National Pregnancy in Diabetes Audit	100%
National Prostate Cancer Audit	100%
National Vascular Registry	93%
Nephrectomy Audit	97%
Oesophago-gastric cancer (NAOGC)	100%
Paediatric intensive care (PICANet)	100%
Paediatric Pneumonia Audit	41%
Patient Reported Outcomes Measures - Hernia	47%
Patient Reported Outcomes Measures - Hip replacements	88%
Patient Reported Outcomes Measures - Knee replacements	93%
Patient Reported Outcomes Measures - Varicose veins	75%
Percutaneous Coronary Intervention (PCI)	99%
Percutaneous Nephrolithotomy	47%
Radical Prostatectomy Audit	99%
Renal Replacement Therapy (Renal Registry)	100%
Sentinel Stroke National Audit Programme (SSNAP)	100%
Severe Sepsis and Septic Shock	100%
Trauma Audit & Research Network (TARN)	86%
UK Cystic Fibrosis Registry	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.

*** NICOR is resolving a technical issue relating to location of operations; data for all 2016/17 patients has been collected by LTHT, and will be submitted once the issue is resolved by NICOR.

**** The system provider for joint replacement surgery is experiencing technical issues, preventing submission of the full dataset to the NJR

Summary table of participation in other national audits

National Audit	Participation Rate*
Breast and Cosmetic Implant Registry (BCIR)	25%
Consultant Sign Off	100%
Cystectomy Audit	100%
NAP6: Perioperative Anaphylaxis in the UK	100%
National Audit of Breast Cancer in Older Patients	100%
National Audit of Clinical Management of Complicated Intra-abdominal Sepsis (CABI)	100%
National Bariatric Surgery Registry (NBSR)	100%
National Complicated Diverticulitis	100%
National Maternal and Perinatal Audit (NMPA)	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	100%
Smoking Cessation	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	84%
Urethroplasty Audit	100%

Appendix E: CQUINS 2017-19

National CQUINS

1. Improving Staff Health and Wellbeing	1a. Improving staff health and wellbeing - Staff Survey
	1b. Healthy food for NHS staff, visitors and patients.
	1c. Improving the uptake of flu vaccinations
2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis	2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings
	2b. Timely treatment of sepsis in emergency departments and acute inpatient settings
	2c. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours
	2d. Reduction in antibiotic consumption (per 1,000 admissions).
3. Improve services - mental health needs who present to A&E	3. Improving services - people with mental health needs presenting to A&E
4. Offering advice and guidance	4. Advice and guidance (NHSE to provide guide to support scheme
5. NHS e-Referrals	5. NHS e-Referrals (1 year CQUIN - 2017/18)
6. Supporting proactive and safe discharge	6. Supporting proactive and safe discharge
7. Risky behaviours, alcohol and tobacco (1 year CQUIN 2018/19)	Tobacco screening, brief advice, referral and medication offer Alcohol screening, brief advice or referral

NHS England Specialist Commissioning CQUINS

BI1 Improving HCV Treatment Pathways through ODNs	Providers participation in ODN & HCV patient access to treatment to accord with ODN guidelines
BI4 Improving Haemoglobinopathy Pathways through ODN Networks	Improve access by developing ODN and ensuring compliance with guidelines
TR3 Spinal Surgery: Networks, Data, MDT oversight	Setting up regional MDT; entering data into British Spinal Registry or Spine Tango: no surgery without MDT sanction
IM3 Auto-immune Management	Review specialised patient cases across Networks by MDTs, with data flowing to registries
WC3 CAMHS Screening	SDQ screening for paed inpatients with listed LTCs
GE3 Medicines Optimisation	To support procedural and cultural changes required fully to optimise use of medicines commissioned by specialist services
CA2 Nationally Standardised Dose Banding for Adult Intravenous Anticancer Therapy (SACT)	Standardisation of chemotherapy doses through a nationally consistent approach
WC4 Paediatric Networked Care	This scheme aims to align to the national PIC service review
IM2 Cystic Fibrosis Patient Adherence (Adult)	Improved adherence and self-management by patients etc
Local QIPP Incentivisation Scheme	Engagement with NHSE local QIPP proposals and delivery of agreed savings

Appendix F: Performance against National Priority Indicators

	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Section A - National Operational Standards													
RTT Incomplete	>=92%	91%	91%	91%	90%	89%	89%	89%	89%	87%	88%	88%	89%
RTT Failing Specialties: Incomplete	=0	7	7	8	7	7	7	8	8	7	7	7	7
A&E Performance	>=95%	90%	90%	87%	87%	92%	90%	86%	81%	78%	82%	84%	91%
Diagnostic Waits	>=99%	95%	97%	97%	97%	98%	99%	100%	100%	100%	99%	99%	100%
Cancelled Ops: Not rebooked within 28 days	=0	16	13	10	14	21	21	31	21	31	50	27	22
Cancer: 62 Day: GP/Dentist Referrals	>=85%	84%	80%	80%	79%	74%	74%	75%	79%	77%	77%	70%	78%
Cancer: 62 Day: Screening	>=90%	90%	91%	100%	92%	94%	96%	97%	98%	93%	98%	93%	89%
Cancer: 31 Day: 1st Treatment	>=96%	98%	98%	98%	97%	98%	97%	97%	97%	97%	95%	94%	97%
Cancer: 31 Day: Subsequent Surgery	>=94%	95%	88%	94%	99%	96%	98%	92%	91%	91%	90%	92%	91%
Cancer: 31 Day: Subsequent Drug	>=98%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cancer: 31 Day: Sub Radiotherapy	>=94%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%
Cancer: 14 Day: Urgent GP Referrals	>=93%	93%	94%	93%	94%	92%	94%	96%	95%	97%	92%	96%	95%
Cancer: 14 Day: Breast Symptoms	>=93%	97%	99%	97%	97%	95%	95%	97%	96%	98%	96%	95%	96%
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	1	2	0	1	1	1	0	0	3	1	0	1
HCAI: CDiff	<=119	7	14	10	10	8	9	4	11	8	15	10	9
VTE Risk Assessment	>=95%	96%	97%	96%	97%	96%	95%	97%	96%	96%	96%	95%	94%
VTE RCA Completion Rate	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%	96%	79%
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	35	45	44	32	77	40	51	61	86	72	98	68
Ambulance Handovers: Over 60 mins	=0	0	2	1	1	1	0	1	0	2	1	0	1
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 (%)	-	30%	27%	29%	27%	27%	26%	29%	28%	33%	30%	37%	41%
Friends and Family Test: Response Rate - A&E (%)	-	29%	27%	31%	35%	20%	21%	15%	22%	14%	10%	31%	29%
eDAN: Completed	-	89%	90%	90%	90%	90%	91%	91%	92%	91%	91%	91%	91%
eDAN: Sent to GP within 24 hrs	>=90%	81%	82%	83%	81%	82%	83%	84%	84%	85%	84%	84%	86%
Complaints: Total	-	69	51	61	60	61	55	69	68	73	86	85	92
Emergency Readmissions Within 30 Days	-	8	8	7	7	7	7	7	7	8	7	7	6

Section C - NHSE Quality and Contract Requirements													
Serious Incidents (SUIs)	-	10	7	4	7	6	6	8	3	8	2	7	6
HCAI: MSSA	<=59	4	7	6	7	5	5	3	11	7	10	4	6
Gynae Cytology 14 Day TATs	>=98%	76%	82%	79%	67%	99%	99%	100%	100%	100%	99%	98%	41%
Harm Free Care	>=95%	95%	95%	95%	95%	96%	95%	95%	94%	95%	94%	95%	94%
Readmissions to PICU Within 48 Hours	<1	0	0	0	0	0	0	0	0	0	0	0	0
Section D - Local Quality and Contract Requirements													
Cancer: 62 Day: Consultant Upgrade	>=85%	71%	94%	67%	100%	88%	87%	68%	86%	74%	62%	82%	97%
OP FUP Backlog: > 3 Mths Overdue (Total Pts)	-	7,394	7,669	8,553	8,769	9,370	12,318	8,745	8,736	9,060	8,041	7,896	7,840
OP FUP Backlog: > 3 Mths Overdue (Specialties >100 Pts)	-	36	36	31	31	30	32	29	29	28	29	31	31
Section E - Internal Monitoring													
Dementia Performance: Stage 1	>=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dementia Performance: Stage 2	>=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dementia Performance: Stage 3	>=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pressure Ulcers (Grade 3) (developed)	-	5	0	0	3	6	3	4	13	5	7	1	2
Pressure Ulcers (Grade 4) (developed)	-	0	0	0	0	0	1	0	0	1	0	0	0
Histo & Diagnostic Biopsy 7 Day TATs	>=45%	53%	57%	51%	54%	48%	58%	56%	57%	55%	75%	77%	67%
OP Appts Cancelled 2 or More Times (Total)	-	2,720	2,337	2,730	2,565	2,582	2,723	2,585	2,784	2,496	2,900	2,448	2,835
OP Appts Cancelled 2 or More Times (By Hospital)	-	1,489	1,030	1,148	1,118	1,110	1,108	1,126	1,117	959	1,058	938	1,196

Section 5
Financial Statements 2016/17

Financial Statements

5.1 Independent Auditor's Report to the Directors of the Leeds Teaching Hospitals NHS Trust

We have audited the financial statements of The Leeds Teaching Hospitals NHS Trust for the year ended 31 March 2017 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 as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual as contained in the Department of Health Group Accounting Manual 2016-17 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 analysis of staff numbers; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of The Leeds Teaching Hospitals NHS Trust, 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 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21 (5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free

from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Directors; and
- the overall presentation of the financial statements.

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of The Leeds Teaching Hospitals NHS Trust as at 31 March 2017 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 Improvement's guidance; 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

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

Auditor's responsibilities

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

On 30 May 2017 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the breach of the Trust's statutory financial duty at 31 March 2017 under Paragraph 2(1) of Schedule 5 of the NHS Act 2006 that:

'Each NHS trust must ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to revenue account'.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Basis for qualified conclusion (except for)

The Trust has delivered a year-end financial outturn at 31 March 2017 of a £1.9 million deficit achieving its adjusted control total as agreed with NHS Improvement. The year-end target included the delivery of £65.5 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 £18.562 million of non-recurrent measures.

For 2017/18 the Trust Board has agreed a financial plan forecast to deliver a £9 million surplus, after taking account of Sustainability and Transformation Funding and the delivery of £63.9 million of savings through its Waste Reduction Programme (WRPs). At the start of 2017/18 the year the Trust has identified 56% of the required WRPs, although the CSU budgets have been reduced for their WRP 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 2016/17 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.

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

Qualified conclusion (except for)

On the basis of our work, having regard to the guidance issued by the C&AG in November 2016, 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 2017.

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.

Gareth Davies

for and on behalf of Mazars LLP,

Tower Bridge House, St Katharine's Way
London, E1W 1DD

30 May 2017

5.2 Leeds Teaching Hospitals NHS Trust Annual Accounts 2016/17

Statement of Comprehensive Income for the year ended 31 March 2017

	Note	2016-17 £000s	2015-16 £000s
Gross employee benefits	9.1	**(679,552)**	(651,993)
Other operating costs	7	**(520,710)**	(468,472)
Revenue from patient care activities	4	**975,548**	943,383
Other operating revenue	5	**197,379**	172,337
Operating (deficit)		**(27,335)**	(4,745)
Investment revenue	11	**68**	124
Other gains and (losses)	12	**96**	(80)
Finance costs	13	**(1,699)**	(12,567)
(Deficit) for the financial year		**(28,870)**	(17,268)
Public dividend capital dividends payable		**(7,926)**	(9,963)
Retained (deficit) for the year		**(36,796)**	(27,231)
Other comprehensive income			
Impairments and reversals taken to the revaluation reserve		**(21,378)**	0
Total comprehensive income for the year		**(58,174)**	(27,231)
Financial performance for the year			
Retained (deficit) for the year		**(36,796)**	(27,231)
IFRIC 12 adjustment (including IFRIC 12 impairments)		**16,038**	0
Impairments (excluding IFRIC 12 impairments)		**18,229**	0
Adjustments in respect of donated asset reserve elimination		**628**	(2,963)
Adjusted retained (deficit)		**(1,901)**	(30,194)

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 impairments to fixed asset values arising from valuation falls. During 2016/17 the Trust's estate was revalued by an independent valuer who identified an overall reduction in value. (See note 15.3).

The retained deficit is adjusted to take account of the costs of a change in the national accounting treatment of donated assets (Note 1.10). 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 197 to 232 form part of these financial statements.

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000s	31 March 2016 £000s
Non-current assets			
Property, plant and equipment	15	**565,856**	618,492
Intangible assets	16	**6,518**	2,835
Trade and other receivables	20.1	**10,495**	9,930
Total non-current assets		**582,869**	631,257
Current assets			
Inventories	19	**16,022**	16,539
Trade and other receivables	20.1	**65,846**	53,928
Cash and cash equivalents	21	**19,967**	3,362
Sub-total current assets		**101,835**	73,829
Non-current assets held for sale	22	**0**	0
Total current assets		**101,835**	73,829
Total assets		**684,704**	705,086
Current liabilities			
Trade and other payables	23	**(105,286)**	(78,672)
Provisions	27	**(864)**	(775)
Borrowings	24	**(6,341)**	(4,957)
DH capital loan	24	**(5,646)**	(4,812)
Total current liabilities		**(118,137)**	(89,216)
Net current (liabilities)		**(16,302)**	(15,387)
Total assets less current liablilities		**566,567**	615,870
Non-current liabilities			
Trade and other payables	23	**(259)**	(2,188)
Provisions	27	**(5,728)**	(5,231)
Borrowings	24	**(181,931)**	(193,112)
DH revenue support loan	24	**(52,399)**	(37,329)
DH capital loan	24	**(49,487)**	(45,113)
Total non-current liabilities		**(289,804)**	(282,973)
Total assets employed		**276,763**	332,897
Financed by			
Public Dividend Capital		**334,888**	332,848
Retained earnings		**(114,005)**	(77,209)
Revaluation reserve		**55,880**	77,258
Total Taxpayers' Equity		**276,763**	**332,897**

The notes on pages 197 to 232 form part of these financial statements.

The financial statements on pages 193 to 232 were approved by the Board on 25th May 2017 and signed on its behalf by:

Julian Hartley, Chief Executive

Statement of Changes in Taxpayers' Equity for the year ending 31 March 2017

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2016	**332,848**	**(77,209)**	**77,258**	**332,897**
Changes in taxpayers' equity for the year ended 31 March 2017				
Retained (deficit) for the year	0	(36,796)	0	(36,796)
Impairments and reversals	0	0	(21,378)	(21,378)
Temporary and permanent PDC received - cash	2,040	0	0	2,040
Net recognised revenue/(expense) for the year	**2,040**	**(36,796)**	**(21,378)**	**(56,134)**
Balance at 31 March 2017	**334,888**	**(114,005)**	**55,880**	**276,763**

Balance at 1 April 2015	**332,833**	**(49,978)**	**77,258**	**360,113**
Changes in taxpayers' equity for the year ended 31 March 2016				
Retained (deficit) for the year	0	(27,231)	0	(27,231)
New PDC received - cash	1,015	0	0	1,015
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**

Information on reserves

Public dividend capital

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

Income and expenditure reserve

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

Revaluation Reserve

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

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016-17 £000	2015-16 £000
Cash Flows from Operating Activities			
Operating (deficit)		**(27,335)**	(4,745)
Depreciation and amortisation	7	**25,979**	24,717
Impairments and reversals	17	**34,267**	0
Decrease in Inventories		**517**	945
(Increase)/decrease in trade and other receivables		**(13,076)**	8,811
Increase/(decrease) in trade and other payables		**21,657**	(6,789)
Provisions utilised		**(619)**	(1,808)
Increase/(decrease) in movement in non cash provisions		**1,205**	(157)
Net Cash Inflow from Operating Activities		**42,595**	20,974
Cash Flows From Investing Activities			
Interest received		**68**	124
(Payments) for property, plant and equipment		**(28,803)**	(30,042)
(Payments) for intangible assets		**(1,064)**	(1,151)
Proceeds of disposal of assets held for sale (PPE)		**110**	124
Net Cash (Outflow) from Investing Activities		**(29,689)**	(30,945)
Net Cash Inflow / (Outflow) before Financing		**12,906**	(9,971)
Cash Flows From Financing Activities			
Gross temporary and permanent PDC received		**2,040**	1,015
Gross temporary and permanent PDC repaid		**0**	(1,000)
Loans received from DH - New capital investment loans		**10,020**	5,394
Loans received from DH - New revenue support loans		**22,993**	63,179
Loans repaid to DH - Capital investment loans repayment of principal		**(4,812)**	(5,112)
Loans repaid to DH - Working capital loans/revenue support loans		**(7,923)**	(25,850)
Capital element of payments in respect of finance leases and on-SoFP PFI		**(9,797)**	(4,702)
Interest paid		**(1,652)**	(12,541)
PDC Dividend (paid)		**(7,170)**	(10,348)
Net Cash Inflow from Financing Activities		**3,699**	10,035
NET INCREASE IN CASH AND CASH EQUIVALENTS		**16,605**	64
Cash and Cash Equivalents at 1 April 2016		**3,362**	3,298
Cash and Cash Equivalents at 31 March 2017	21	**19,967**	3,362

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 Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2016-17 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 Group Accounting Manual 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

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

Going Concern

These accounts have been prepared on a going concern basis.

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 35.1 for further explanation.

1.2 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.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS 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.

1.3.1 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 NHS 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 1.13 Leases and 1.14 PFI transactions.

1.3.2 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. 1.7 and Note 15
- Provision for Impairment of Receivables - Note 20.3
- Provisions - Para 1.17 and Note 27

During March the Trust estimates its total income from patient activity for the month and invoices commissioners accordingly. Estimates are based on activity in the year to date. Once actual activity information is available in the early part of the new financial year commissioners are invoiced with any adjustments. The risk of a material misstatement to the Trust's income position reported in the accounts is deemed to be negligible.

1.4 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 or an appropriate expenditure provision is made.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid 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.

1.5 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 Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a 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 NHS Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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.

1.6 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.

1.7 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.

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

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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment 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 in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.

- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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.

1.8 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 £5,000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation 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; and
- 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 current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 are 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.

1.10 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at 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 treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.11 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at 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.

1.12 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.

1.13 Leases

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

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 NHS Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS 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.

1.14 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 NHS 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 or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

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 initial 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 accrual 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 operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS 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 NHS Trust's Statement of Financial Position.

Other assets contributed by the NHS 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.

1.15 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.

1.16 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 three 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 NHS Trust's cash management.

1.17 Provisions

Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS 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 rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015/16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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.

1.18 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 NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 27.

1.19 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 NHS 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.

1.20 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 NHS 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.

1.21 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.

1.22 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.

Financial assets are initially valued at fair value. 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 NHS 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 that occurred after the initial recognition of the asset and that have 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.

1.23 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 historic 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.

1.24 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.

1.25 Foreign currencies

The NHS Trust's functional 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.

1.26 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 36 to the accounts.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS 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.

1.28 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.

1.29 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.

1.30 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 2016/17. 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 from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- 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.

All of these would require futher consideration although it is not anticipated that the application of these standards would have a material impact on the 2016/17 accounts of the Trust.

1.31 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return.

Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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.

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 notes 5 and 7 below.

4. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS England	**476,132**	460,543
Clinical Commissioning Groups	**486,784**	462,945
Foundation Trusts	**119**	91
NHS Other (including Public Health England and Prop Co)	**1,218**	1,960
Additional income for delivery of healthcare services	**0**	7,000
Non-NHS:		
Local Authorities	**0**	936
Private patients	**5,593**	4,715
Overseas patients (non-reciprocal)	**559**	592
Injury costs recovery	**4,420**	3,766
Other	**723**	835
Total revenue from patient care activities	**975,548**	943,383

5. Other operating revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**11,498**	10,766
Education, training and research	**99,442**	100,886
Charitable and other contributions to revenue expenditure - NHS	**1,186**	888
Charitable and other contributions to revenue expenditure - non NHS	**956**	913
Receipt of charitable donations for capital acquisitions	**1,031**	4,390
Non-patient care services to other bodies	**44,417**	39,981
Sustainability & Transformation Fund Income	**24,665**	0
Rental revenue from operating leases	**1,686**	1,152
Other revenue	**12,498**	13,361
Total other operating revenue	**197,379**	172,337
Total operating revenue	**1,172,927**	1,115,720

Sustainability and Transformation income was paid to the Trust by NHS England as part of a national programme to support improvements in service accessibility and help trusts to deliver agreed financial control totals. Payment under the scheme is quarterly and dependent on NHS trusts meeting milestone targets.

Other revenue incorporates income received for goods and services which are incidental to the Trust's core activity of healthcare, for example, car parking, creche fees, access to health records income and catering.

6. Overseas visitors disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016/17 (invoiced amounts and accruals)	**559**	592
Cash payments received in-year (re receivables at 31 March 2016)	**72**	36
Cash payments received in-year (iro invoices issued 2016/17)	**278**	127
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**64**	197
Amounts added to provision for impairment of receivables (iro invoices issued 2016/17)	**266**	337
Amounts written off in-year (irrespective of year of recognition)	**415**	89

7. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts*	**472**	526
Purchase of healthcare from non-NHS bodies	**11,005**	12,212
Trust Chair and Non-executive Directors	**93**	96
Supplies and services - clinical	**325,712**	309,083
Supplies and services - general	**8,339**	8,580
Consultancy services	**1,001**	585
Establishment	**8,262**	7,651
Transport	**3,359**	3,471
Service charges - On-SoFP PFIs and other service concession arrangements	**8,251**	13,185
Business rates paid to local authorities	**4,872**	4,781
Premises	**35,679**	34,310
Hospitality	**155**	146
Insurance	**796**	741
Legal fees	**470**	698
Impairments and reversals of receivables	**313**	959
Depreciation	**24,529**	24,176
Amortisation	**1,450**	541
Impairments and reversals of property, plant and equipment (see note 17)	**34,267**	0
Audit fees	**120**	120
Other auditor's remuneration - audit of Quality Accounts	**10**	12
Clinical Negligence Scheme for Trusts - contribution	**32,900**	29,909
Research and development (excluding staff costs)	**64**	1
Education and training	**4,236**	4,702
Change in discount rate	**306**	(14)
Other expenses	**14,049**	12,001
Total operating expenses (excluding employee benefits)	**520,710**	468,472
Employee benefits		
Employee benefits excluding Board members	**678,129**	650,563
Board members	**1,423**	1,430
Total employee benefits	**679,552**	651,993
Total operating expenses	**1,200,262**	1,120,465

*Services from NHS bodies does not include expenditure which falls into a category in the remainder of note 7

Other expenses incorporates the costs for goods and services which are incidental to the Trust's core activity, for example, hosted services or 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. Leeds Teaching Hospitals NHS Trust as lessee

	Buildings £000s	Other £000	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense				
Minimum lease payments	1,405	4,218	**5,623**	5,133
Contingent rents	0	0	**0**	0
Sub-lease payments	0	0	**0**	0
Total	**1,405**	**4,218**	**5,623**	5,133
Payable:				
No later than one year	1,564	3,896	**5,460**	4,717
Between one and five years	4,520	3,485	**8,005**	6,931
After five years	3,294	0	**3,294**	3,211
Total	**9,378**	**7,381**	**16,759**	14,859

8.2. Leeds Teaching Hospitals NHS Trust as lessor

The Generating Station complex at Leeds General Infirmary is licenced to Engie Ltd who supply the Trust and University of Leeds with electricity. Other leases relate to various retail facilities provided across the Trust's sites.

	2016-17 £000	2015-16 £000
Recognised as revenue		
Rental revenue	**1,686**	1,152
Contingent rents	**0**	**0**
Total	**1,686**	**1,152**
Receivable:		
No later than one year	**1,701**	874
Between one and five years	**1,869**	2,973
After five years	**2,046**	2,301
Total	**5,616**	6,148

9. Employee benefits

9.1 Employee benefits

Employee benefits - Gross expenditure	2016-17 Total £000s	2015-16 Total £000s
Salaries and wages	**568,864**	556,196
Social security costs	**48,390**	36,614
Employer contributions to NHS BSA - Pensions Division	**63,072**	60,084
Other pension costs	**135**	13
Termination benefits	**0**	57
Total employee benefits	**680,461**	652,964
Employee costs capitalised	**909**	971
Gross employee benefits excluding capitalised costs	**679,552**	651,993

9.2 Retirements due to ill-health

Employee benefits - Gross expenditure	2016-17 Number £000s	2015-16 Number £000s
Number of persons retired early on ill health grounds	**25**	25
Total additional pensions liabilities accrued in the year	**1,227**	1,081

9.3. 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

9.3 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 31 March there were 376 employees enrolled in the scheme (133 at 31 March 2016). Further details of the scheme can be found at www.nestpensions.org.uk.

10. Better Payment Practice Code

10.1 Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**205,555**	**487,533**	219,731	494,089
Total non-NHS trade invoices paid within target	**192,370**	**453,124**	203,551	416,744
Percentage of non-NHS trade invoices paid within target	**94%**	**93%**	93%	84%
NHS payables				
Total NHS trade invoices paid in the year	**7,428**	**84,070**	6,050	87,664
Total NHS trade invoices paid within target	**5,897**	**76,848**	4,517	79,587
Percentage of NHS trade invoices paid within target	**79%**	**91%**	75%	91%

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 prior year.

11. Investment revenue

Interest revenue	2016-17 £000s	2015-16 £000s
Bank interest	68	124

12. Other gains and losses

	2016-17 £000s	2015-16 £000s
Gain (Loss) on disposal of assets held for sale	96	(80)

13. Finance costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	2,036	1,570
Interest on obligations under finance leases	8	8
Interest on obligations under PFI contracts:		
main finance cost	(6,027)	10,962
contingent finance cost	5,654	0
Total interest expense	1,671	12,540
Provisions - unwinding of discount	28	27
Total	1,699	12,567

During the course of the year the Trust completed a re-financing arrangement for its Bexley Wing private financing initiative (PFI) agreement which secured a reduced rate of interest. The revised arrangement delivers an overall benefit of £50 million over the life of the contract. Of this sum, £10 million has been brought into account in 2016/17 as a cash lump sum and the balance will be spread across the remaining 20 years of the contract via a reduction in the unitary charge. The £10 million brought into account in 2016/17 was taken as a reduction to existing PFI main finance costs from £3,973k (Bexley Wing PFI £3,309k, Wharfedale PFI £664k) to a closing credit balance of £6,027k.

14. Other auditor remuneration

14.1 Other auditor remuneration

Other auditor remuneration paid to the external auditor	2016-17 £000s	2015-16 £000s
Audit-related assurance services (Quality Accounts)	10	12

14.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

15.1 Property, Plant and Equipment

2016-17	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 2016	20,475	590,522	2,352	10,135	200,338	884	62,388	1,387	888,481
Additions of assets under construction	0	0	0	8,360	0	0	0	0	8,360
Additions purchased	0	9,399	0	0	8,022	0	4,809	0	22,230
Additions - Purchases from cash donations	0	159	0	195	677	0	0	0	1,031
Reclassifications	0	4,533	0	(8,602)	0	0	0	0	(4,069)
Reclassifications as held for sale and reversals	0	0	0	0	(22,859)	(352)	(21,829)	0	(45,040)
Impairments/ reversals charged to operating expenses	0	(50,037)	(596)	0	0	0	0	0	(50,633)
Impairments/ reversals charged to reserves	639	(31,564)	(99)	0	0	0	0	0	(31,024)
At 31 March 2017	21,114	523,012	1,657	10,088	186,178	532	45,368	1,387	789,336
Depreciation:									
At 1 April 2016	(639)	66,357	509	0	158,175	855	43,350	1,382	269,989
Reclassifications as held for sale and reversals	0	0	0	0	(22,846)	(352)	(21,828)	0	(45,026)
Impairment/reversals charged to reserves	639	(10,271)	(14)	0	0	0	0	0	(9,646)
Impairments/ reversals charged to operating expenses	0	(16,282)	(84)	0	0	0	0	0	(16,366)
Charged during the year	0	8,764	52	0	9,203	13	6,494	3	24,529
At 31 March 2017	0	48,568	463	0	144,532	516	28,016	1,385	223,480
Net Book Value at 31 March 2017	21,114	474,444	1,194	10,088	41,646	16	17,352	2	565,856

2016-17	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
Assett financing:									
Owned - Purchased	21,114	325,265	1,194	9,260	28,385	16	17,104	2	402,340
Owned - Donated	0	10,987	0	482	4,713	0	248	0	16,430
Held on finance lease	0	613	0	0	0	0	0	0	613
On-SOFP PFI contracts	0	137,579	0	346	8,548	0	0	0	146,473
Total at 31 March 2017	21,114	474,444	1,194	10,088	41,646	16	17,352	2	565,856
Revaluation reserve balance for property, plant & equipment									
At 1 April 2016	310	69,662	0	0	5,953	14	364	955	77,258
Movements - impairments	0	(21,378)	0	0	0	0	0	0	(21,378)
At 31 March 2017	310	48,284	0	0	5,953	14	364	955	55,880
Additions to assets under construction in 2016-17									
Buildings excl dwellings				8,360					
Balance as at YTD				8,360					

15.2 Property, Plant and Equipment prior year

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	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
Assett 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

15.3. (cont). Property, plant and equipment

All land and building assets were revalued as at 1st April 2016 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 2017 a further exercise was undertaken by the valuer to assess movement in building cost indices since 1st April 2016 and the impact of capital expenditure during the year. The results of this exercise indicated valuation falls of £55 million which have been reflected in the carrying values of fixed assets at 31 March 2017.

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)	2	88
Plant and machinery	5	15
Transport equipment	5	10
Information technology	5	10
Furniture and fittings	5	10

During the year the Trust received grants and donations to fund assets from the following:

	2016-17 £000s	2015-16 £000s
Medical Research Council	109	2,834
NHS Litigation Authority - Patient Safety	0	681
Leeds Teaching Hospitals Charitable Foundation	863	839
Others	59	36
Total	**1,031**	4,390

16. Intangible non-current assets

16.1 Intangible non-current assets

2016-17 Cost or valuation:	IT - in-house and 3rd party software £000s	Computer licences £000s	Total £000s
At 1 April 2016	5,014	1,136	6,150
Additions purchased	293	771	1,064
Reclassifications	4,069	0	4,069
Reclassified as held for sale and reversals	(820)	0	(820)
At 31 March 2017	8,556	1,907	10,463
Amortisation			
At 1 April 2016	2,833	482	3,315
Reclassified as held for sale and reversals	(820)	0	(820)
Charged during the year	1,218	232	1,450
At 31 March 2017	3,231	714	3,945
Net Book Value at 31 March 2017	5,325	1,193	6,518
Asset Financing: Net book value at 31 March 2017 comprises:			
Purchased	4,675	1,023	5,698
Donated	650	170	820
At 31 March 2017	5,325	1,193	6,518

16.2 Intangible non-current assets prior year

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 - government granted	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: Net book value at 31 March 2016 comprises:			
Purchased	1,360	440	1,800
Donated	821	214	1,035
At 31 March 2016	2,181	654	2,835

16.3 Intangible non-current assets

The Trust's intangible assets are not considered sufficiently material to warrant revaluation. They have been measured at historic cost less amortisation (Note 1.9). The carrying amount if assets had been held at historic cost would be £9,742k (£5,184k in 2015/16).

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
Buildings (including dwellings)	5	5
Plant and machinery	5	5
Transport equipment	5	5

17. Analysis of impairments and reversals recognised in 2016-17

	Property, plant & equip.	Total £000s
Impairments and reversals taken to SoCI		
Loss or damage resulting from normal operations	0	0
Over-specification of assets	0	0
Abandonment of assets in the course of construction	0	0
Total charged to Departmental Expenditure Limit	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	34,267	34,267
Total charged to Annually Managed Expenditure	34,267	34,267
Total Impairments of Property, Plant and Equipment changed to SoCI	34,267	34,267

The impairment charge of £34,267k arose as a result of an independent valuation of the Trust's estate (see Note 15.3) as at 1 April 2016. The valuation determined that there had been an overall reduction in the value of estate held by the Trust since the previous independent valuation at 1 April 2014.

18. Commitments

18.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	13,429	3,100
Intangible assets	81	766
Total	13,510	3,866

Property, plant and equipment includes £9m relating to the Generating Station Complex, equipment replacement programme.

19. Inventories

	Drugs £000s	Consumables £000s	Energy £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2016	**6,388**	**9,976**	**175**	**16,539**	0
Additions	170,617	100,623	30	**271,270**	0
Inventories recognised as an expense in the period	(171,116)	(100,671)	0	**(271,787)**	0
Balance at 31 March 2017	**5,889**	**9,928**	**205**	**16,022**	**0**

20.1 Trade and other Receivables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
NHS receivables - revenue	**26,430**	24,169	**0**	0
NHS prepayments and accrued income	**10,533**	438	**0**	0
Non-NHS receivables - revenue	**8,045**	7,930	**0**	0
Non-NHS receivables - capital	**441**	87	**0**	0
Non-NHS prepayments and accrued income	**7,365**	8,188	**0**	0
PDC Dividend prepaid to DH	**0**	590	**0**	0
Provision for the impairment of receivables	**(2,221)**	(2,896)	**(1,120)**	(804)
VAT	**1,722**	2,505	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**7,300**	6,754	**6,733**	7,076
Other receivables	**6,231**	6,163	**4,882**	3,658
Total	**65,846**	53,928	**10,495**	9,930
Total current and non current	**76,341**	63,858		

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.

20.2 Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	**5,263**	2,738
By three to six months	**348**	797
By more than six months	**730**	1,710
Total	**6,341**	5,245

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.

20.3 Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	(3,700)	(3,398)
Amount written off during the year	672	657
(Increase) in receivables impaired (see note 7)	(313)	(959)
Balance at 31 March 2017	(3,341)	(3,700)

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.

21. Cash and cash equivalents

	31 March 2017 £000s	31 March 2016 £000s
Balance at 1 April 2016	3,362	3,298
Net change in year	16,605	64
Balance at 31 March 2017	19,967	3,362
Made up of		
Cash with Government Banking Service	19,907	3,252
Commercial banks	41	92
Cash in hand	19	18
Cash and cash equivalents as in statement of financial position and cash flows	19,967	3,362
Patients' money held by the Trust, not included above (note 36)	1	19

22. Non-current assets held for sale

	Plant and machinery £000s	Total £000s
Balance at 1 April 2016	0	0
Plus assets classified as held for sale in the year	14	14
Less assets sold in the year	(14)	(14)
Balance at 31 March 2017	0	0
Balance at 1 April 2015	0	0
Plus assets classified as held for sale in the year	204	204
Less assets sold in the year	(204)	(204)
Balance at 31 March 2016	0	0

During the year the Trust sold items of plant and minor equipment which had become surplus and obsolete. The sales resulted in a gain on disposal of £96k (Loss of £80k in 2015/16).

23. Trades and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
NHS payables - revenue	3,366	2,573	0	0
NHS accruals and deferred income	3,048	2,911	0	0
Non-NHS payables - revenue	44,904	24,978	0	0
Non-NHS payables - capital	6,013	3,198	0	0
Non-NHS accruals and deferred income	24,648	23,731	259	2,188
Social security costs	7,588	5,806	0	0
PDC Dividend payable to DH	166	0	0	0
Accrued Interest on DH Loans	127	80	0	0
Tax	6,073	6,219	0	0
Other payables	9,353	9,176	0	0
Total	105,286	78,672	259	2,188
Total payables (current and non current)	105,545	80,860		
Included above				
Outstanding pension contributions at the year end	8,941	8,551		

24. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Loans from Department of Health	5,646	4,812	101,886	82,442
PFI liabilities - main liability	6,303	4,920	181,558	192,702
Finance lease liabilities	38	37	373	410
Total	11,987	9,769	283,817	275,554
Total other liabilities (current and non current)	295,804	285,323		

Borrowings / Loans - repayment of principal falling due in:

	DH £000s	31 March 2017 Other £000s	Total £000s
0-1 Years	5,646	6,341	11,987
1 - 2 Years	42,975	8,298	51,273
2 - 5 Years	31,702	26,695	58,397
Over 5 Years	27,209	146,938	174,147
Total	107,532	188,272	295,804

25. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Opening balance at 1 April 2016	**6,931**	5,846	**2,188**	2,291
Deferred revenue addition	**6,105**	4,965	**0**	1,472
Transfer of deferred revenue	**(5,952)**	(3,880)	**(1,929)**	(1,575)
Current deferred Income at 31 March 2017	**7,084**	6,931	**259**	**2,188**
Total deferred income (current and non current)	**7,343**	**9,119**		

26. 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.

Amounts payable under finance leases (buildings)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2017 £000s	31 March 2016 £000s	31 March 2017 £000s	31 March 2016 £000s
Within one year	**45**	45	**38**	37
Between one and five years	**179**	179	**159**	156
After five years	**224**	269	**214**	254
Less future finance charges	**(37)**	(46)	**0**	**0**
Minimum lease payments / Present value of minimum lease payments	**411**	**447**	**411**	**447**
Included in:				
Current borrowings			**38**	**37**
Non-current borrowings			**373**	**410**
Total			**411**	**447**

27. Provisions

		Comprising:		
	Total £000s	Early departure costs £000s	Legal claims £000s	Other £000s
Balance at 1 April 2016	**6,006**	5,591	**340**	75
Arising during the year	**871**	575	**183**	113
Utilised during the year	**(619)**	(392)	**(153)**	(74)
Unwinding of discount	**28**	28	**0**	0
Change in discount rate	**306**	306	**0**	**0**
Balance at 31 March 2017	**6,592**	**6,108**	**370**	**114**

Expected Timing of Cash Flows:				
No Later than One Year	864	380	370	114
Later than One Year and not later than Five Years	1,520	1,520	0	0
Later than Five Years	4,208	4,208	0	0

Amount included in the Provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:	**£000s**
As at 31 March 2017	361,147
As at 31 March 2016	337,256

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 £178k (£258k in 2015/16) 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.

28. Contingencies

Contingent liabilities	**31 March 2017 £000s**	**31 March 2016 £000s**
NHS Litigation Authority legal claims	**(91)**	(122)
Other	**(513)**	(1,083)
Net value of contingent liabilities	**(604)**	(1,205)

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 relate to personal injury claims which 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.

29. PFI - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of on-SoFP PFI	2016-17 £000s	2015-16 £000s
Service element of on-SoFP PFI charged to operating expenses in year	8,251	13,185
Total	8,251	13,185

Payments committed to in respect of the service element of on-SoFP PFI	2016-17 £000s	2015-16 £000s
No later than one year	10,686	10,444
Later than one year, no later than five years	45,294	44,262
Later than five years	158,058	169,777
Total	214,038	224,483

Imputed "finance lease" obligations for on-SoFP PFI contracts due	2016-17 £000s	2015-16 £000s
No later than one year	14,438	15,625
Later than one year, no later than five years	64,540	70,076
Later than five years	206,551	249,594
Sub-total	285,529	335,295
Less: interest element	(97,668)	(137,673)
Total	187,861	197,622

Present Value Imputed "finance lease" obligations for on-SoFP PFI contracts due Analysed by when PFI payments are due	2016-17 £000s	2015-16 £000s
No later than one year	6,303	4,920
Later than one year, no later than five years	34,835	30,406
Later than five years	146,723	162,296
Total	187,861	197,622

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

There are two PFI schemes which have been assessed as on-SoFP:

Institute of Oncology at St James's Hospital - Bexley Wing

This is a 30 year contract which expires in 2037. It provides for the construction, maintenance and partial equipping of Bexley Wing by the PFI partner in return for an annual charge to the Trust. The Trust has full use of the facilities to provide healthcare services and will take ownership of the building and equipment at the end of the contract period. The PFI partner is responsible for providing a managed maintenance service for the length of the contract after which the responsibilities revert to the Trust. The contract contains payment mechanisms providing for deductions from the annual charge for any poor performance or unavailability. Future charges to the Trust will be determined by reference to the Retail Price index. In 2022 the annual charge will reduce significantly to reflect the fact that the contractual commitment to meet equipment costs will be complete although the contractor is obliged to continue to provide equipment that is fit for purpose. The contract was subject of a refinancing agreement during 2016/17 as detailed further in note 13.

Wharfedale Hospital

This is a 30 year contract which expires in 2034. It provides for the construction and maintenance of Wharfedale Hospital by the PFI partner in return for an annual unitary charge to theTrust. The Trust has full use of the Wharfedale Hospital to provide healthcare services and will take ownership of the building at the end of the contract period. The PFI partner is responsible for providing a managed maintenance service for the length of the contract after which the responsibilities revert to the Trust. The contract contains payment mechanisms providing for deductions from the annual charge for any poor performance or unavailability. The unitary charge is subject for an annual uplift for future price increases determined by reference to the Retail Price index.

30. Impact of IFRS treatment 2016-17

The information below is required by the Department of Heath for budget reconciliation purposes

	2016-17		2015-16	
	Income £000s	Expenditure £000s	Income £000s	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on-SoFP under IFRIC12 (e.g PFI)				
Depreciation charges	0	**4,441**	0	4,531
Interest expense	0	**(6,027)**	0	10,961
Impairment charge - AME	0	**16,038**	0	0
Other expenditure	0	**13,904**	0	13,339
Impact on PDC dividend payable	0	**(758)**	0	(765)
Total IFRS expenditure (IFRIC12)	**0**	**27,598**	**0**	**28,066**
Revenue consequences of PFI schemes under UK GAAP / ESA95 (net of any sublease revenue)	0	**19,624**	0	30,946
Net IFRS change (IFRIC12)	0	**7,974**	0	**(2,880)**

Capital consequences of IFRS : PFI and other items under IFRIC12		
Capital expenditure 2016-17	**3,193**	836
UK GAAP capital expenditure 2016-17 (Reversionary Interest)	**3,023**	3,023

	2016-17		2015-16	
	Income/ Expenditure IFRIC 12 £000s	Income/ Expenditure ESA 10 £000s	Income/ Expenditure IFRIC 12 £000s	Income/ Expenditure ESA 10 £000s
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**4,441**	0	4,531	0
Interest expense	**(6,027)**	0	10,961	0
Impairment charge - AME	**16,038**	0	0	0
Other expenditure				
Service charge	**8,250**	**19,624**	13,339	30,946
Contingent rent	**5,654**	**0**	0	0
Impact on PDC dividend payable	**(758)**	**0**	(765)	0
Net revenue cost under IFRIC12 vs ESA10	**27,598**	**19,624**	**28,066**	**30,946**

31. Financial instruments

31.1 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 approval by NHS Improvement. 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 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note (Note 20).

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.

31.2 Financial assets

	Loans and receivables £000s	Total £000s
Receivables - NHS	36,963	**36,963**
Receivables - non-NHS	10,089	**10,089**
Cash at bank and in hand	19,967	**19,967**
Total at 31 March 2017	**67,019**	**67,019**
Receivables - NHS	24,608	**24,608**
Receivables - non-NHS	8,776	**8,776**
Cash at bank and in hand	3,362	**3,362**
Total at 31 March 2016	**36,746**	**36,746**

31.3 Financial liabilities

	Other £000s	Total £000s
NHS payables	12,743	**12,743**
Non-NHS payables	71,246	**71,246**
Other borrowings	107,532	**107,532**
PFI & finance lease obligations	188,272	**188,272**
Total at 31 March 2017	**379,793**	**379,793**
NHS payables	11,124	**11,124**
Non-NHS payables	48,512	**48,512**
Other borrowings	87,253	**87,253**
PFI & finance lease obligations	198,069	**198,069**
Total at 31 March 2016	**344,958**	**344,958**

32. 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.

33. 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, See table on next page.

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 £78k to Town Centre Securities Plc Group for 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

	Expenditure with related party £000s	Income from related party £000s	Amounts owed to related party £000s	Amounts due from related party £000s
NHS Airedale, Wharfedale and Craven CCG	0	6,890	15	45
NHS Bradford Districts CCG	0	11,382	34	183
NHS Calderdale CCG	70	5,896	80	13
NHS Greater Huddersfield CCG	0	7,133	12	28
NHS Harrogate And Rural District CCG	141	6,527	159	19
NHS Leeds North CCG	32	87,908	568	837
NHS Leeds South And East CCG	0	144,771	891	1,080
NHS Leeds West CCG	0	161,742	923	1,195
NHS North Kirklees CCG	0	8,553	44	61
NHS Vale Of York CCG	0	9,678	22	107
NHS Wakefield CCG	123	17,107	177	44
NHS England	88	509,191	0	22,192
Department of Health	0	9,889	0	1,280
Leeds Community Healthcare NHS Trust	585	6,754	488	541
Mid Yorkshire Hospitals NHS Trust	1,825	3,554	325	500
Bradford Teaching Hospitals NHS Foundation Trust	815	8,434	297	2,295
Leeds and York Partnership NHS Foundation Trust	258	3,641	18	497
Sheffield Teaching Hospitals NHS Foundation Trust	334	7,226	14	276
University of Leeds	14,748	5,108	1,180	651
NHS Health Education England	16	70,254	2	1,076
NHS Litigation Authority	33,537	0	8	0
NHS Blood and Transplant	7,921	1,594	169	54

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. Alison Page, Non Executive Director is Managing Partner of DLA Piper. During the year the Trust paid DLA Piper £151k for legal services. Mark Chamberlain, Non Executive Director and Chair of the Quality Committee is an Associate of Capsticks LLP. The Trust paid Capsticks LLP £45k in 2016/17 for legal services.

The Trust's Director of Finance (to 12 June 2016), Tony Whitfield is a Trustee of the Healthcare Financial Management Association. In 2016/17 the Trust made payments totalling £3k to the Association for corporate membership, training materials and attendance at training events.

34. Losses and special payments

The total number of losses cases in 2016/17 and their total value was as follows:

	Total value of cases £000s	Total number of cases
Losses	646,002	852
Special payments	194,691	192
Total losses and special payments	**840,693**	**1,044**

The total number of losses cases in 2015/16 and their total value was as follows:

	Total value of cases £000s	Total number of cases
Losses	695,120	465
Special payments	290,915	219
Total losses and special payments	**986,035**	**684**

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.

35. 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.

35.1 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	2016-17 £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	1,172,927
Retained surplus/(deficit) for the year	355	3,093	471	(43,426)	5,799	2,829	1,498	496	(19,988)	(27,231)	(36,796)
Adjustment for:											
impairments	0	0	0	42,075	(5,813)	0	0	0	(2,897)	0	34,267
impact of policy change re donated/government grants assets	0	0	0	0	0	0	353	150	(1,501)	(2,963)	628
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12	0	0	0	2,314	2,065	1,378	1,238	969	0	0	0
Break-even in-year position	**355**	**3,093**	**471**	**963**	**2,051**	**4,207**	**3,089**	**1,615**	**(24,386)**	**(30,194)**	**(1,901)**
Break-even cumulative position	**304**	**3,397**	**3,868**	**4,831**	**6,882**	**11,089**	**14,178**	**15,793**	**(8,593)**	**(38,787)**	**(40,688)**

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 %	2016-17 %
Materiality test (i.e. is it equal to or less than 0.5%):											
Break-even 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)	(0.16)
Break-even 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)	(3.47)

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 2016/17 and the prior year the Trust has reported deficits and required revenue loans. 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 2017/18 the Trust has a plan to deliver a surplus in line with an agreed control total, inclusive of Sustainability and Transformation funding. 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, revenue loans are available from the Department of Health. 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.

35.2 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%.

35.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit	(3,814)	33,223
Cash flow financing	(4,084)	32,860
External financing requirement	**(4,084)**	32,860
Underspend against external financing limit	**270**	**363**

35.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	32,686	28,075
Less: book value of assets disposed of	(14)	(204)
Less: capital grants	0	(3,515)
Less: donations towards the acquisition of non-current assets	(1,031)	(875)
Charge against the capital resource limit	**31,641**	23,481
Capital resource limit	31,705	23,759
Underspend against the capital resource limit	**64**	**278**

36. Third party assets

The Trust held cash which relate to monies held on behalf of patients at 31 March as shown below. This has been excluded from the cash and cash equivalents figure reported in the accounts (see Note 21).

	31 March 2017 £000s	31 March 2016 £000s
Patient monies held by the Trust	1	19

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, some 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.

For queries or to make a general comment, please visit our website at www.leedsth.nhs.uk

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The Chief Executive's Office

Trust Headquarters

The Leeds Teaching Hospitals NHS Trust

Beckett Street

Leeds LS9 7TF

Published by the Leeds Teaching Hospitals NHS Trust
Trust Headquarters
St James's University Hospital
Beckett Street
Leeds LS9 7TF

contact: communications.lth@nhs.net

website: www.leedsth.nhs.uk

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