NHS
The Leeds Teaching Hospitals
NHS Trust

Quality Account
2025-2026

aligned to the
LTHT Patient Safety and Quality Strategy
2024-2027

Contents

Part 1:

Chief Executive's Statement from the Board

1.1 Introducing the Trust

The Leeds Teaching Hospitals NHS Trust (LTHT) is one of the largest and busiest NHS acute health providers in Europe, a regional and national centre for specialist treatment, a renowned biomedical research facility, and the local hospital for the Leeds community.

We provide care and treatment 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

Last year we provided treatment to almost £1.8 million patients, including 109,000 inpatient admissions, 1.3 million outpatient attendances and 359,000 attendances in our Emergency Departments. We spend over £2.1 billion of NHS money, treating illness and disease in Leeds and on specialised services for people across Yorkshire and the Humber and nationally.

We are increasingly seeking to use our economic influence to improve the health and wellbeing of our community, as an employer of over 22,000 staff, purchaser of goods and services and civic partner. We work with academia and industry to play a leading role in education, research and innovation.

The Trust plays an important role in training and education of colleagues, including medical, nursing, dental, allied health and medical science students and it is a centre of world-class research, pioneering new treatments.

1.2 Development of the Quality Account

Our Quality Account for 2025/26 has been developed with our colleagues, stakeholders and partner organisations, including clinicians and senior managers, Patient Safety Partners, Patient Safety Specialists, Integrated Care Board (ICB) and Healthwatch Leeds. It has been approved by the Trust Board.

1.3 Chief Executive's Statement on Patient Safety and Quality

On behalf of the Trust Board of Directors and all colleagues here at Leeds Teaching Hospitals NHS Trust, I am pleased to introduce our Quality Account for 2025/26. While we continue to face challenges both as a Trust and across the wider health and care system, progress has continued to be made over the past year in improving the quality and safety of care for our patients.

We have continued to work closely with our external stakeholders and regulators to ensure that the care we provide is safe, effective and compassionate. During the year the Care Quality Commission published inspection reports following reviews of two of our core services - maternity and neonates - undertaken in 2024/25, alongside a Trust-wide Well-Led review. These inspections have provided important opportunities for reflection and learning. We have worked constructively with both the CQC and NHS England to respond to the findings, strengthen our governance and quality systems, and ensure improvements are embedded across the organisation.

This year also marked the opening of the Rob Burrow Centre for Motor Neurone Disease, a specialist centre providing world-class care and support for people living with motor neurone disease and their families. The centre reflects our commitment to delivering compassionate, specialist care in environments designed around the needs of patients.

We continue to embed and refresh The Leeds Way values and Our People Priorities, supporting a positive culture where colleagues feel valued, engaged and empowered in their roles. We are extremely proud of our colleagues, who remain committed to delivering safe, high-quality care while supporting one another in often challenging circumstances. Listening to and involving patients and the public remains central to our approach as we seek to continually improve our services.

Our quality improvement programme remains fundamental in addressing patient safety challenges. The Leeds Improvement Method (LIM) continues to provide a structured framework to support improvement across the Trust. During the year we also refreshed our Trust Strategy and supporting strategies to ensure they remain aligned with our ambitions in delivering care to the communities we serve.

Working with our senior leaders and Trust Board, we reviewed our annual commitments and continue to build on feedback from the diverse group of colleagues we work alongside and our partners across the Leeds Health and Care Partnership, NHS West Yorkshire Integrated Care Board and Healthwatch Leeds to build on progress and identify priorities for 2025/26.

I hope this Quality Account provides a clear overview of our achievements over the past year and the steps we continue to take to improve quality and safety for patients across our hospitals.

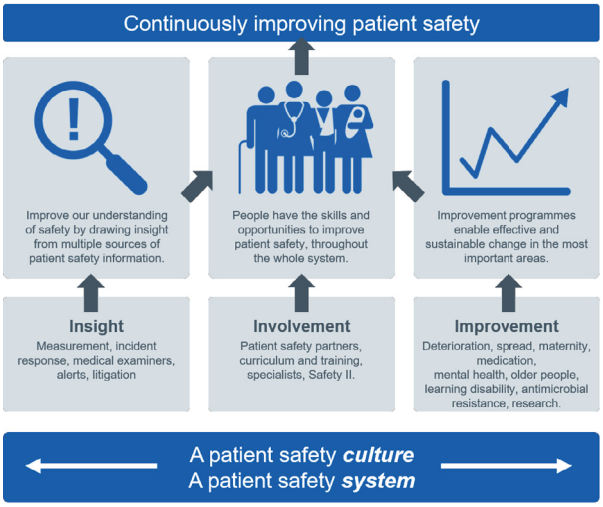
Part 2:

Improving Patient Safety and Quality at the Trust

2.1 Patient Safety and Quality Strategy 2024-2027

In April 2024 we launched our first Patient Safety and Quality Strategy which built on the principles of the previous Clinical Quality Strategy published in 2021.

The Trust's Patient Safety and Quality Strategy 2024-27 sets out what we will do in response to the NHS Patient Safety Strategy and its supporting programme of insight, involvement and improvement.



Our strategy describes how we will continuously improve patient safety and sets out our key workstreams under each program and key deliverables for the next three years. In 2024-25 we aligned the Quality Account to this strategy and have continued this approach into 2025-26.

Our strategy sets out how we will develop our patient safety culture, learn from incidents and change the way we investigate through implementing the Patient Safety Incident Response Framework (PSIRF).

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. It is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience.

This strategy forms part of a broader suite of strategies that collectively support the Trust in delivering its overarching vision. At the centre of this framework sits the Trust's corporate strategy, supported by three core strategies and ten enabling strategies. This structured approach ensures alignment across all strategies and enables them to be reviewed and updated as needed to reflect and support the overall direction of the Trust.

During 2026-27 we will develop our next strategy, using learning from the last three years and incorporating the new NHS England Quality Standards, once published.

2.2 Progress against our Quality Goals 2025/26

Following the implementation of the Trust's Patient Safety and Quality Strategy 2024-27 our quality goals are set around our strategy and the NHS Patient Safety Strategy and its supporting programme of insight, involvement and improvement.

Insight

In 2025/26, we strengthened our understanding of safety across the Trust and wider healthcare system by drawing on intelligence from multiple patient safety information sources.

We used patient safety incidents, investigations and regional learning to strengthen our understanding of safety risks. Insights informed improvements to reporting, learning and system-wide safety culture.

We continued to develop a psychologically safe culture through Freedom to Speak Up, Guardians of Safe Working and colleagues feedback. This intelligence helped identify risks early and informed improvements to colleagues support and patient safety.

Colleague engagement data from the Pulse Survey and NHS Staff Survey provided insight into organisational culture and experience. Findings were triangulated with safety and quality metrics to inform improvement priorities.

Involvement

In 2025/26, we equipped patients, colleagues and partners with the skills and opportunities to improve patient safety and learn from experience.

We expanded support for colleagues to undertake involvement activity and increased opportunities for patients and communities to shape service improvement through listening events, training and insight resources.

We strengthened the Partner Programme and enhanced support for unpaid carers, increasing involvement in improvement, governance and patient safety initiatives.

Feedback from surveys, Friends and Family Test, complaints and PALS informed improvement priorities and supported service development.

Improvement

In 2025/26 we continued to advance quality and patient safety through the Leeds Improvement Method and targeted collaboratives, delivering measurable improvements in care, efficiency, and leadership.

Key achievements included faster treatment pathways, reduced hospital-acquired pressure ulcers, improved medicines management, strengthened mortality reviews, and the rollout of Martha's Rule for deteriorating patients. National audits, research, and innovation were embedded into everyday practice, supporting evidence-based care and colleague development.

2.3 Our Priority Improvement Areas for 2026/27

Our priorities for 2026/27 are aligned with the Trust's Patient Safety and Quality Strategy 2024–27. Our quality goals are guided by this strategy as well as the NHS Patient Safety Strategy and its supporting programmes of insight, involvement, and improvement

Insight

- We will strengthen patient safety incident reporting with improved forms, guidance, and colleague education.
- We will embed the Patient Safety Incident Response Framework through our specialists to ensure consistent learning and improvement.
- We will foster psychological safety, enabling colleagues to speak up and share concerns without fear.
- We will expand Freedom to Speak Up champions in every service and link colleague feedback to patient safety insights.
- We will boost colleague engagement, acting on survey results to promote positive behaviours, wellbeing, and leadership support

Involvement

- Complaints & Feedback - We will improve timeliness of patient feedback offering early resolution, act on insights from patient voices, and deliver the complaints improvement plan.
- Patient & Public Involvement - We will embed Partners across CSUs, expand the Complaints Panel, and use patient insight to guide decisions. We will run Listening Events and support projects addressing health inequalities.
- Carers & Families - We will launch a new Carer Passport, an Unpaid Carers Policy, and John's Campaign Ambassadors to improve support for carers.
- Safeguarding & Vulnerable Groups - We will embed safeguarding lessons and strengthen our processes. We will improve care for patients with learning disabilities and autism through training, colleague champions, reasonable adjustments, and policy pathways.
- Service Improvements - We will act on national survey findings and review interpreting and chaplaincy services to ensure access and compliance with national standards.

Improvement

- We will continue to design and support programmes that deliver effective and sustainable change through quality improvement, audit, and research.
- We will launch our RISE ward/department accreditation scheme designed to standardise and improve the quality and safety of care across hospital wards.
- We will embed improvement into daily management and frontline initiatives using the Leeds Improvement Method.
- We will measure our improvements through the use of national indicators and standards to benchmark our Trust practice and patient outcomes with peers.
- We will strengthen our improvement collaboratives, key workstreams and develop effective methods of sharing learning.

Part 3:

Review of our Patient Safety and Quality programme

3.1 Insight

Our patient safety 'insight' work aims to improve understanding of safety across the Trust and the wider healthcare system by drawing intelligence from multiple sources of patient safety information.

We continue to do this by listening to what our incident data is telling us and to what our people share through colleague surveys and established processes for speaking up. We are also committed to creating a psychologically safe workplace where everyone can be themselves and feel seen and heard.

3.1.1 Patient Safety Incident Response Plan & Patient Safety Incidents

Background

We are committed to identifying, reporting, and investigating patient safety incidents, and ensuring that learning is shared across the organisation. In line with the Patient Safety Incident Response Framework (PSIRF), we promote a just and restorative culture focused on learning and improvement. We continue to strengthen support for patients, families, and colleagues affected by incidents, ensuring a compassionate and responsive approach.

We introduced our Patient Safety Incident Response Plan (PSIRP) for 2024-26 in April 2024. This plan took the findings of the first plan (2022-2024) and a review of multiple data sources to develop new local priorities, the planned response and improvement route. The plan was scheduled to be reviewed for 2026-2028, however in order to provide time for the plan to be delivered and for the Trust to develop a Trust Learning Response Toolkit and associated training this has been extended to 1 April 2027. This will also be in line with the scheduled Patient Safety and Quality Strategy update.

Incident data 2025/26

Indicator	Trust Performance 2025/26
Total patient safety incidents reported	39576
Patient safety incident investigations undertaken against LTHT PSIRP	12
Referrals to Maternity and Neonatal Safety Investigation (MNSI)	15
Other formal patient safety incident reviews	2450
Patient safety incidents resulting in severe harm including psychological harm	143
- physical harm	113
- psychological harm	70

Key Achievements in 2025/26

- Improved access to Datix training materials, through the Risk Management intranet site, including video guides.
- Development of Datix system to provide more effective data capture across key areas.
- Review of the "Service to Service" pathway for sharing incidents, improving engagement with other providers and sharing learning across the region through WYAAT (West Yorkshire Association of Acute Trusts).

Never Events

The NHS 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.

We have reported four Never Events during 2025/26. Incidents were reported under the following categories:

- Retained foreign object post procedure x3
- Overdose of Insulin due to incorrect device.

All never events are reviewed, and Patient Safety reviews are carried out in line with our Patient Safety Incident Response Plan. Learning is shared across the Trust and regionally through our work with the West Yorkshire Association of Acute Trusts

Aims for 2026/27

- Development of a patient safety event response education plan to support all colleagues engaging with reviews of safety events and liaison with patients and their families.
- Review of the incident reporting form to improve the reporting process for users.
- Develop a 'back to basics' incident reporting guide/video resource for all colleagues to increase the understanding of reporting, the process after reporting and how learning is shared.

3.1.2 Patient Safety Specialists

Background

NHS England introduced the Patient Safety Specialist role as part of the NHS Patient Safety Strategy.

The Trust has continued to support designated Patient Safety Specialists, to develop their role in line with NHS England role requirements published in August 2020. The Trust has twelve Patient Safety Specialists, eight of whom have completed the National Patient Safety Training at levels 3 & 4.

The Trust Patient Safety Specialists continue to work with national and local networks to manage patient safety risks by understanding system issues, involving those effected and supporting the design of solutions.

Key Achievements in 2025/26

- Since supporting the introduction of NHS England National Patient Safety Level 1 training into the mandatory training programme for the Trust, 90% compliance is being achieved.
- Designed and launched the Patient Safety Learning Cascade, sharing key findings and safety actions from Patient Safety Incident Investigations to enable the opportunity for wider learning throughout the Trust.
- Delivered patient safety training to new starters as part of the Trust's Introduction to Professional Practice and New to Care education programmes.
- Introduced our first patient safety learning burst videos to target and deliver key safety messages to relevant colleague groups.
- Utilised the NHS Patient Safety Strategy and its supporting programme of Insight, Involvement and Improvement to help Clinical Service Units focus quality assurance presentations.
- Delivered the second Trust Patient Safety Conference focusing on Moments that Matter to our colleagues and patients.
- Continued facilitation of the Patient Safety Learning Hub, increasing membership and promoting a brave space.
- Facilitated four Patient Safety Ambassador Network meetings to hear the voices of colleagues, what matters to them and sharing key patient safety messages.
- Continued support and contributions to the group implementing Martha's Rule.
- Supporting the organisation to deliver actions required in response to National Patient Safety Alerts
- Continued participation in the West Yorkshire Association of Acute Trusts (WYAAT) Patient Safety Learning Group.

Aims for 2026/27

- Support, engage and deliver the Trust's third iteration of the Patient Safety Incident Response Plan.
- Continue to support the embedding of the Patient Safety Incident Response Framework, assisting the organisation to use a variety of tools and response methods to enable learning and improvement.

3.1.3 Psychological Safety

In the NHS, "psychological safety" refers to a workplace environment where colleagues feel comfortable speaking up, admitting mistakes, and raising concerns without fear of negative repercussions. Therefore, it is significant in improving the safety and quality of patient care.

Developing a psychological safe, just culture means we can all hear and learn more, and act to improve patient care. Our people's voices act as an early warning system so we must enable each individual to feel able to speak up about anything they feel or know isn't working. This is an essential part of being assured that safety is being proactively and effectively managed.

Our priorities to support this are defined in our Patient Safety and Quality Strategy as:

- We will ensure colleagues involved in patient safety events are supported.
- We will ensure colleagues are aware of how to raise concerns through Freedom to Speak Up

In September 2025, as part of the Patient Safety Conference, our keynote speaker was Gina Battye, founder of the Psychological Safety Institute who shared her lived experiences demonstrating how these shaped her understanding and teaching of psychological safety, ending with a call to action: small daily choices shape healthier cultures where everyone can thrive. 300 colleagues attended the conference and the talk is accessible to all colleagues on our dedicated intranet page.

We also continue to use this and other methods of fostering a culture of psychological safety by creating spaces for colleagues to ask questions about psychological safety, to understand what it means to feel psychologically safe and the impact it has on patient care. We will continue to build on this work in 2026/27.

3.1.3.1 Freedom to Speak Up

Background

In July 2025 Dr Penny Dash scrutinised patient safety oversight, her conclusions stated that speaking up mechanisms are inconsistently applied and urges a more cohesive, efficient approach to safety and improving the culture for colleagues to raise concerns without fear.

This review aims to ensure that all colleagues have access to a Freedom to Speak Up Guardian and that the work of Guardians is integrated into local and national structures.

Key Achievements in 2025/26

- Development of a lead champions infrastructure.
- Provide CSUs with quarterly data regarding number of cases and themes.
- Implemented a Freedom to Speak Up app for easier access and reporting of concerns by colleagues.
- Development of a Managers guide to dealing with concerns.

Aims for 2026/27

- Increase the Freedom to Speak Up Guardian Infrastructure by at least one w.t.e.
- Ensure each CSU and corporate area has a lead champion, to ensure speaking, listening and following up are embedded.
- Triangulation using qualitative feedback from colleagues about their ability to raise concerns with quantitative patient safety metrics (e.g. incident reports, audits, and mortality rates) to gain a comprehensive, actionable view of patient care.
- Create a community of practice in the Leeds based Guardian network.

3.1.4 Guardians of Safe Working

Background

The Guardians of Safe Working Hours (GoSWH) ensure that doctors and dentists in training continue to work in safe and supportive environments, with adequate opportunity for rest and can make best use of the educational opportunities.

Resident doctors can raise reports which are directly reviewed by GoSWH. The Guardians engage with resident doctors, trainers, deployment, and managers to find workable solutions.

Resident Doctor Forums are held quarterly. These feed into Education Committee meetings and report annually to Trust Board.

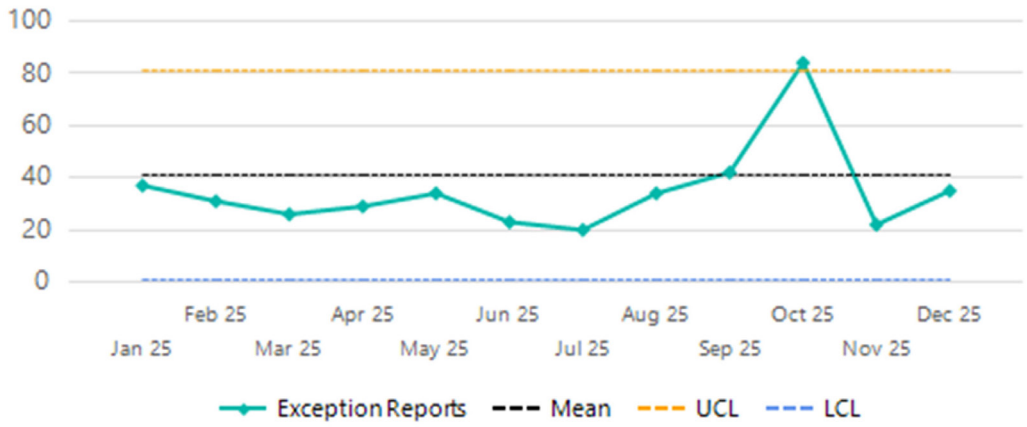
Key Achievements in 2025/26

- The Terms and Conditions for Resident Doctors set out clear requirements for issuing penalties when safe working conditions are not met. Reinstating this process was a key objective for 2024–25, recognising its importance in safeguarding both patient care and colleague wellbeing. Working closely with our Deployment and Finance teams, a robust pathway for identifying breaches has been developed, confirming their validity, and collecting the associated penalties. Effective and proactive communication was also ensured with Resident Doctors and CSU managers so that the process is well understood and embedded into routine practice.
- In line with the Leeds Way value of Fairness, we are developing a standardised and equitable approach for how these funds can be accessed and utilised. All monies collected will be ring fenced for initiatives that directly improve the working conditions and overall wellbeing of Resident Doctors.
- National reforms to the exception reporting process have been implemented from 4 February 2026. These changes are significant and will alter the workflow for every exception report submitted, including who can view them and how they are actioned. In preparation, we have worked collaboratively with Resident Doctors, the Chief Medical Officer, Medical Education, Deployment and software providers to ensure the Trust is fully ready for the transition. This has involved updating internal processes and supporting engagement so that the new model can be implemented smoothly across the organisation.
- In the last 12 months there were 407 exception reports, out of which 11 were raised as immediate safety concerns. The majority were for additional hours and resulted in payments.

Aims for 2026/27

- Analyse how exception reporting reforms impact the number, type and spread of reports across CSUs and training grades in the coming year.
- We will continue to work towards improving engagement with Chief registrars, BMA representatives and the management to adapt to the new reforms.

Number of Exception Reports - January to December 2025



3.1.4.1 National Quarterly Pulse Survey

Background

The National Quarterly Pulse Survey invites all colleagues to take part, an integral part of the People Promise 'we each have a voice that counts'. This survey complements other listening tools such as the NHS Staff Survey to provide a consistent insight into the working experience of our NHS people.

Colleague engagement has been proven to have strong links with positive organisational and individual outcomes.

The quarterly pulse survey asks the same nine engagement questions which make up the colleague engagement score allowing Clinical/Corporate Service Units to monitor and assess colleague engagement.

Motivation

- I look forward to going to work.
- I am enthusiastic about my job.
- Time passes quickly when I am working.

Involvement

- There are frequent opportunities for me to show initiative in my role.
- I can make suggestions to improve the work of my team/department.
- I can make improvements happen in my area of work.

Advocacy

- Care of patients/service users is my organisation's top priority.
- I would recommend my organisation as a place to work.
- If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.

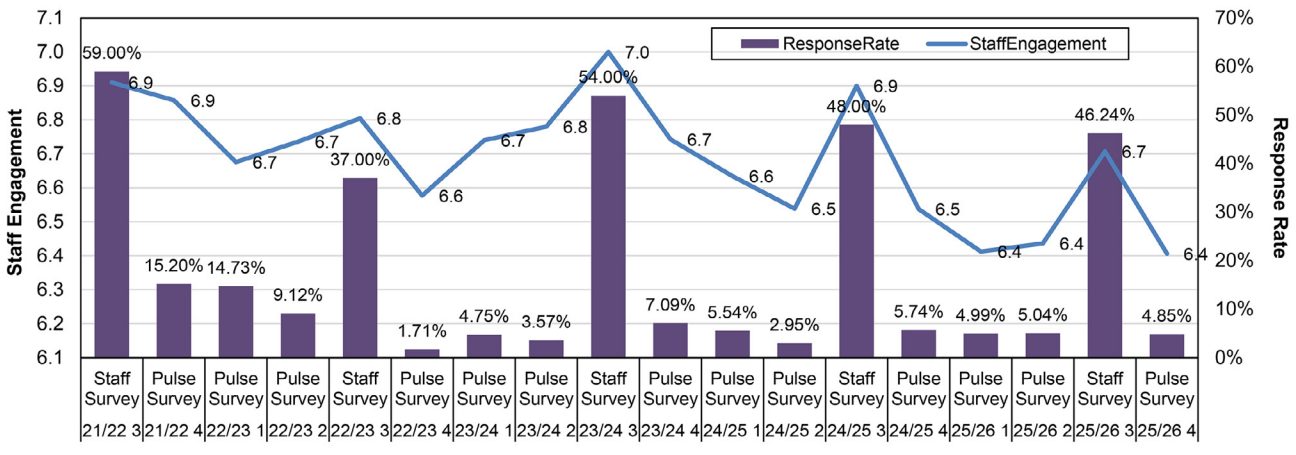
Key Achievements in 2025/26

- Results are aligned with LTHT People Priorities triangulated with other key metrics to identify focus areas and drive meaningful change.
- Results are reviewed at a Clinical/Corporate Service Unit level through monthly performance review meetings.
- The questions aligned with a focus on driving improvement across 7 in-year commitments.
- Accessibility to review data has been improved to increase usage.

Aims for 2026/27

- Improve the colleague engagement scores across the 2026/27 quarters.
- Pulse survey results will remain a key metric within the Improvement Quality and Performance Review.
- Results will align with LTHT People Priorities and the Performance Improvement Framework.
- Pulse survey results will inform improvement activity across the next year.
- Continue to improve accessibility of the results to increase usage.

LTHT Colleague Engagement Score and Response Rate



3.1.4.2 NHS Staff Survey

Background

The annual NHS Staff Survey was available for all colleagues to complete from September to November 2025, with initial results published in January 2026. The survey was completed by 47% of the workforce, 10,213 people.

The survey is a national colleague engagement tool used across all NHS providers, enabling colleagues to have their voice heard across a variety of questions and themes.

The questions and themes align to the NHS People Promise themes presented as:

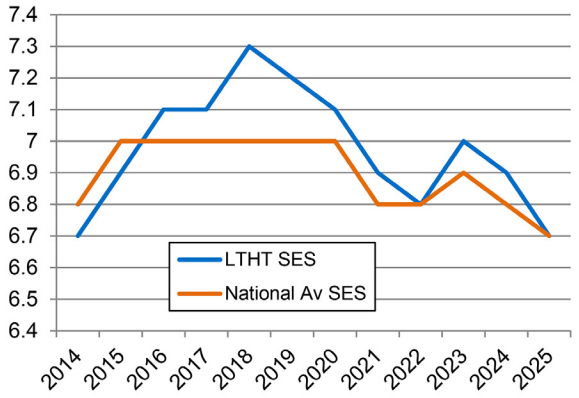
- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff Engagement
- Morale

Findings

The NHS Staff Survey has played a key part in informing and sharing improvements towards the Trust's 2025/26 In-Year Commitments.

In 2025 the colleague engagement score deteriorated slightly from 6.9 to 6.7. This trend mirrors the national average score which has also seen a decline to 6.7.

LTHT Staff Engagement Score compared to National Average (Acute and Acute & Community Trusts)



Aims for 2026/27

The results have informed Trust wide priority areas of focus:

- Promote positive behaviours and act on colleague feedback.
- Strengthen wellbeing support to help colleagues stay healthy at work.
- Reinforce our organisational values to guide inclusive and collaborative behaviours.
- Equip leaders with tools and skills to engage and support their teams.
- Improve appraisal processes to enhance colleague recognition and development.
- Provide focused improvement support to areas and colleague groups with lower engagement.

A communications strategy is in place for the communication of results at Trust level and local level. This involves key stakeholders including senior leaders, engagement leads and line managers supported by post survey resources and guidance.

Results continue to be triangulated with key metrics with local leaders throughout the year, with actions embedded in local operational workforce action plans.

3.2 Involvement

We will equip patients, colleagues and partners with the skills and opportunities to improve patient safety.

We continue to ensure patients, colleagues and partners are meaningfully involved in improving care by listening to patient voice, working collaboratively on improvement programmes, and creating opportunities for colleagues to contribute to safer, higher-quality care.

3.2.1 Patient Experience Priorities

We have continued this year to build the support provided to frontline teams so they are able to deliver an improved experience for patients. To do this, alongside listening to patients, we have listened to colleagues and undertaken surveys to understand where there are opportunities for improvement.

Key Achievements in 2025/26

We will support colleagues to have access to information and support which enables them to confidently undertake involvement and engagement activities to inform improvement programmes.

Throughout 2025/26 the patient, care and public involvement team expanded their support to colleagues to enable them to grow confident in undertaking involvement and engagement activities.

This included:

- Supporting multiple teams directly to deliver engagement activities, including listening events.
- Enabling access to an insight library to assist in planning interventions.
- Facilitating the Trust Patient Reference Group meetings.
- Developing and delivering an annual training programme.
- Offering coaching sessions for colleagues.
- Supporting the delivery of the Trust patient story programme.

We will test our new remunerated Partner role and expand our work to support Partners to align with CSUs.

In 2025/26, a Senior Partner remunerated role was embedded into the Trust and completed all safety checks and Trust induction. Objectives have been agreed for the role and the postholder is supporting work to assist in aligning Partners with CSUs, including becoming a CSU Partner themselves. Their first job has been to review the partner handbook.

Currently Partners are actively supporting:

- Adult Therapies CSU
- Head and Neck CSU
- Urgent Care CSU

During Q3 2025/26, Partners have been introduced into the following CSUs:

- Cardio-Respiratory
- Abdominal Medicine and Surgery

A further four CSUs will have Partners introduced following recruitment planned for 2026.

We will publish the Trust policy for unpaid carers and use this as an opportunity to engage colleagues to consider carers within the assessment of patient care and planning process.

An Unpaid Carers Policy has been developed with support from the Trust Carers Working Group and has been reviewed by external stakeholders, including Carers Leeds and Healthwatch Leeds.

The policy will complement the Paid Carers Procedure in the Trust and sets out expected standards for supporting the carers of patients.

The policy was shared at the Trust Patient Experience and Engagement Group in October 2025 in preparation for publication.

We will act upon the findings from National Patient Surveys and seek to drive improvements where these are needed.

The results of the Adult Inpatient Survey 2024 were published in September 2025 and the Maternity Survey 2025 was published in December 2025.

Results for both surveys have been shared at the Trust Patient Experience and Engagement Group (PEEG) and with responsible teams within the Trust, such as the Nutrition Mission group, Heads of Nursing and the Women's CSU, to take forward actions to address the findings.

The focus of improvement for the inpatient survey relates to food and dietary provision, and for the maternity survey relates to postnatal care at home after birth.

In line with one of the Trust annual commitments, we will focus on supporting outpatient areas to engage with Friends and Family Test (FFT) feedback to support their individual improvement programmes.

In January 2026 we began to test a new way of capturing outpatient feedback to increase the amount of FFT feedback we recieve about our Outpatient Service. This will support colleagues to make imporvements based on the patients voice..

We selected an outpatient clinic that was receiving a FFT response rate of 0.4% using traditional methods of capturing feedback and developed a survey that we embedded into our outpatient appointment system.

The survey was automatically deployed by the system to all patients, after a clinic appointment had occurred. Within two days of switching on the survey, 20% of patients had responded to the request for feedback.

We will work with Healthwatch Leeds and our Trust partners to review our complaint and Patient Advisory and Liaison Service (PALS) processes.

The Head of Patient Experience attended the Healthwatch complaints group this year to support complaint managers across Leeds to consider how best to capture the themes arising from complaints across organisations, to encourage system learning. It was recognised that it is important to analyse the experience of people who may have complaints that relate to more than one organisation, so that we can understand how well organisations work together to provide co-ordinated care. This work links to the city-wide 'How Does It Feel For Me' programme, to which the Trust is a core contributor.

The Trust Complaints panel has also been reestablished following a period of inaction due to panel members leaving the group. The panel brings members of the public (Trust Partners) together with colleagues to review complaint processes, consider complainant experience and to advise on improvements that could be tested. The panel are currently reviewing the Trust PALS leaflet.

We will develop a Trust PALS action plan

A Trust PALS action plan has been developed and was first presented to PEEG in August 2025.

To date, key developments have included

- Supporting CSUs to improve their reporting of PALS outcomes.
- Improving the allocation of work in the team to improve the service user experience.
- Reallocating responsibility for reviewing PALS resolution letters to senior members of CSUs.
- Introducing the choice of an online meeting with a PALS case handler for people who would like to raise a concern.
- Working more closely with Chapel Allerton and Urgent Care CSUs to find quicker ways for people raising concerns to receive a response.

Aims for 2026/27

1) We will deliver a complaints improvement programme which:
   - focuses on improving the timeliness of our complaint responses;
   - helps people who have a concern achieve a quick resolution by offering the opportunity of a discussion with a senior colleagues;
   - will have the oversight of a new complaints working group which will report to PEEG.
2) We will review our PALS information and service experience and take action to respond to feedback.
3) We will review our interpreting provision and ensure that available solutions for providing access to this support at all times of the day and night are explored. Our review will initially focus on our maternity services.

   As part of our work we will also undertake a Trust self-assessment against the NHS England interpreting framework.
4) We will review our Friends and Family Test service and implement a new system for supporting our patients to provide their feedback.
5) We will undertake a Trust self-assessment against the National Chaplaincy Guidelines and will develop a Trust improvement plan to improve compliance, which will be reported to PEEG.
6) We will review the work of our Trust volunteers and identify priority roles for recruitment, which will focus on working alongside colleagues to improve the experience of patients.

3.2.1.1 Patient Carer and Public Involvement

Background

The Patient Carer and Public Involvement team ensures the Trust meets its legal duty to involve people and communities in the decisions it makes and design of services. This year has involved significant change and improvement driven locally and nationally. The Trust recognises and is grateful for the pivotal role patients and members of the public have played in this.

Key Achievements in 2025/26

2025 saw the team moving into the second year of its current strategy with much of its work supporting significant change driven nationally by the NHS 10 Year Plan and priorities set locally by the Trust alongside people and communities.

The Trust is keen to honour and act upon the experience already shared by patients which is held within a Patient Insight Library. This approach enables a greater and broader cohort of patients to contribute to Trust decision making. For example, 363 patients were able to contribute to the development of the Trust strategy alongside new engagement activity this year through the use of the library. The library was developed by the Leeds Peoples Voices Partnership of which the team is an active member.

The Patient Reference Group remains active with four meetings held during this period, with a total of 88 attendees. Members gifted their time to support the development of the Trust, Mental Health, Dementia Strategies, and digital projects this year.

The team also recognises that many people find it difficult to attend forums and accommodate this by conducting Listening Events. This involves 'interviewing' patients whilst on hospital premises. Approximately 350 patients have been interviewed this year with the help of Healthwatch and Trust Volunteers. Examples of work undertaken using this approach include the redesign of the Paul Sykes Centre and gaining a better understanding of the Radiology experience using Compassion, Communication, and Co-ordination as a focus. The team are particularly grateful to patients supporting the development of a new Mental Health strategy including members of the Service User Network supported by Leeds and York Partnership Foundation Trust.

A programme of colleague development continues with 143 colleagues attending training sessions this year. This enables colleagues to embed involvement into daily practice. Subjects covered included Supporting Patient Forums, Patient Stories and how to engage people where capacity is a challenge.

The programme is now popular beyond the Trust with external organisations attending. The team also operates in a consultative role offering 'Head-to-Head' sessions with colleagues seeking to progress engagement with the public which have supported thirty-six projects between April and December 2025.

Health inequalities continue to receive focus with a volunteer Community Connector recruited to interview people in receipt of support from health and social care in their home about Digital Health.

Finally, the team conducted a review of the Trust's Patient Hardship Fund (funded by Leeds Hospitals Charity) to better understand its impact and improve the application process.

Aims for 2026/27

- Improve our use of 'What patients have already told us' to make decisions.
- Conduct a minimum of four Listening Events in 2026/2027.
- Support two Leeds Hospital Charity funded projects to better understand the needs of people experiencing health inequalities.

3.2.1.2 Partner Programme

Background

Founded in 2019, the Partner Programme recruits members of the public and embeds them into work that aims to improve experience, quality and safety of Trust services.

The programme successfully supports the organisation to meet the requirements of NHSE National Patient Safety Strategy.

We continue to exceed the contractual requirement to have a minimum of two Patient Safety Partners supporting patient safety activity.

During the year, Partners have continued to make a significant contribution to improving the quality, safety, and experience of care. Partners supported 36 groups and workstreams, providing valuable input into our improvement activity. The programme has been strengthened by the recruitment of three additional partners, supporting the Trust's strategic ambition to increase direct partner involvement within Clinical Service Units (CSUs).

Key Achievements in 2025/26

- Good progress is being made against the actions and aspirations identified in our partner strategy.
- Four partners are now embedded into CSUs, working alongside colleagues supporting their improvement aims.
- There is ongoing Partner involvement with four partners holding membership of the following governance groups; Quality Improvement, Infection Prevention and Patient Experience and the Patient Safety Learning Hub.
- Partners continue to support the work of the Trust improvement team and remain directly involved in improvement work taking place in the Trust, including work on patient safety, complaints, Never Events, Patient Transport and the Patient Meal Service this year.
- We continue to make good progress towards testing a senior partner role which attracts an honorarium in line with NHSE guidance. The funding identified is expected to be continued into the next year, enabling the Trust to further embed and sustain the partnership.
- Partners have joined other work this year including; Carers Working Group; Patient Letters Group; Sepsis improvement collaborative; Scan4Safety; Clinical Leadership Walkarounds; Martha's Rule and work on implementing the national guidance for a one stop shop for Urology patients amongst others.

Aims for 2026/27

- We will continue to prioritise integrating partners into CSUs within the organisation.
- We will expand the Trust Complaints Panel to six partners, supported by the senior partner role.
- We will continue commitment to and evaluation of the senior Patient Safety Partner role, while ensuring compliance with the NHS Patient Safety Strategy.
- We will further expand the programme through targeted recruitment to meet increasing demand for partner involvement.

3.2.1.3 Carers

Background

The Trust continues to make progress to support unpaid carers in our hospitals. Carers Passports are in use and a new action plan has been developed to support ongoing improvement through 2025-27.

The Carers Working Group meet regularly, membership includes carers and improvement partners. LTHT also supports John's Campaign.

Key Achievements in 2025/26

Three 'Carer and Young Carer Awareness' training sessions were co-delivered by Family Action, Carers Leeds and the Trust's Unpaid Carers Lead. Additionally, bespoke training sessions for Ward Clerks were designed and delivered twelve times during 2025/6.

Additional questions were added to the Friends and Family Test in July 2025, to understand the Carer's experience. The feedback suggests that of the carers who completed the survey, most were made to feel welcome and felt involved in discussions about the person they care for.

Were you made to feel welcome?

YES	**520** (89%)
NO	**10** (26%)

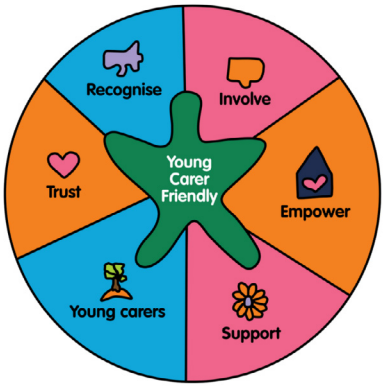
Did you feel involved in discussions about patient care?

YES	499 (95%)
NO	28 (5%)

Raising the profile of unpaid carers is important, so during Carers Week in June 2025, Trust colleagues were invited to take part in a Carers quiz with a chance to win a hamper generously donated by Carers Leeds. The competition received over 130 entries, and team members were delighted to present the hamper to the winner on J43.

Carers Leeds supports unpaid carers in the Trust and has recently recruited an additional Carer Support Worker (CSW) to support carers at Chapel Allerton Hospital with the support of Leeds Hospitals Charity. This is in addition to two CSWs that are already based at St James's and also cover the Leeds General Infirmary.

The Leeds Dental Institute has been awarded Leeds Young Carers Support Services (LYCSS) 'Young Carer Friendly' Quality Mark, in recognition of the creation and implementation of their new young carer pathway.



Aims for 2026/27

- Develop a new Carer Passport to better support Young Carers.
- Launch an LTHT Unpaid Carers Policy to raise awareness among colleagues and drive further improvements.
- Develop the John's Campaign Ambassadors programme.

3.2.1.4 National Patient Surveys

Background

The Trust received two CQC nationally mandated survey reports during 2025/26. These were the Adult Inpatient Survey 2024, published in September 2025 and the Maternity Survey 2025, published in December 2025.

Key Achievements in 2025/26

In both surveys the results were '**about the same**' in comparison with all other Trusts.

Adult Inpatient Survey 2024

The following five areas show where patient experience was considered to be best. This was calculated by comparing Trust results to the average results for all Trusts.

1250 invited to take part

447 completed

59% urgent/emergency admission

41% planned admission

39% response rate

41% average response rate for all trusts

41% response rate for LTHT in 2024

Explaining change of wards: Reasons for changing wards explained in a way patients can understand

Sleeping: Patients being prevented from sleeping at night due to hospital lighting

Sleeping: Patients being prevented from sleeping at night due to noise from other patients

Waiting list: Length of time on waiting list before hospital admission

Information about virtual wards: Patients getting information about risks and benefits of continuing treatment on virtual wards

Maternity Survey 2025

Maternity Survey 2025 results were significantly better for three questions, compared with the previous year. These were:

- During labour and birth, were you able to get a member of staff to help you when you needed it?
- During your labour, were you ever sent home when you were worried about yourself or your baby?
- Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?

598 invited to take part

221 completed

37% response rate

39% average response rate for all trusts

36% response rate for LTHT in 2024

The following five areas show where the maternity patient experience was considered to be best.

Antenatal care: Start of pregnancy: Being offered a choice about where to have their baby

Care in the Ward: Partner or someone else close being able to stay as much as they wanted

Labour and Birth: Being given appropriate information and advice on the associated risks with induced labour

Labour and Birth: Being sent home when worried about themselves or their baby

Labour and Birth: Feeling that they were given appropriate advice and support when they contacted a midwife or the hospital

Aims for 2026/27

Areas requiring improvement based on the Adult Inpatient Survey results include:

- Improving food provision outside of mealtimes.
- Consideration of dietary needs.
- Receiving help from staff to eat meals.
- Patients being able to get help from staff when needed.

Areas requiring improvement based on the Maternity Survey results related to Postnatal Care, specifically care at home after birth.

- Inpatient survey results have been shared with Heads of Nursing and the Trust Nutrition Mission Group.
- Maternity Survey results are discussed with the Maternity Voices Partnership (MVP) who support the development of an action plan to address findings.
- All improvement work is reported and monitored at the Patient Experience and Engagement Group.

3.2.1.5 Friends and Family Test

Background

The Friends and Family Test (FFT) is a short, anonymous survey that helps service providers understand how patients feel about the care they have received. There are various ways that patients can complete FFT and these include by SMS (text message), IVM (interactive voice mail), postcards or digital methods (QR code or a ward iPad). In 2025, over 133,000 patients shared their experiences which helped us improve our services and the quality of care we provide.

Key Achievements in 2025/26

"You Said" We Did (YSWD)

Wards and departments are encouraged to regularly review patient feedback and take action to address areas for improvement. It is important to communicate these changes to patients, which can be achieved through a "*You Said, We Did*" (YSWD) poster. Below are examples of improvement work carried out on Ward C03 at Chapel Allerton Hospital and Adult Critical Care LGI during 2025.

Ward C03, Chapel Allerton Hospital

You said: A patient left the following FFT feedback:

"I was left from after the pre op routines until 4pm no one checked in. The area got colder as the day went on. There were no pillows on the bed. I was cold! Uncomfortable and tired from no food or water! Then.... My operation was cancelled and that is fine. But please don't leave patients so long without checking in and avoiding basic comforts. I was on Ward C03 at Chapel Allerton. I am going back there for my op when it comes. Please don't repeat this for me".

We did: The ward have responded to this feedback by putting the following measures in place:

We have set standard working practices for staff to be present in pre-wait areas at all time, checking patients are comfortable and updated relating to their planned care. Pillows and blankets are available. We are in the process of also training staff across the Trust to feel effective within the pre-wait area and escort patients into theatre. The training should provide further opportunities for enabling positive experiences for patients.

Adult Neuro Critical Care, LGI

You said:

a) The ward environment can feel loud and bright at night

b) Days can feel long, particularly between visiting times.

We did: To help reduce boredom and enhance experience, the team have introduced the following initiatives:

a) Bedside lamps have been introduced to avoid bright, overhead lighting;

Sleep champions take a lead in ensuring the unit is as quiet as possible overnight for every shift.

b) The ward has increased the number of TVs and radios that are available within the ward and the team have created a distraction box to help patients with long days.

An Amazon wish-list has also been introduced so the ward can buy items to improve the patients stay.

3Cs - Communication, Compassion and Co-Ordination

Through a city-wide listening programme, the Trust has learned that the '3Cs' are key to ensuring patients and families feel satisfied with the care they receive. These principles represent what matters most to them.

FFT Team Fabulousness Awards

In April 2025, the FFT team launched its new recognition scheme 'FFT Fabulousness for Teams'. Each month a handful of outstanding patient comments which relate to the 3Cs are shortlisted and shared with the senior management team for scoring. The highest scoring feedback receives the 'Winners' certificate and the two wards with the second and third highest scores are awarded a 'Highly Commended' certificate. Winners are with the Trust Communications team for inclusion in internal and external communications.

Promotion of FFT

The team continues to collaborate with the Trust Communications team to promote patient feedback through various social media platforms on a weekly basis. The team is actively exploring new and innovative approaches to increase awareness and engagement with the Friends and Family Test (FFT) among all patients.

Internal promotion plays a vital role in driving colleague engagement with the FFT. Throughout 2025, the team hosted information stalls at key events, including the Cardio-Respiratory Patient Safety & Sustainability summits in June, July, and September. FFT stalls were also featured at the "*Hello My Name Is…*" campaign in July and the LTHT Patient Safety Conference in September, providing opportunities to raise awareness and encourage participation among colleagues.

Supplementary surveys

The FFT team has the capability to incorporate additional, bespoke questions into the standard FFT survey. Throughout 2025, the team conducted several supplementary surveys across the Trust to gather targeted feedback. One such survey supported the implementation of the newly launched Martha's Law campaign within the Children's Hospital as part of the national NHS England pilot, aiming to assess whether patients felt listened to whilst in our care.

The first question asked was:

"Did you feel listened to during your child's stay?"

Of the 118 parents who responsed to this question:

- 100 felt listened to all of the time (85%)
- 15 said most of the time (13%)
- 2 said some of the time (2%)
- 1 said rarely (1%)

The same survey is scheduled to run again in January 2026, enabling teams to evaluate performance and take action based on the feedback received.

Aims for 2026/27

- Collaborate with outpatient clinics to promote increased FFT feedback through patients' preferred methods.
- Develop and implement a mechanism for capturing FFT feedback from non-clinical teams, such as administration and booking departments.
- Continue enhancing opportunities for patients to provide feedback in their preferred language.

3.2.1.6 Complaints

Background

The complaints service provides information and confidence to the public that any concerns or complaints raised about services provided by the Trust will be managed in a way that reflects statutory guidance and the Trust values. Anyone can raise a concern or complaint about the care of a patient, though we will need patient consent.

Key Achievements in 2025/26

Complaints Improvement programme (CIP)

Our complaints improvement programme (CIP) had a focus on driving improved timeliness. Improvement events were held with Neurosciences and Urgent Care services.

Working with Neurosciences, we trialled improved capture of complainants' concerns and desired outcomes at first contact. Concerns were agreed with service users before investigation, with response times monitored. This approach is now embedded and has reduced reopened complaints. In 2025/26, the CSU was involved in 84 responses; 8 were reopened, with only 2 due to a defect (2%). This marks a 14% improvement from the CSU's 23/24 defect rate (16%).

Working with Urgent Care services, we improved complainant engagement and reduced escalation from PALS to formal complaints. A pilot in May 2025 enabled senior ED colleagues to contact complainants directly when concerns escalated, aiming for swift telephone resolution. To date, 15 service users received quicker resolutions, reducing anxiety and distress.

To improve performance, CSUs were given responsibility for quality assuring their own single-CSU complaint responses, streamlining the process and supporting more timely responses. Response quality continued to be monitored to ensure standards were maintained.

A review also identified delays in quality assurance for complex, multi-specialty complaints. Changes to the process for low-risk cases were agreed, with a new approach commencing in February 2026.

The Trust Independent Complaints Review Panel, which includes public members, supports improvements to complaint handling. Following a review of its purpose, additional panel members were recruited this year to strengthen work to improve the complaints process.

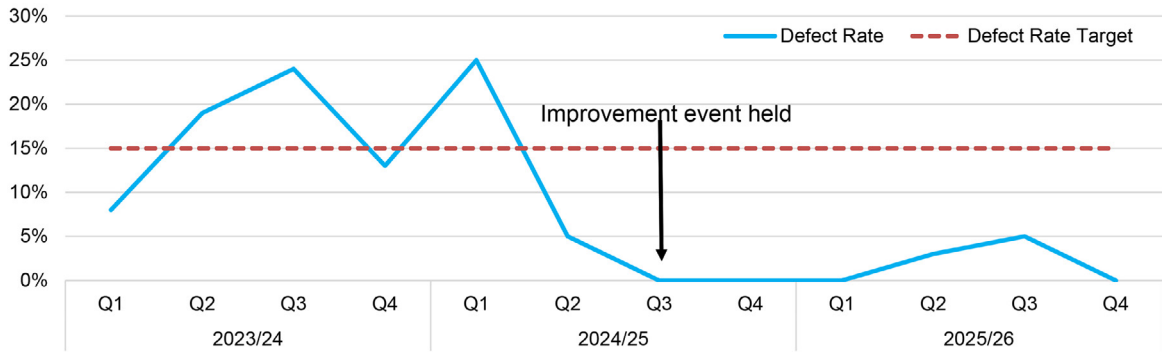
Complaints Training

Complaints training for Trust colleagues has continued to be provided by an external provider. The training includes modules on Complaint Response Writing and Mediation skills aimed at early resolution of concerns.

Aims for 2026/27

- Implement the removal of the external quality assurance review for simple multi complaints.
- Improve the recording of actions taken in response to complaints and monitoring the completion of these.
- Introduce a complaint working group to support delivery of the plan and drive improvement.
- Progress a strategic improvement plan to enhance responsiveness to complaints, aiming to meet the locally set target of 80% timely responses.
- Continue to support education, training and learning opportunities associated with complaints management.

Neurosciences CSU Complaint Response Defect Rate



3.2.1.7 Patient Advisory Liaison Services (PALS)

During 2025/26 the Trust recorded 8,074 PALS contacts. The table below shows the reasons for the different types of contact with the Trust PALS Team.

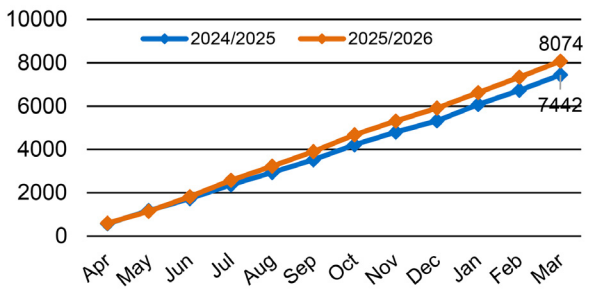
PALS activity

PALS Activity Type	2024/ 2025	2025/ 2026
PALS concern (including out of time complaints)	5,585	6,382
Advice/enquiry	1,092 (828 resolved by CSUs, 264 resolved by PALS)	899 (736 resolved by CSUs, 163 resolved by PALS)
Signposting	43	32
Compliment	633	544
Other	89	217
Total	**7,442**	**8,074**

During 2025/26 there were 6,382 concerns and enquiries requiring input from clinical teams, all of which were passed to the relevant service within two working days of receipt to be investigated; a further 163 concerns were resolved by the PALS team on the same day. 8.5% of the concerns received by the team were complex and required input from more than one clinical service, which is the same as the previous year.

Overall activity increased from 7,442 in 2024/25 to 8,074 in 2025/26, a rise of 632 (+8.5%). PALS concerns (including out-of-time complaints) rose from 5,585 to 6,382 (+797, +14.3%). In contrast, advice/enquiries fell from 1,092 to 899 (-193, -17.7%), signposting decreased from 43 to 32 (-11, -25.6%), and compliments reduced from 633 to 544 (-89, -14.1%). Other types of PALS activity increased from 89 to 217 (+128, +143.8%).

PALS concerns received by month



Subjects are recorded for each PALS case. In many cases multiple subjects are recorded for each case. The top four subjects recorded for PALS in 2025/26 were Communication, Admin, Access, Patient Flow, Treatment and Staff Interaction.

The subjects recorded are further divided into sub-subjects, which give more detail about the nature of the concern. The top 10 sub-subjects that were linked to PALS concerns in 2025/26 are shown in the table below.

Top 10 PALS Sub-subjects

Sub-Subject	2024/ 2025	2025/ 2026	Change
Waiting list time (outpatient)	1180	1291	111
Communication - difficulty contacting department	677	700	23
Undesirable staff behaviour	663	703	40
Communication with patient regarding future treatment plan/care	558	733	175
Delay/failure in treatment/ procedure	405	710	305
Communication - delay in giving information/results	462	535	73
Lack of compassion	415	511	96
Communication with patient regarding diagnosis/condition	355	543	188
Communication with patient - telephone call/ text	456	427	-29
Communication - appointment/cancellation letter not received	257	483	226

In keeping with the previous year, the top sub-subject for 2025/26 by far was waiting list time for out-patients. This sub-theme was raised 111 more times than in the previous six months (9% increase). Most of the other top sub-subjects relate to patient interactions with staff, communication difficulties and delays in diagnostic and treatment pathways.

The PALS team conducts regular review meetings with Clinical Service Units (CSUs) to discuss open PALS cases, assess any support required from the team, and offer guidance on handling challenging complainants.

In collaboration with the PALS team, the Urgent Care CSU has developed five standardised responses addressing key concerns. Additionally, CAH CSU are coordinating with the PALS team to facilitate them responding directly to service users on common topics for the CSU.

Compliments

The PALS team continue to receive compliments for services across the Trust. There were 544 compliments recorded in 2025/26, 89 less (14% decrease) than the previous year. All of these were shared with the relevant teams and individuals concerned.

PALS compliments received by CSU

Subject	2024/ 2025	2025/ 2026	Change
Abdominal Medicine & Surgery	69	64	-5
Adult Critical Care	6	7	1
Adult Therapies	17	12	-5
Cardio-Respiratory	31	33	2
Centre for Neurosciences	31	29	-2
Chapel Allerton Hospital	34	29	-5
Chief Nurse	58	27	-31
Children's	34	16	-18
Estates & Facilities	9	3	-6
Head & Neck	32	22	-10
Leeds Dental Institute	12	10	-2
Medical Directorate	0	1	1
Medicines Management & Pharmacy Services	2	0	-2
Oncology	30	41	11
Outpatients	6	8	2
Pathology	2	0	-2
Radiology (inc. Medical Illustration)	38	56	18
Specialty & Integrated Medicine	21	15	-6
Theatres & Anaesthesia	18	19	1
Trauma & Related Services	23	14	-9
Urgent Care	91	59	-32
Women's	69	78	9
Other	0	1	1
Total	**633**	**544**	**-89**

Resolution method for PALS concerns and enquiries

In 2025/26, 6,799 concerns and enquiries were recorded as resolved. The table below illustrates the methods of resolution that were used (this does not include reopened case resolution outcomes). Everyone using the service is contacted to ask them what method of resolution they would prefer. The most prominent resolution method was telephone, with 65% of cases resolved via this method, followed by email for 19% of cases. Other core concern resolution methods (highlighted in bold) included discussions with complainants on the ward or in clinic (5%), letters (2%), appointment arranged to discuss further (2%), resolution meetings (0.5%), escalated to formal complaints (0.4%).

PALS resolution methods

PALS Concern and Enquiry Outcomes	Received in 2025/26
Telephone	4,408
Email	1,272
Discussion on ward	257
Escalated to formal complaint	240
Letter	160
Closed for other reason	107
Appointment/meeting arranged to discuss further	94
Resolved during discussion in clinic	77
Unable to make contact - letter sent	49
Signposted to other organisation	43
Meeting	33
Awaiting further information from complainant	20
Complaint form sent out	19
Passed to Risk Management	13
PALS withdrawn	5
No patient consent received	2
Total	**6,799**

Key Achievements in 2025/26

- A PALS action plan for 2025-2027 has been developed to drive improvements in business processes and to provide better support to clinical teams.
- An open PALS report is provided to CSUs every two weeks, which provides better data for clinical teams on the number of open PALS they have awaiting contact and resolution. This helps clinical team manage their PALS activity.
- PALS officers hold meetings with clinical teams to work on PALS concerns that are reaching their time limit or are overdue. This enables the team to support completion of PALS concerns that remain unresolved or without any contact.
- The team carried out a review of their working practices and highlighted where improvements could be made. As a result, the team have implemented a new process where officers are assigned specific responsibilities for either, handling telephone enquiries or managing email correspondence. Early benefits include a reduction in voicemails, as the PALS officers dedicated to phone duties can focus solely on calls during working hours. Equally, PALS officers concerned with email management are not interrupted by phone calls.
- We are very proud that one of our PALS officer, Janet, won an Iris award for her outstanding care to a patient of the Trust.

Aims for 2026/27

- Continue to progress the actions included in the PALS action 2025-27 action plan.
- Monitor the approved changes and impact to the quality assurance process for written PALS responses.
- Focus on PALS concerns that remain open longer than 10 days.
- Improve information about the service that is available to the public.

3.2.1.8 Safeguarding Vulnerable People

Background

The Trust remains committed to advancing safeguarding arrangements across the organisation to ensure that care is delivered safely and in line with statutory safeguarding duties. This work focuses on protecting those most at risk and reinforcing a culture in which safeguarding is embedded as a fundamental component of clinical practice and patient care.

Key Achievements in 2025/26

Allegations against staff training

A safeguarding survey indicated 66% of colleagues were unaware of the 'Safeguarding: Managing Allegations against Staff Policy. Since January 2025 the Safeguarding Team rolled out 'Allegations Awareness' training to over 200 managers and provided 3 bespoke CSU sessions to 67 managers alongside Human Resources managers to raise awareness of the Allegations Against Staff policy, risk assessment tool and staff procedure.

New PPM -Safeguarding Alert

In August 2025, the Safeguarding and DIT team introduced a 'Safeguarding Alert' on PPM+ to alert colleagues to patients with safeguarding concerns including those who pose a risk to others. Work is on-going to ensure the alert is utilised and to increase awareness across the Trust.

Young Carers Accreditation

The Leeds Children Hospital and the Leeds Dental Institute both achieved "Young Carer Friendly" accreditation from Family Action in 2025. This includes a 'No Wrong Door for Young Carers' pathway alongside an assessment tool to help young carers and their families to access the right support through a 'Think Family' and 'Early Help' approach.

The Navigator Service

This service continues to make a significant contribution to the safeguarding landscape in Leeds, supporting vulnerable young people at the critical intersection of health, safety and wellbeing. Contributing to initiatives such as 'Guiding a New Generation' and the knife crime awareness schoolwork. The service has helped to create a more cohesive and proactive approach to supporting young people in our city. They also hosted a city-wide conference at LTHT in 2025.

Maintaining Professional Boundaries with Children

The Children and Midwifery Safeguarding Team published a guide in June 2025 for Leeds Children Hospital colleagues. The purpose is to outline clearly defined professional boundaries to protect colleagues professional integrity.

Safe Voices Work

Leeds Hospital Charity kindly funded a joint project with the Patient Carer and Public Involvement (PCPI) team to seek the views of young people aged 16/17 attending the Adult Emergency Department where safeguarding concerns were noted. The purpose was to understand whether young people's voices were appropriately heard and responded to. The final report and accompanying video was shared in June 2025.

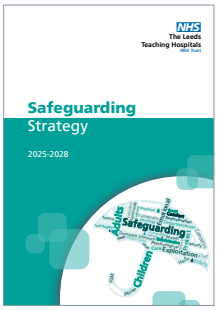
Safeguarding Lead Professionals and Champions

The Safeguarding Teams have supported CSUs to establish the Lead Professional role across all services. This role provides strategic leadership, supports the delivery of effective and sustainable change, and acts as the designated point of contact for safeguarding related communication. The Champion's role has also been clearly defined, with improved clarity regarding expectations and responsibilities.

CSU Notification of Statutory Safeguarding Reviews

The Safeguarding Team has developed a consistent approach to notifying CSUs when they are involved in a Statutory Safeguarding Review. A supporting leaflet has been produced to guide CSUs and provide onward support for colleagues involved. This approach enables CSUs to implement, monitor, and assure actions and improvements identified through the review process.

Aims for 2026/27



During 2025-2026 a full comprehensive review of the Trust Safeguarding Strategy and strategic plan took place involving internal and external stakeholders.

The final revised Safeguarding Strategy and Plan was approved in summer 2025 and published early 2026. These will be monitored through the Trust Safeguarding internal governance meetings.

Our priorities this year will be embedding the achievements mentioned above as well as focusing on:

- Dissemination of findings from safeguarding incidents and from case and safeguarding practice (child specific), Domestic Homicide and Safeguarding Adult Reviews in order to share learning and improve practice to keep service users and colleagues safe.
- Improve and strengthen the birth planning process in collaboration with internal and external stakeholders to reduce risk and enhance patient and colleague experience.

3.2.1.9 Learning Disabilities and Autism

Background

The Trust is committed to reducing health inequalities for people with a learning disability and Autistic people (LDA).

Meeting the needs of our patient's is the responsibility of the whole organisation in line with the Health and Social Care Act 2012 and the Equality Act 2010

Key Achievements in 2025/26

- The Oliver McGowan Mandatory Training Programme has been made mandatory for Part 1 - E Learning Module.
- Successful recruitment into the Lead Nurse and Clinical Team Manager positions within the Acute Liaison Team creating strong leadership and stable service provision.
- All outpatient appointment letters now have an Easy read summary as standard.
- 188 Easy Read patient information leaflets published. We completed a national project with the National Kidney Federation to produce over 20 Easy Read leaflets relating to kidney care.
- Team referrals have transitioned to PPM+, creating a standing approach for internal referrals releasing capacity within the team and improving our data capture.

Clinical Support

- Paediatric pre-assessment teams are conducted with reasonable adjustment plans for all LDA patients pre surgery.
- Introduction of a duty phone for internal clinicians requiring urgent support has increased accessibility.
- Re-focussed documentation on PPM in line with Trust goals and now including clear Reasonable Adjustment plans.

Quality Improvement

- Revised the LDA Internal Audit to align to NICE guidance and statutory requirements improving assurance processes.
- Ongoing digital work to further improve visibility of diagnosis and reasonable adjustment care plans across internal systems.
- Hosted our second Staff Champion Conference with excellent feedback and engagement.

Training and Education

- Ongoing training sessions for LTHT Teams that are co designed and co facilitated by Trainers with lived experience, that are well evaluated.
- Delivery of a bespokse session as part of the Excellence in You Band 3 Enhanced Care Programme of training.
- Continued to enhance our LDA workforce:
  - A team member commenced on Masters Autism program
  - A team member commenced on PG Cert in Health Research
  - A member of senior team completed the Excellence in Leadership Program

Aims for 2026/27

- Embed the Oliver McGowan Mandatory Training programme.
- Increased recruitment of co trainers/ patient partners in line with the wider organisation.
- Relaunch staff champion program with executive sponsorship.
- Increase NICE guidance compliance year on year.
- Launch reasonable adjustment alert, assessment and care plan.
- Develop stable funding streams for a centrally held Easy read budget.
- Launch the Learning Disability and Autism Policy and embedded Pathway.

3.2.2 Regulation - Care Quality Commission

The Care Quality Commission (CQC) no longer routinely gives an "overall" rating at Trust level. Instead, it now gives a single organisation-level rating for "well-led" (leadership). The other domains (safe, effective, caring, responsive) are still rated but only at service or location level, not aggregated into one overall Trust score.

	Safe	Effective	Caring	Responsive	Well led	Overall
St James's University Hospital	Inadequate May 2025	Good May 2025	Requires Improvement May 2025	Requires Improvement May 2025	Requires Improvement May 2025	Requires Improvement May 2025
Leeds General Infirmary	Requires Improvement May 2025	Good May 2025	Requires Improvement May 2025	Requires Improvement May 2025	Requires Improvement May 2025	Requires Improvement May 2025
Chapel Allerton	Good Feb 2019	Good May 2025	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Leeds Dental Institute	Good Feb 2019	Outstanding Feb 2019	Good Feb 2019	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019
Wharfedale Hospital	Good Sept 2016	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Sept 2016

Outstanding Good Requires improvement Inadequate

You can read the full report on the CQC website

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 Trust has continued to engage with the CQC and has kept them informed of changes to the Statement of Purpose to reflect the changes to the Executive Team and alignment of registered managers to regulated services.

The Care Quality Commission has not taken enforcement action against Leeds Teaching Hospitals NHS Trust during 2025/26. However, following the inspection of Maternity Services CQC issued a section 29A warning notice in relation to staffing.

In 2025/26 the CQC published inspection reports following reviews of two of our core services, maternity and neonates undertaken in 2024/25, alongside a Trust-wide Well-Led review conducted in June 2025. These inspections have provided important opportunities for reflection and learning. We have worked constructively with both the CQC and NHS England to respond to the findings, strengthen our governance and quality systems, and ensure improvements are embedded across the organisation.

CQC's service inspection of Maternity and Neonatal services at St James' University Hospital and Leeds General Infirmary identified the Trust was in breach of legal regulations relating to learning following incidents, risk management, safe environment, infection prevention and control, medicines management and some governance processes. A Perinatal Improvement Plan was developed and is being delivered with oversight of NHS England and CQC.

In June 2025 the CQC inspected the Trust against the Well Led quality statements. The CQC rated the well led key question as requires improvement and identified the Trust were in breach of legal regulations relating to complaints, good governance and staffing. A Trust Improvement Plan was developed and is being delivered with oversight of NHS England and CQC.

3.2.3 Regulation - NHS England

The Leeds Teaching Hospitals NHS Trust is an NHS acute trust delivering hospital services within the West Yorkshire Integrated Care System. We operate within the national framework set by NHS England, which provides oversight and sets standards for quality, safety, and performance.

The Trust are accountable to NHS England and work in partnership with NHS West Yorkshire Integrated Care Board and system partners to deliver safe, effective, and high-quality care for our population.

Following the inspection of Maternity and Neonatal core services in 2024/25, reports published in 2025/26, NHS England held a multi stakeholder Rapid Quality Review in partnership with the Trust senior leadership team. In line with NHS England's commitment to supporting the improvement of maternity care provision in England, the Trust was entered onto the Maternity Safety Support Programme (MSSP) and benefits from dedicated Maternity Improvement Advisors.

Following the publication of the Trust Well Led report and entry into the Maternity Support Programme NHS England put in place enforcement undertakings (as per section 106 of the Health and Social Care Act 2012) to underpin and guide the actions required in response to breaches, or suspected breaches, of the NHS provider licence principles, systems and standards of good corporate governance .

During 2025/26 the Trust have worked constructively with NHS England and key stakeholders to respond to the findings providing regular oversight of delivery of the Perinatal and Trust Improvement Plans and measures of performance, finance and quality to the Integrated Quality Improvement Group.

3.3 Improvement

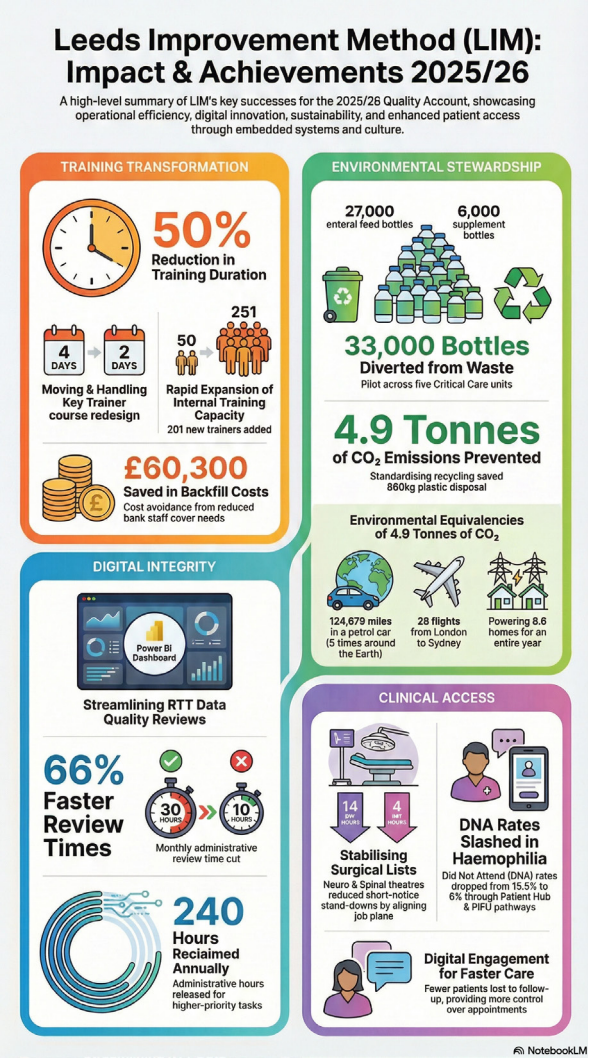
We will design and support programmes that deliver effective and sustainable change in the most important areas.

We continued to design and support programmes that deliver effective and sustainable change in the areas that matter most, while empowering colleagues to use the Leeds Improvement Method to lead improvement and learn from when things go wrong.

3.3.1 Summary of Leeds Improvement Method & Value Streams

Background

The Leeds Improvement Method (LIM) is the Trust's structured approach to delivering quality improvement of services to eliminate waste. Improvement at the Trust has been reviewed against the NHS IMPACT domains to ensure alignment with national improvement direction and to position improvement as our operating model.



Key Achievements in 2025/26

Domain 1: Building a Shared Purpose and Vision

Improvement was aligned to organisational priorities through the 7 Commitments until they were discontinued mid-year. The central improvement team are now aligned to Executive portfolios to support the delivery of larger, more transformational cross organisation work. Some of the achievements seen this year:

- **Care – supporting patients to get home sooner.** The Liver Disease Early Detection Clinic reduced referral to treatment time from 9.5 months to 3 weeks, improving access and timeliness of diagnosis.
- **Quality – improving patient experience and outpatient efficiency.** Medical Dermatology reduced referral to clinic lead time from 38 to 18 days, creating 117 additional weekly appointments and reducing backlog by 9%.
- **Oncology Research** reduced invoice processing time by 70%, strengthening financial governance and sustainability.

These projects demonstrate clear links between strategic priorities and measurable operational delivery.

Domain 2: Investing in People and Culture

Our focus has been on creating a culture where colleagues feel psychologically safe, empowered to improve care, and supported to make improvement part of everyday practice.

Some of the achievements seen this year:

- Psychological safety was actively monitored, with 100% of participants in LIM Events reporting feeling safe to speak up.
- A falls medication review project in Elderly Medicine increased structured medication reviews from 0% to 75%, with 74% of patients now involved in shared decision making about medication changes.
- The Peritoneal Dialysis team increased home treatment for stable patients from 10% to 34% avoiding 80 hospital attendances in three months.

These changes reflect growing frontline ownership.

Domain 3: Developing Leadership Behaviours

Executive portfolio alignment has clarified sponsorship and reinforced improvement as a core leadership responsibility. Leaders increasingly model data driven decision making and structured testing. Some of the achievements seen this year:

- Redesign of Pressure Ulcer and Falls investigations reduced time from incident to shared learning by 73% and 86% respectively, strengthening transparency and learning.
- A Coaching for Improvement offer was developed, enabling clinical leads to run regular coaching clinics and support frontline teams to test and sustain change.
- In Gynaecology, backlog reduced by 59% and waits fell from 14 to 5 weeks without additional staffing.

This demonstrates that leadership for improvement is increasingly embedded as a practical expectation across all management tiers, rather than remaining the responsibility of specialist teams.

Domain 4: Building Improvement Capability and Capacity

- Strengthening improvement capability and protected capacity remains a priority to ensure improvement can be delivered at scale.
- Bespoke Business Manager cohorts trained 28 managers, each completing a live improvement project to ensure learning translated into measurable service change and reinforced leadership accountability.
- Intermediate LIM training was redesigned to improve accessibility and inclusion, including adjustments to support colleagues with neurodiversity. Adapted materials, varied delivery formats and enhanced facilitation ensured improvement capability is accessible across our diverse workforce.
- The previous quota based training model has been revised with a leadership level capability framework defining the knowledge, skills and behaviours expected at each tier. This shifts the focus from attendance to role based competence, ensuring leaders demonstrate the capability required for their responsibilities.

Domain 5: Embedding Improvement into Management Systems and Processes

Improvement is increasingly embedded in daily management practice. Some of the achievements seen this year:

- Blood Born Virus testing uptake increased through embedding standard panels and reflex testing, progressing towards the national 80% target, while also achieving the 20% national target by reducing repeat testing in frequent attenders, avoiding overtreatment and improving use of resources.
- Length of stay at Chapel Allerton reduced by 1.7 days through visible management and structured huddles.
- Radiology returned reports reduced by 88% through standard work and escalation processes.
- Environmental stewardship has been embedded in daily operations in Critical Care. A standardised recycling process across five units diverted 27,000 enteral feed bottles and 6,000 supplement bottles from domestic waste, preventing 860kg of plastic disposal and about 4.9 tonnes of carbon emissions annually.

These examples demonstrate the integration of improvement into routine operational systems.

Aims for 2026/27

Alignment

- 100% of LIM projects to have named Executive/ Senior Leader sponsorship and aligned driver metrics.
- Embed improvement reporting within established governance routes.

Ownership

- Maintain ≥95% positive psychological safety responses of colleagues attending LIM training.
- Increase frontline initiated improvement initiatives by 30%.

Accountability

- Publish and implement the revised Improvement Capability Framework outlining behavioural expectations for leadership roles.
- Continue to embed structured daily management systems consistently across the trust.
- Require documented standard work before programme closure and to achieve the highest certification grades.

Capability and Capacity

- Implement the leadership capability framework across all tiers.
- Expand accessible and flexible education provision.
- Maintain ≥97% positive feedback across all training.

These priorities will strengthen improvement as our operating model, ensuring it becomes systematic, measurable and sustainable.

3.3.2 Quality Improvement Collaboratives

The next few pages describe the achievements of the Quality Improvement Collaboratives in 2025/26 and their aims for 2026/27.

3.3.2.1 Deteriorating Patient (Adult and Children) including sepsis and Marthas Rule

Background:

The Trust are committed to continually improving our multisystem approach to the prevention, recognition, and response to deterioration, including sepsis.

Marthas Rule has successfully been launched across both Adult and Paediatric services providing colleagues, patients and their advocates direct access to deterioration escalation pathways and encouraging partnership working.

Key Achievements in 2025/26

This year has continued to be a significant challenge as operational pressures have remained high.

This year we have:

- Launched a Deteriorating Child and Neonatal Strategy outlining our commitment to a programme of work.
- Identified gaps in education and awareness of sepsis triggers for all patients.
- Formulated clear educational programmes to upskill colleagues across the range of professions for both deteriorating adult and child.
- Collaborated with the digital team to upgrade existing digital tools in line with National Guideline changes and new patient safety initiatives.
- Worked closely with our patient partners to create tools and patient information platforms in relation to Sepsis and Marthas Rule.
- Demonstrated assurance of equity of access relating to the Martha's Rule pathway in children and achieved a 30% increase in the number of parents reporting they felt listened to during their child's inpatient stay.
- Consistently reviewed performance of escalation and management of the deteriorating patient, with clear routes of information sharing created Trust wide. 607 Adult patients received rapid reviews for deterioration within this period.
- Launched Marthas Rule and evaluated the implementation to inform shared learning, continuous improvement and embed this service.
- Worked closely with women's services to provide rapid reviews for the deteriorating pregnant patient.

Aims for 2026/27

- Support the role out of National Maternity Early Warning System (MEWS) for all pregnant patients.
- Implement National PEWS digitally within Leeds Children's Hospital.
- Implement all components of Marthas Rule at our peripheral sites and Women's services and create a clear pathway of escalation for patients within our Emergency Departments.
- Monitor and benchmark progress according to the Deteriorating Child key performance indicators and develop ward-based metrics for adults using the RISE accreditation scheme.
- Launch an electronic sepsis screening and management tool for both Children's and Adults.

3.3.2.2 Reduction in the Incidence of Falls and Harm sustained by patients following a fall

Patient falls remain one of the most significant safety concerns at the Trust, with a profound impact on patient outcomes and overall care quality.

Mid Quarter 4, the Trust is 14.5% above trajectory for falls and in comparison, to the same time period last year, a 9% increase in falls per 1000 bed days.

Falls prevention continues to be a primary patient safety focus for the organisation, with the aim to reduce our rate of falls, and continue our improvement journey.

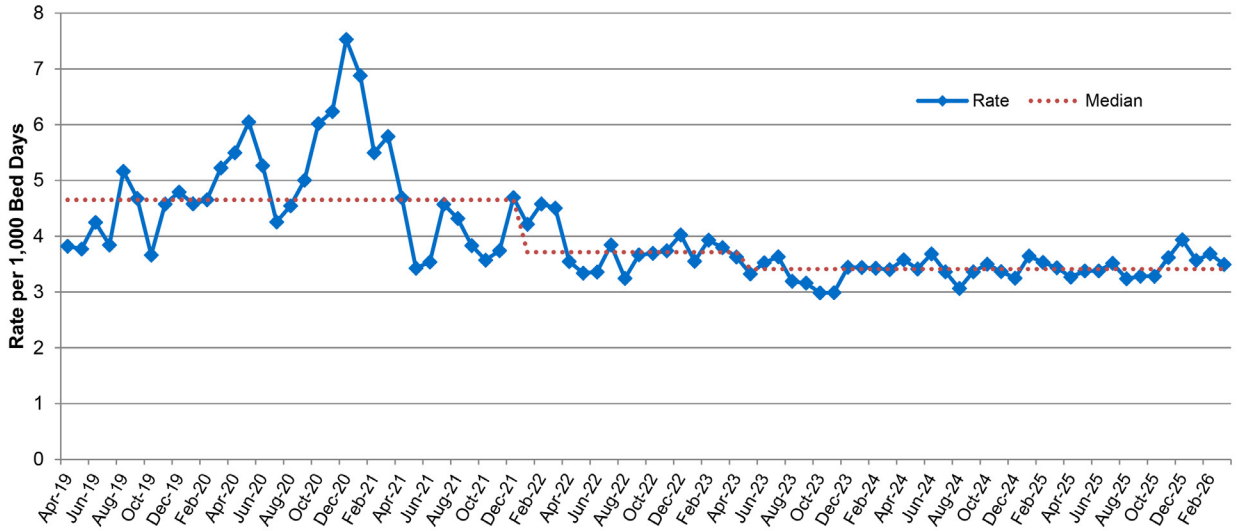
Key Achievements in 2025/26

- The process for investigating falls and sharing the learning across the Trust has been improved through the Patient Safety Incident Response Framework. It is now embedded across the Trust, strengthening safety culture and focusing on continuous improvement.
- New falls rescue kits are now available across all hospital sites.
- The falls team have worked collaboratively with individual areas providing bespoke support and targeted education with excellent feedback from clinical areas.
- A drive towards quality improvement in falls reduction through the revamp and re-launch of the Falls Champion training program. This refreshed, interactive session is rooted in the Leeds Improvement Method (LIM) and encourages active participation and idea generation.
- A thematic review was conducted that identified key learning and new recommendations to improve falls prevention throughout the Trust.
- The decaffeinated drinks trial initially conducted on two medically optimised discharge wards within Specialty & Integrated Medicine CSU has expanded to include two additional older adult wards within the same CSU and Trauma and Related Services CSU, in collaboration with expert teams.

Aims for 2026/27

- We will work closely with Digital to develop electronic falls documentation aligned to the National Safety Alert.
- We will introduce a subject matter expert led hot debrief and safety sweep to gain immediate safety on wards where falls have occurred. We will work collaboratively with the Patient Safety team to further streamline the investigation process for falls, combining the falls improvement review with the Datix investigation thereby increasing learning from incidents.
- We will pilot an Enhanced Therapeutic Observations and Care (ETOC) team, improving the care for a cohort of patients requiring within arm's reach supervision with the aim of reducing ETOC related falls.
- We will update our falls prevention video to empower our patients to contribute to their own safety, providing education of falls prevention on admission and throughout their stay.

Falls rate per 1000 bed days



3.3.2.3 Pressure Ulcer Prevention

Pressure ulcer prevention continues to be a key patient safety priority for the Trust, with a strong focus on reducing pressure ulcer incidence through ongoing education, training, and awareness for colleagues, patients, and carers.

Throughout 2025/26 we have seen a sustained reduction in hospital-acquired pressure ulcers across the organisation. Despite ongoing operational pressures, we remain under trajectory by 23.5%, supported by targeted quality improvement work, testing of new interventions, and consistent sharing of learning across the Trust.

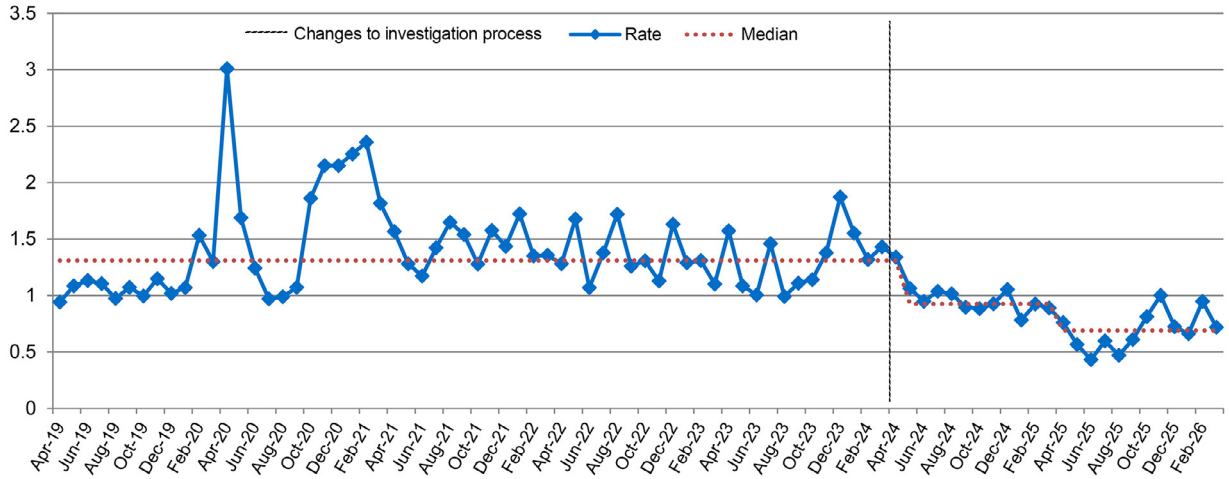
Key Achievements in 2025/26

- The Trust achieved a 23.5% reduction in hospital acquired pressure ulcers, exceeding the 2025/26 agreed 10% reduction target.
- Strengthened the pressure ulcer investigation process, with enhanced use of PSIRF to drive thematic learning and improvement.
- Reduced hospital acquired Category 4 pressure ulcers, with one case recorded in 2025/26 compared to three the previous year.
- Tissue Viability presented quality improvement work at local and national conferences, receiving several awards and nominations.
- Delivered a successful "Stop the Pressure" event in November 2025 as part of the national awareness campaign.
- Implementation of the Purpose T risk assessment standard for use on admission and transfer across LTHT.
- Delivered focused pressure ulcer training via Trust-wide study days, ward-based bespoke sessions, and shadowing to support embedding of good practice. In Q4, following ward feedback, the new 'Wound Wagon' model was introduced to provide flexible, bite-sized ward-level teaching with minimal disruption to clinical duties.
- Continued work to ensure every ward has dedicated Tissue Viability Link Practitioners.
- Successfully recruited over 90 patients to the Pressure III Trial, researching how to improve the care of patients with a fractured neck of femur in preventing pressure ulcers.

Aims for 2026/27

- Set and achieve a further reduction trajectory for hospital-acquired pressure ulcers across the Trust.
- Continue collaborative work with DIT to prepare Pressure Ulcer Prevention documentation for digitisation, including pressure ulcer prevention and wound care plans.
- Hold a "Stop the Pressure" week in 2026 to continue raising awareness of prevention.
- Work with the Patient Safety Team to streamline the pressure ulcer investigation process, integrating review documentation into Datix to create a single, centralised platform that enhances efficiency and access to learning, themes, and emerging trends.

Developed Pressure Ulcer rate per 1,000 bed days



3.3.2.4 Reducing rates of Healthcare Associated Infections (HCAI)

Background

The reduction of healthcare associated infections (HCAIs) remains a key priority; our annual plan and the Infection Prevention and Control (IPC) board assurance framework continues to reflect the actions and key work streams required to deliver reduction. Antimicrobial resistance (AMR) is a growing threat to health and impedes the safe provision of all healthcare services. The number of AMR infections has increased in Leeds over recent years, in line with the rest of the UK. The Chief Medical Officer as Director of Infection Prevention and Control leads a diverse programme of improvement to ensure the Trust is providing the best leadership, education, laboratory support, guidance and infection prevention practices to keep patients safe from AMR.

Key Achievements in 2025/26

- A patient partner became a core member of the Infection Prevention and Control Sub-Committee to provide a patient's perspective to the IPC decision making process.
- CSU's have identified themes and risks drawn from an established HCAI specialist review aligned to the Patient Safety Incident response framework - (PSIRF) resulting in actions and improvement projects.
- A HCAI Improvement Group has been launched to provide a forum for CSUs to share their learning and support Trust wide improvements.
- Launch of 'antimicrobial guidance for children and neonates' on the Eolas platform, providing rapid access to diagnostic infection advice and antimicrobial treatment at the touch of a button. This complements the 'adult antimicrobial guidance', where additional guidance on infection prevention, high consequence infectious diseases and prescribing advice is now also available.
- Careful use of antimicrobials is an essential aspect to controlling AMR and our approach to monitoring the safe use of antibiotics known as '#CARES' is an important element supporting timely reviews.
- Antimicrobial-resistant (AMR) bacteria can persist in wastewater systems, posing a risk to vulnerable patients, particularly those in intensive care and those who are immunosuppressed. IPC interventions help reduce this risk. The Trust continues to pioneer 'water safe care' through a multidisciplinary approach supported by the Trust Water Safety Group.
- The Trust has shared its work on water safety with NHS England and the New Hospitals Programme. As a result, the educational resources and practical interventions developed in Leeds will be used to inform upcoming national guidance.

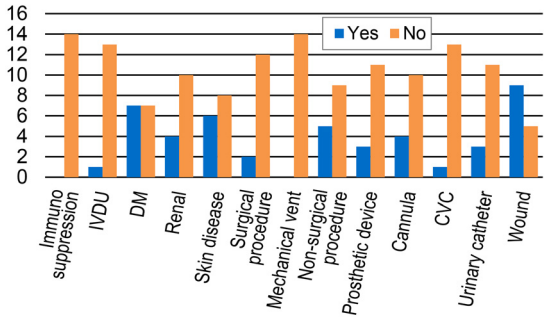
Scrub away Staph-A

In response to an increase in meticillin-sensitive and meticillin-resistant *Staphylococcus aureus* (MSSA and MRSA) bloodstream infections, detailed analysis identified a number of key risk factors. The Infection Prevention and Control (IPC) team subsequently implemented a targeted awareness campaign focused on three priority areas:

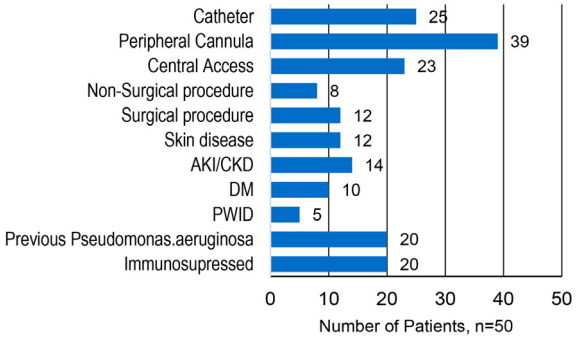
- Being Hands Ready
- Devices
- Decolonisation

In addition, a detailed review of *Pseudomonas* bloodstream infection cases identified invasive devices - particularly cannulae and urinary catheters - as the highest risk factors, requiring further targeted intervention.

Risk factors for MRSA



Risk factors in patients who tested positive for Pseudomonas.aeruginosa at LTHT 2025



Aims for 2026/27

- Deliver an IPC Strategy to provide a framework to respond to the continued threat from AMR.
- Provide further focused work reducing healthcare inequalities for patients attending LTHT.
- Develop a Trust wide urinary device group to provide speciality specific interventions that reduce infection in the urinary tract.
- Promote water safe care expansion.

3.3.2.5 Care With Medicines

Background

We aim to optimise the use of medicines for each patient, recognising individual needs and circumstances. Our goal is to ensure that medicines are used in a way that supports patients to improve and maintain their health. We are exploring a range of approaches to consistently involve patients and their families in decisions about their care and treatment. Achieving this will improve patient outcomes while also reducing medicines waste.

Key Achievements in 2025/26

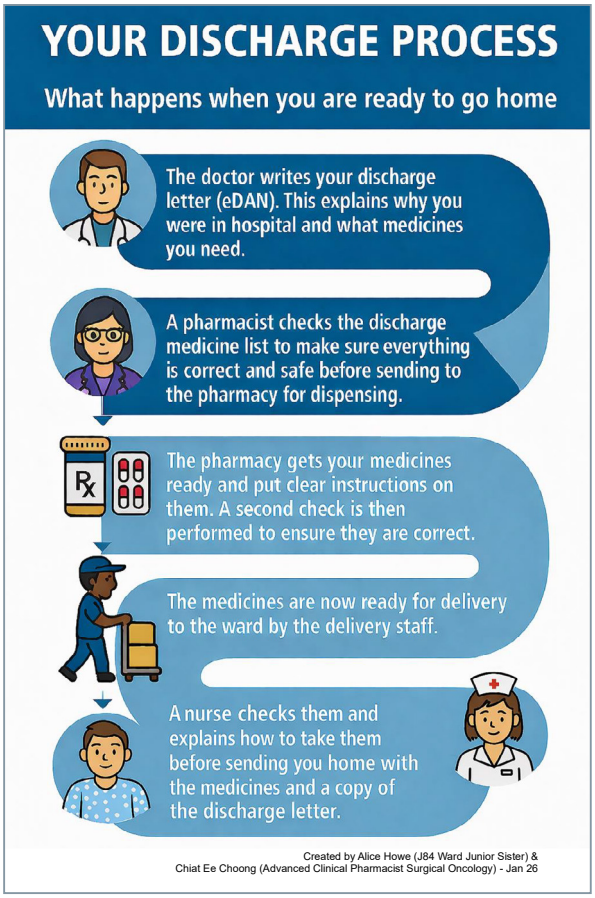
We aim to ensure pharmacy teams are always available to patients who want to talk about their medicines. We have worked with older patients and their families to review their medicines as part of a research study. CHARMER (Comprehensive Geriatrician-led Medication Review - CHARMER Study) is a 6-year England-wide research project to develop and test an approach that enables conversations with patients about stopping medicines that are no longer useful or could be harmful. Over a 13-week period on 2 wards 1110 medicines were stopped. We have also introduced a collaborative review of medicines for older people who have been admitted after a fall. Over a 6-week period we reviewed 106 patients and stopped or reduced the dose of medicines that increase the risk of falls in 48% of those patients.

We have continued to expand the use of referrals to community pharmacy services after discharge to enable patients to access different types of medicines support when they leave hospital. This is well established for patients being discharged from our adult medical beds, and we recognise there are opportunities to increase community pharmacy referrals for other specialties and in our children's hospital. This video explains how the service works: Mo's Medicines: from Hospital to Home

We are always looking for ways to reduce waste and support sustainable medicines use. We have established an inhaler recycling scheme, which collects unwanted inhalers to ensure they are disposed of safely. The propellants are recycled for use in refrigeration and air conditioning systems. Between April 2024 and November 2025 (20 months) we collected 4,011 inhalers with an estimated carbon footprint of 21,719,831 gCO2e.

Aims for 2026/27

- We aim to ensure pharmacy teams are always available to patients who want to talk about their medicines. This year we are focussing on colleagues in training to equip them with the skills they need to have better conversations with patients and their families.
- We want to support patients to self-administer their medicines while in hospital. We plan to launch a project to investigate how self-administration of medicines can be enabled across the Trust.
- We are working to improve the information available to inpatients about how their discharge medicines are prepared.
- We are consulting with third party providers to enable patients' access to treatments nearer to home and to improve options for the delivery of medicines prescribed in outpatient clinics across all parts of the Trust.



3.3.2.6 Positive Patient Identification

Background

Patient Identification is a known contributory factor in patient safety events, resulting in some patients receiving medications and tests that were not meant for them.

An improvement group is in place focusing on supporting Positive Patient Identification across the Trust through small tests of change and improvement projects.

Areas of focus remian in place for:

- Wristbands
- Initial Patient Identification checks
- Empowering colleagues to raise concerns about patient identification
- Patient Information and raising concerns
- Culture change of not referring to patients by bed numbers or identification numbers
- Utilisation of systems such as Scan for Safety
- Education and Training of our workforce.

Key Achievements in 2025/26

- One of the aims for this year was to launch "Name not a Bed Number" campaign on a ward and test before rolling out. Due to organisational changes we have not achieved it within this year, but intend to carry this forwards to 2026/27.
- Work is continuing to explore how patients are identified from a pharmacy and out-patient perspective to enable greater understanding of how the "Name not a Number" campaign can be adapted to these areas.
- An easy-read leaflet has been published for Positive Patient Identification which is accessible on the Trust website.
- Positive Patient identification is incorporated into the Patient Safety training for Introduction to Professional Practice and New to Care educational programmes.
- Carried out an idea's generation session with group members to establish the possibilities of what can be achieved over the next year.
- Created a Microsoft Teams space to enable sharing of resources and recording of actions.
- Additional questions added to Friends and Family Test during February 2026 to gain insight and feedback on positive patient identification.

Aims for 2026/27

- Test the "Name not a Bed Number campaign on a test ward and evaluate the impact.
- Continue to explore how Scan for Safety technology can improve positive patient identification.
- Gain insight into how and who applies wristbands to patients.
- Revise the Positive Patient Identification Policy focusing on work as done.

3.3.2.7 Nutrition Mission

Background

Launched in November 2023, the Nutrition Mission aims to provide outstanding nutrition and hydration care to every patient every time. Good nutrition and hydration play a vital role in patient recovery, reducing harm and length of stay.

Throughout 2025/2026, the Mission has continued to take a collaborative approach, supporting colleagues to drive improvement in their areas. Our strong multidisciplinary team, including colleagues from all roles across the Trust, is actively testing and implementing innovative interventions to enhance nutrition and hydration care for all patients.

Key Achievements in 2025/26

- Finalists in the HSJ patient Safety awards 2025.
- We continue to support sustained Improvements in the overall Ward Metrics in relation to Nutrition and Hydration.
- Our metrics have been piloted through the local ward accreditation program and our own accreditation continues.
- We have finalised the LTHT Food and Drink strategy.
- Our Adult and Children Nutrition and Hydration Standards have been updated.
- We have established priority training for swallow awareness across LTHT for registered nurses.
- Funding was sourced to begin roll out of standard cups and beakers.
- J15 won an internal SHINE award for their new meal service delivery QI project (which is rolling out across CSU'S) and were finalists in PENNA (Patient Experience Network National Awards).
- On the back of patient feedback, we have introduced and are increasing meal mate volunteers.
- We have finalised assessments and care plans ready for digitalisation.

Aims for 2026/27

- We will continue to target and improve nutrition and hydration care metrics and our improvement journey.
- We continue to increase the number of areas accredited.
- In the collaborative we are focusing on the role of the mealtime champion.
- We will launch the Food and Drink strategy and progress the actions we have set ourselves.
- Continue to support Nutrition and Hydration week to engage with all colleagues.
- Continue standardisation of the Safety huddles including Nutrition and Hydration.
- Launch our updated dysphagia and thickener polices.
- The new electronic ordering system will roll out next to patients.
- Continue to embed "its everyone's business".

3.3.2.8 Dementia

Background

Supporting people with significant memory problems or dementia remains a Trust priority. The Dementia Steering Group, established in 2010 and made up of clinical leads, dementia champions, external partners and dementia focused teams have continued to drive improvements throughout 2025/26.

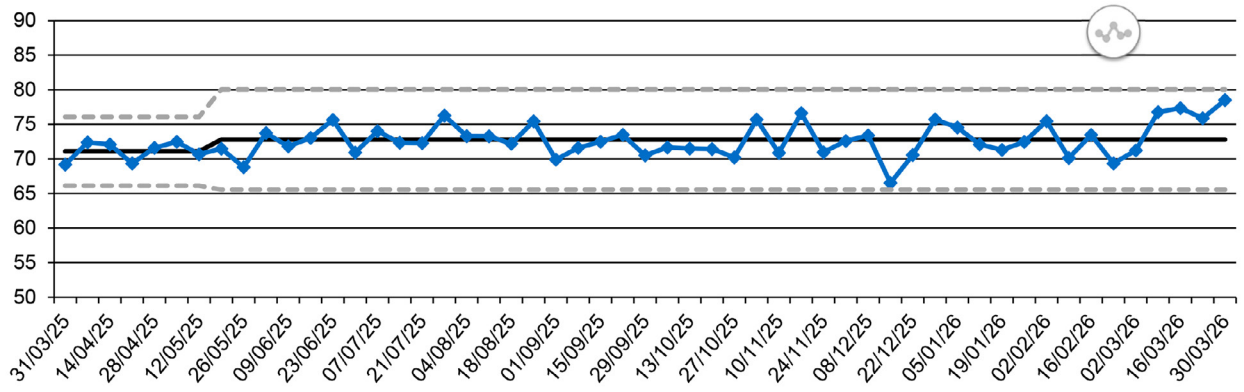
Key Achievements in 2025/26

- Focused face-to-face training continues to be delivered through a multidisciplinary approach and in collaboration with external stakeholders
- Colleagues, patients, and the public including our Patient Reference Group are contributing to the renewal of our Dementia Strategy.
- Since launching our delirium strategy in 2023, compliance with the 4AT (a rapid, validated, bedside screening tool designed to detect delirium and severe cognitive impairment in under 2 minute) and Delirium Care Plan has increased, with overall CSU compliance at 70% for 4AT and 70.1% for care plan use (nursing metrics).
- 88% of colleagues in 2025 reported feeling confident in recognising delirium, up from 49% just 18 months earlier.
- We continue to collaborate with the Centre for Dementia Research at Leeds Beckett University, contributing to national studies including research on outpatient experience.
- A 'Know Who I Am' personalised document has been developed by the Dementia Steering Group and launched for use across Outpatients and departments.
- Pain, Deteriorating Patient and DIT teams are improving recognition of pain in people with dementia who are unable to verbalise it.
- Members of the Leeds Age Friendly Steering Group visited St James in February 2026 and completed a dementia and age -friendly review.
- Our PLACE (Patient- Led Assessments of the Care Environment) dementia score remains strong and above the national average at 90%.
- We launched our Frailty Strategy in October 2025 which will also benefit people with dementia.
- Audits of delirium care plan quality and dementia care have been completed to identify good practice and areas for improvement.

Aims for 2026/27

- Launch a new 3-year Dementia Strategy, aligned with Leeds Dementia strategy.
- Roll out dementia e-learning as a priority training requirement.
- Participate in the National Audit of Dementia, including the annual census and continuous patient/carer survey feedback over nine months.
- Continue embedding our delirium strategy and submit it for publication in the Age and Ageing Society Journal.
- Launch our Outpatient Standard on Leeds Health Pathways.
- Commence pilot of the 'Forget Me Not' visual identifiers and care resource bags in Emergency Departments.
- Act on recommendations from the Age Friendly Steering Group environmental review.
- Embed the use of Inpatient 'Forget Me Not' identifier and 'This is Me' (personalised care document) within RISE accreditation.

Percentage of over 65s admissions with a 4AT form



3.3.3 Measuring Improvement

We measure improvement using national indicators and standards to benchmark Trust performance and patient outcomes against peers. We triangulate internal and external data to gain a comprehensive understanding of outcomes and to identify areas for improvement, including metrics such as the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI).

We also monitor performance against constitutional standards, with a focus on patient safety for those waiting for treatment and the actions required to support their health and wellbeing.

3.3.3.1 Hospital Mortality

Background

There are two national Trust-level mortality indicators: The Summary Hospital-level Mortality Indicator (SHMI) produced and published by NHS Digital and the Hospital Standardised Mortality Ratio (HSMR). Healthcare Evaluation Data (HED) publishes Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality (SHMI) in their own modules as well as other mortality measures within the dashboard.

Both SHMI and HSMR compare the number of observed deaths at the Trust against a risk adjusted expected number of deaths. Neither adjusts for the severity of patient's illness.

During 2025/26, the Trust continued to strengthen its approach to understanding mortality and learning from deaths, building on the foundations of the digital developments introduced in previous years.

Following the introduction of the in house Structured Judgement Review (SJR) tool in 2023/24 and further embedding of the digital mortality processes in 2024/25, this year was marked by a focus on improving data insight, strengthening analytical capability, and commissioning an independent review of the Mortality Framework.

Key Achievements in 2025/26

Strengthening Digital Insight and Mortality Analytics

A significant development in 2025/26 was the procurement of Healthcare Evaluation Data (HED) - an NHS developed national benchmarking and performance analytics platform created by University Hospitals Birmingham (UHB). HED provides monthly updated mortality indicators, clinical quality dashboards, access to multiple national datasets and the functionality to establish automated mortality alerts, benchmarks against peers, and generates specialty level insights to support CSU discussions and governance processes.

During the year, colleagues across Quality Governance, Mortality, and Analytical teams completed training and onboarding sessions with HED to familiarise themselves with the platform's dashboards, reporting tools and alerting mechanisms. Work has now begun to define local mortality reporting methods, thresholds and triggers for escalation alerts and incorporating HED outputs into CSU level and Trust level oversight

This forms a key component of strengthening data driven mortality oversight for 2026/27.

Ongoing Use of Internal Digital Systems

The Trust continued to use the internal SJR tool and PPM+ mortality screening data to support case record review processes. While coverage and usage remain variable across specialties, also noted in the internal audit findings, the in house tool continues to provide a valuable dataset for understanding review outcomes, care scores and themes.

SHMI and HSMR remained an important part of mortality surveillance, alongside detailed case based reviews. In the most recent published period (October 2024–September 2025), the Trust's SHMI remained within the 'as expected' range.

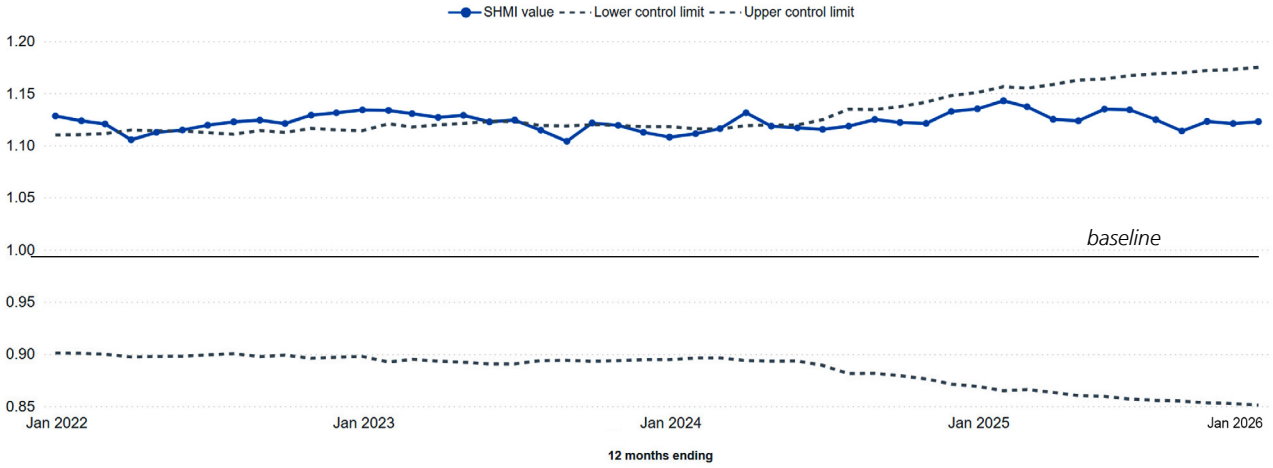
Trust SHMI, HSMR and SMR

Trust level mortality, Nov-24 to Oct-25	Spells	Value	Observed Deaths	Expected Deaths	95% Confidence Interval
SHMI	102,320	1.121	4,000	3,565	0.8526-1.1729
HSMR	62, 030	113.81	2254	1980.54	118.61-109.16

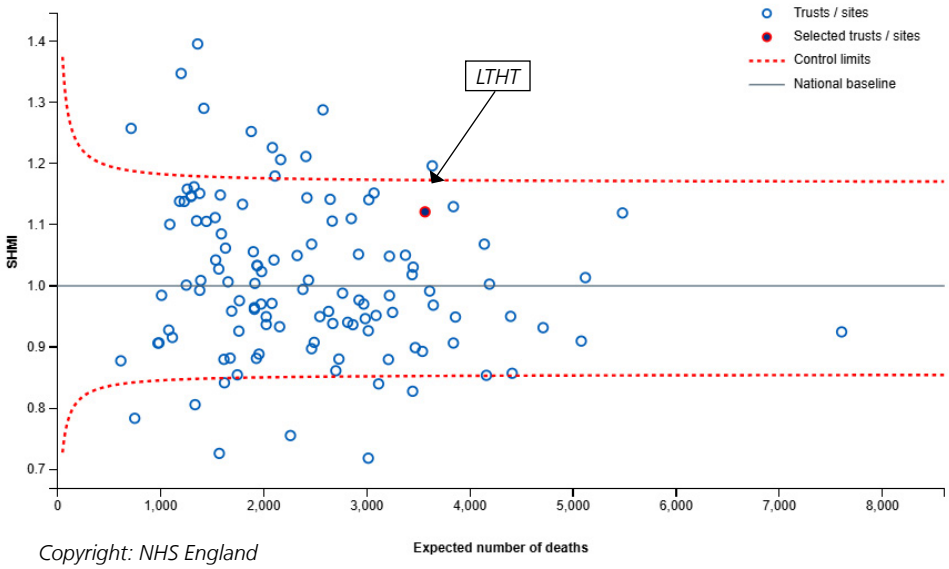
SHMI Indicator by rolling 12 month reporting period

Month of Publication	Reporting Period	Trust Rate	National Range
Apr-25	Dec-23-Nov-24	113.26	0.72-1.27
May-25	Jan-24-Dec-24	113.51	0.72-1.35
Jun-25	Feb-24-Jan-25	114.28	0.70-1.28
Jul-25	Mar-24-Feb-25	113.71	0.71-1.34
Aug-25	Apr-24-Mar-25	112.5	0.70-1.33
Sep-25	May-24-Apr-25	112.36	0.72-1.31
Oct-25	Jun-24-May-25	113.48	0.71-1.27
Nov-25	Jul-24-Jun-25	113.42	0.72-1.26
Dec-25	Aug-24-Jul-25	112.47	0.71-1.28
Jan-26	Sep-24-Aug-25	111.37	0.72-1.40
Feb-26	Oct-24-Sep-25	112.3	0.72-1.34
Mar-26	Nov-24-Oct-25	112.1	0.71-1.36

SHMI Trend - Rolling 12 month SHMI Value at Leeds Teaching Hospitals NHS Trust over time



SHMI Funnel Plot all diagnosis groups November 2024 – October 2025



Commissioning of an Independent Internal Audit Review (2025/26)

In 2025/26, the Trust commissioned PwC to undertake an independent internal audit review of the Mortality Framework, with a focus on Structured Judgement Reviews, assurance mechanisms, and the governance of learning from deaths.

The audit highlighted a variability in SJR tool usage and access to training, in addition to the need to strengthen discussion and follow up of learning and improvement action.

The review also recognised examples of good practice, including strong specialty level action tracking, embedded mortality governance structures, and established arrangements for screening deaths.

In response to the audit findings the Trust has developed a Mortality Improvement Plan which is being overseen by the Quality Assurance Committee.

Learning From Deaths

Identification of good practice and areas for improvement in care following a patient's death are an integral element of the mortality process within LTHT. Information from the Mortality Screening Tool and the Medical Examiner service were used to select cases for SJRs. The learning from SJRs and Patient Safety Investigations were reported in the quarterly Learning From Deaths reports.

Aims for 2026/27

To address the findings of the internal audit report and learning identified through the Mortality Improvement Group, the Trust has developed and commenced a Mortality Framework Improvement Plan. The plan will remain dynamic and will be developed further as actions progress and new priorities emerge. Key areas for improvement are:

- Mandate use of the SJR online tool and review requirements for enhancements to the SJR online tool.
- Align the SJR process, method of recording outcome and escalation process with PSRIF and strengthen integration into the Trust patient safety event processes.
- Develop standardised processes for outcome statements and action recording.
- Review monitoring and reporting arrangements to provide clearer visibility of SJR completion, quality of care and, where required, action.
- Develop and establish a formal SJR training programme aligned to national expectations.
- Integrate HED mortality analytics into routine assurance and CSU governance.

This work will ensure the Trust continues to strengthen its approach to learning from deaths, improves consistency in mortality review practice, and enhances confidence in mortality data and oversight.

Medical Examiner

Background

The Trust implemented the Medical Examiner Service in February 2021, and the system became statutory in September 2024. We now have an established team of 18 medical examiners who work on a sessional / part-time basis. This includes hospital consultants and general practitioners from a range of specialties to provide a breadth of clinical experience and expertise. Medical examiners are supported by 6 medical examiner officers. The service is integral to the Trust, serving as a key component of the patient safety, governance, and the learning from deaths framework. All deaths that are not investigated by a coroner are subject to mandatory independent scrutiny. Their aim is to help improve quality by providing, from an independent perspective, a review of care and engagement with the next of kin, allowing them to ask questions and raise concerns about care.

The medical examiner service helps the Trust improve quality by:

- providing greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths;
- ensures the appropriate direction of deaths to the coroner;
- provides the bereaved with an opportunity to ask questions and raise any concerns to someone not involved in the care of the deceased;
- improves the quality of death certification;
- improves the quality of mortality data.

Key Achievements in 2025/26

Since the service became statutory in England and Wales, the Leeds Medical Examiner office has scrutinised 100% of all non-coronial deaths within primary and secondary care (neonatal/paediatric/adults). Following scrutiny, the medical examiner may identify cases that require further investigation and recommend a further review by the most appropriate governance process such as a Structured Judgement Review (SJR). This further helps identify organisational learning and improvement opportunities within the organisation responsible for patient care.

Summary of medical examiner activity

	Number of Cases Referred
Clinical Governance issues detected at LTHT - Number of deaths where medical examiner recommend case record reviews (e.g. structured judgement review or equivalent) at host organisation for the medical examiner office, by category	
a) Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers	19
b) Deaths where a significant concern about the quality of care provided is raised by medical examiner or staff	20
c) Deaths of those with learning disabilities and with severe mental illness	1
d) Deaths in a service speciality, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means	0
e) Deaths in areas where people are not expected to die, for example in relevant elective procedures	2
f) Deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis or end of life care	7
Clinical governance issues detected at other healthcare providers - Number of deaths where medical examiners recommend case record reviews (e.g. structured judgement review or equivalent) at other organisations:	
a) Other NHS acute hospital/trust	1
b) NHS mental health trust or provider	1
c) NHS Ambulance Service	0
d) GPs and Primary Care	0
e) Independent Provider	1
f) Other provider not included in (a) to (e)	1
Deaths referred by the medical examiner office to other clinical governance processes for review not covered in 10 and 11 (for example safeguarding or mortality and morbidity (M&M) meetings)	75
Number of Patient Safety Incidents notified by medical examiner office as a result of scrutiny	15
Number of cases referred to Patient Advice and Liaison Service or equivalent by medical examiner office	0

Aims for 2026/27

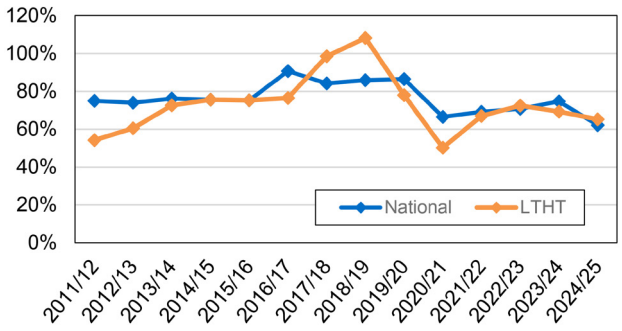
To ensure that the voices and experiences of carers, relatives and colleagues are actively sought following the death of a patient, in order to maximise learning, identify necessary actions and to improve on good practice.

3.3.3.2 Patient Reported Outcome Measures

Patients undergoing elective inpatient surgery for hip and knee replacement, funded by the English NHS are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves. This publication is for Finalised Patient Reported Outcome Measures (PROMs) in England - April 2024 to March 2025.

Trust participation rates for hip and knee replacement are in line with the national average.

Pre-Operative Participation Rates (PROMs) - all procedures



Source: NHS Digital; 2024/2025

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 with the expected range across the various procedures.

PROMs Scores - Casemix-adjusted average Health Gain - April 2024 to March 2025

Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	805	500	62.1%	414	82.8%
Hip Replacement	374	235	62.8%	195	83.0%
of which[1]					
Primary	322	180	1	180	1
Revision	52	15	0	15	1
Knee Replacement	431	265	61.5%	219	82.6%
of which[1]					
Primary	365	200	1	200	1
Revision	66	19	0	19	1

Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	500	464	92.8%	238	51.3%
Hip Replacement	235	219	93.2%	107	48.9%
of which					
Primary	180	171	1	91	1
Revision	15	15	1	5	0
Knee Replacement	265	245	92.5%	131	53.5%
of which					
Primary	200	188	1	98	1
Revision	19	18	1	11	1

1. Only procedures that can be linked to an eligible hospital procedure can be split between a primary and revision procedure.

3.3.3.3 Venous Thromboembolism (VTE)

Background

Patients admitted to hospital face a significantly elevated risk of Venous Thromboembolism (VTE) comprising deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is a leading cause of preventable in-hospital death. Hospital-associated thrombosis (HAT) accounts for 50%-60% of all venous thromboembolism.

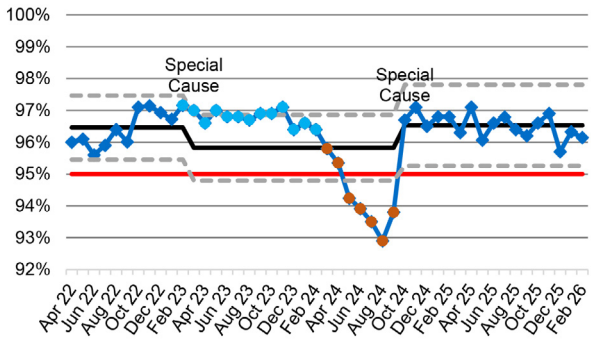
HAT is defined as VTE occurring during a hospital stay (after the first 72 hours of admission have passed) or within 90 days of hospital admission. Prevention and management are key in morbidity and mortality hospital associated thrombosis.

Completion of a VTE risk assessment form, and acting on decisions regarding safe modality of VTE prevention (pharmacological or non-pharmacological) for all adult patients from 16 years of age within 14 hours of admission, timely administration of pharmacological prophylaxis and accurate assessment and appropriate management of post discharge VTE risk, are all factors that contribute to prevention and reducing the incidence of HAT.

Key Achievements in 2025/26

- The completion of VTE risk assessments continues to be achieved above 95% trust wide.
- Antenatal/postnatal and children's 13-15 years VTE risk assessment forms have been designed and imminently ready to go live on the electronic patient records.
- Education sessions have been delivered by the VTE service to increase knowledge and awareness through presentations at trust wide patient safety groups.
- The process for investigating Hospital Associated Thrombosis continues to be reviewed to ensure alignment with the Patient Safety Incident Response Framework (PSIRF) by completing HAT specialist reviews.
- Collaboration strives to ensure learning is shared in trust wide patient safety groups such as the Patient Safety Ambassador Network.
- The VTE service continues towards completion of all criteria required to apply for external accreditation to become a VTE Exemplar centre and to demonstrate provision of a high-quality service to patients and commissioners and recognition of excellence in VTE prevention.

VTE compliance of risk assessments in LTHT



Aims for 2026/27

- Continue to work with individual Clinical Service Units to enable all CSUs to achieve compliance of VTE risk assessment above the Trust target of 95%.
- Embed the antenatal/postnatal and children's VTE risk assessments to the electronic patient records system.
- Continue to review and monitor the specialist review process for Hospital Associated Thrombosis with clinicians and implement improvements with DIT to ensure optimal learning from events.
- Collaborate with sub- specialties within LTHT and national VTE services to share learning across all CSUs.
- Implement VTE champions across LTHT to promote education/learning, to include all Healthcare Professionals to drive VTE management and prevention for all patients in hospital and post discharge.
- Strive for VTE exemplar status and work towards submitting a successful application for LTHT, to showcase a high quality service and excellence in VTE prevention.

3.3.3.4 Participation in Clinical Research

Background

The Trust has a strong and growing commitment to research and innovation as a core contributor to the quality, safety and effectiveness of patient care. The Trust's Research and Innovation Strategy 2025–2030 sets out a clear ambition to embed research and innovation into everyday clinical practice, ensuring that every patient and colleague across the Trust is able to participate in and benefit from, high-quality research activity.

Evidence consistently demonstrates that research-active NHS organisations deliver better patient outcomes and improved quality of care. The role of the Research and Innovation service is to provide the governance, infrastructure and specialist support required to enable safe, efficient and inclusive research delivery, supporting CSUs to translate research evidence and innovation into measurable improvements in patient care and experience.

Key Achievements in 2025/26

In July 2025, we published our new five-year strategy, a bold and ambitious roadmap that builds on our strong foundation and sets out a clear vision for the future. It outlines how we will develop a supportive, inclusive research culture, embed research and innovation into everyday clinical practice, harness the power of data, AI and diagnostics, and make Leeds a true testbed for new ideas and technologies.

We held our fourth annual Research and Innovation Conference 'Shaping Future Healthcare' which was attended by over 400 colleagues, partners, innovators and clinicians from across Leeds and beyond. We were proud to host over 70 expert speakers across research, healthcare, academia and industry, showcasing innovation, impact, and collaboration right across healthcare.

In November we announced that we are a key partner in the launch of a new £2 million Health Innovation Leeds Incubator, a collaborative initiative designed to accelerate growth of healthtech businesses in the region. Funded by the West Yorkshire Healthtech Investment Zone, the new Incubator will enable us to expand the Innovation Pop-Up to connect even more pioneering businesses with clinicians.

We continue to be recognised for our innovations in patient treatment. We became the first Trust outside London to use robotic technology for minimally invasive liver and kidney cancer treatment, using the Epione system. This new robotic guidance system is enabling precise, minimally-invasive CT-guided ablation of tumours, allowing clinicians to accurately locate and destroy cancerous tissue without the need for traditional surgery.

We have introduced a new AI pilot "one stop shop" to speed up prostate cancer diagnosis, which could save some men up to a month of waiting. Through the pilot, men will be called for an MRI scan and this will be reviewed by Lucida Medical's Pi™ AI Technology. If a scan is found to have a high-risk of cancer, a biopsy will take place on the same day, removing the waiting time between appointments which can often cause distress and anxiety.

We are the lead site in a pioneering new research study aimed at improving the detection and prevention of childhood lead exposure. The Elevated Childhood Lead Interagency Prevalence Study (ECLIPS) is co-led by Northumbria University, the UK Health Security Agency (UKHSA) and LTHT. The study will test an innovative home-testing approach that could transform how lead exposure in young children is monitored nationwide. It builds on ongoing work to raise awareness of the risks associated with lead exposure.

We will continue to work towards integrating research and innovation within everyday clinical practice processes and will be introducing initiatives across the Trust to drive further integration between IT systems to ensure that clinical research data is shared effectively across departments.

Research and Innovation has continued to foster collaboration, academic excellence and encourage colleagues to become research active. During the year 25/26, 32 colleagues have applied for prestigious academic fellowship awards. These colleagues are from a wide range of professional disciplines (Doctors, nurses, AHPs, healthcare scientists and pharmacists). Furthermore, in collaboration with our academic partner institutions LTHT have supported more than 50 research grant applications from multi professional disciplines. These applications give colleagues protected time to develop their research careers and contribute to the evidence base that improves the care the we give our patients.

Our 2025/26 Leeds Patient and Public Involvement and Engagement (PPIE) priority focused on underserved communities. We delivered 24 outreach events, engaging 657 people new to research/PPIE, and held 12 group sessions with 145 attendees across Prostate Cancer, Lung Cancer and Antimicrobial Resistance. Several participants progressed to active PPIE roles, supporting grants, joining steering committees, and presenting at the UKCRF Conference.

Our RIDERS service for commercial partners continued to grow, with 16 studies completing pre-HRA reviews involving 31 PPI members. Feedback was provided in writing or through focus groups, with members reviewing patient-facing documents to ensure they were accessible, clear and patient-centred.

Aims for 2026/27

Our five-year Research and Innovation (R&I) strategy sets out ambitions to embed research across every Trust department to improve patient care. We will continue engaging colleagues and launch a new internal communications programme to support involvement in research across all roles.

Our 2025–30 targets will guide our priorities:

- Recruit 100,000 research participants
- Generate £140m in R&I income
- Collect 150 colleague R&I ideas
- Train 1,250 colleagues in R&I practice
- Form 10 strategic industry partnerships
- Deliver 1,250 new R&I projects
- Support 1,000 people annually in PPI

In July 2026, we will host our annual conference, Tomorrow's Healthcare Today, with Health Innovation Leeds to showcase best practice and transformation. In 2026, the event will expand further, highlighting citywide collaboration and impact.

We will continue supporting innovation through initiatives such as Innovation Pop Up and development of the Old Medical School with Scarborough Group International, creating a healthtech hub and advancing the Innovation Village.

We will also strengthen collaboration with academic, NHS and industry partners to deliver world-leading research and innovation that benefits the region's health and economy.

3.3.3.5 Trust Participation in NCEPOD

Background

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) supports NHS care quality through outcome reviews. The Trust process is coordinated via Quality Governance to ensure study participation, timely data submission, and response oversight. Learning is shared to inform evaluation, improve practice, and enhance patient safety.

Key Achievements in 2025/26

- Participated in all NCEPOD studied that we were eligible to participate in.
- Improved clinician questionnaire completion rates.

NCEPOD Studies Participated In 2025-2026

NCEPOD Study
Acute Limb Ischaemia (2025)
Acute illness in people with a learning disability (2025)
Blood sodium (2025)
Emergency surgery in children and young people (2025)
Rehabilitation following critical illness (2025)

Study Participation		
Metric	**2024/25**	**2025/26**
NCEPOD studies participated in	4	5
Applicable studies completed	100%	100%
Organisational questionnaires submitted	6	7

Questionnaire Completion		
Metric	**2024/25**	**2025/26**
Clinician questionnaires completed	≥85%	82%
Organisational questionnaires completed	100%	100%

Aims for 2026/27

Our aims are to:

- Further improve clinician completion rates, targeting an overall completion rate of at least 85% by 31 March 2027.
- Improve timeliness, with at least 90% of questionnaires submitted before the deadline by March 2027.
- In addition, we will work to eliminate long-outstanding questionnaires, with a target of zero questionnaires more than 21 days overdue by December 2026.

3.3.3.6 Participation in Local and National Clinical Audit

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 (CSUs) by the Clinical Director and Head of Nursing supported by the Clinical Audit Leads in each specialty.

Key Achievements in 2025/26

Review of the Trust Mandatory Audit Programme

Over the past year, the Trust has significantly strengthened its Clinical Audit for Improvement Programme by embedding a full audit-cycle approach that enhances consistency, accountability, and measurable change across services. The programme was streamlined to focus on audits with clear clinical ownership, robust standards, and defined governance routes, removing activity that did not drive improvement. New data collection windows and quarterly audit phases improved planning, timeliness and follow-through, supported by clearer escalation processes for non-participation. Clinical leadership and governance oversight were strengthened, while refreshed training, improved reporting expectations, and a more structured evaluation process enhanced assurance, learning and the delivery of sustainable improvements across both medical and nursing audits.

Local Project Process Improvement

Separately, the Trust has enhanced its local improvement processes by replacing three separate forms; for audit, quality improvement and service evaluation; with a single unified local project form. This new approach provides clearer signposting to the correct methodology, improved guidance on Information Governance requirements, and better support for selecting appropriate improvement methods. The change has simplified the process for colleagues, reduced duplication and strengthened the quality, consistency and governance of locally delivered improvement work.

Participation in National Audit

The Trust seeks to provide data to all of the Quality Account reportable national audits. This process is being enhanced with a better reporting and escalation through our meeting structure, with early identification of non-submission anticipated. Reports from National Audits are reviewed by the relevant service, whilst identifying whether the Trust is a positive or negative outlier.

Clinical Service Units are invited to regularly report to the Clinical Effectiveness and Outcomes Group to outline their participation in National Audit and subsequent action plans.

Sentinel Stroke National Audit Programme (SSNAP)

During 2024/25, the Trust faced significant challenges in meeting the national SSNAP audit requirements following major changes to the national data-capture process. These changes increased the complexity of data collection, requiring a fully complete dataset for approximately 270–280 patients per quarter, each with over 300 data fields. Technical limitations within internal systems, combined with gaps in form design and inconsistent data entry across specialties, resulted in six consecutive quarters of non-compliance. The Trust has since undertaken extensive remedial work, including developing a hybrid approach to default missing data where appropriate, revising internal forms to address missing or outdated questions, and securing dedicated data entry clerical support. Engagement with nine contributing specialties is ongoing, alongside learning from peer organisations such as Bradford Teaching Hospitals. While full compliance is unlikely in the immediate term, the Trust anticipates improvements once clerical colleagues are in post and trained. Progress is being closely monitored, with enhanced oversight through the Quality Assurance Committe and planned engagement with the National Director for Stroke Services.

National Neonatal Audit Programme Report – NNAP Summary Report 2023 (Published October 2024)

The NNAP Summary Report 2023 outlines performance across key neonatal quality indicators benchmarked against national standards. The service assessed its performance against the national position in several areas.

In response, the service is progressing a range of improvement initiatives. Work is underway to improve data capture for consultant ward rounds, particularly later in the day, alongside engagement with parents to explore virtual attendance options. Quality improvement programmes, including the Bronchopulmonary Dysplasia and preterm optimisation groups, are focusing on increasing the early use of non-invasive respiratory support and other strategies to reduce chronic lung disease. The "Immune Boost" initiative has successfully improved early breastmilk use and is now targeting sustained improvement through to day 14 and discharge, supported by a dedicated breastfeeding lead.

Processes have also been strengthened to improve compliance with Retinopathy of Prematurity screening timelines, including the introduction of structured "screening Tuesdays." Work is ongoing to enhance parental engagement with neonatal follow-up services through improved patient information and physiotherapy-led resources. In parallel, recruitment and training initiatives continue to address nursing workforce gaps, including expansion of Qualified in Specialty (QIS) training.

PICANET STATE OF THE NATIONS REPORT 2024 (Published December 2024)

The PICANET national audit report 2024 highlights the PICU activity, interventions and outcomes delivered on all paediatric intensive care units across the UK.

Improvements in data collection are supporting a better understanding of activity and demand. Quality improvement initiatives remain focused on patient safety, including reducing unplanned extubations and strengthening escalation processes. Efforts to support the outreach team, enhance multidisciplinary collaboration, and improve patient flow are ongoing. In parallel, targeted work on recruitment and retention aims to strengthen the nursing workforce, alongside initiatives to improve culture, communication and colleague experience within PICU.

PICANet monitor mortality in each provider using Risk-adjusted resetting sequential probability ratio test (RSPRT). From August 2024 to November 2024 the rate of mortality in LTHT PICU reached threshold for close monitoring and in November 2024 reached the threshold for internal review. A full review was undertaken and reported to the Quality and Safety Assurance Group and the Quality Assurance Committe which provided an overview of potential causes for increased mortality over this period. It was noted there were no serious patient safety incidents during the period of the review and monitoring of mortality rate over the subsequent year has shown that we remain in the expected range. The Trust will continue to monitor mortality rate to ensure this remains in the acceptable range and continue to monitor a wide range of quality indicators.

Local Audit on Spasticity Management in Neuro-rehabilitation MDT Leeds General Infirmary – compliance against Royal College of Physicians Guidelines, "Spasticity in adults: management using botulinum toxin" (May 2025)

An audit was carried out to ascertain if patients on neurosurgical wards were managed in accordance with the Royal College of Physicians National Guidelines 2016.

Overall, there were opportunities for improvement in the way the MDT worked together in collaboration on patient cases with spasticity, as well as room to implement a robust documentation strategy of patient interventions, plans, goals and review dates. The service took action to improve communication within MDT to provide more timely intervention.

Aims for 2026/27

- The Quality Governance Team to continue to work closely with the Clinical Information and Outcomes Team to strengthen the governance arrangements relating to National Audit participation and assurance, and to use the online Clinical Audit Database to log and monitor these, with input from Information Governance.
- To improve accessibility of reports for specialties and ward areas to better support the 'cycle' of audit for improvement so that evidence based action plans can be developed.
- To continue to develop training options for colleagues using the Clinical Audit Database, and to revise the online e-learning to reflect the improvements to the programme.
- To ensure the timely completion of audit reports to support improvement work
- To focus on supporting services to use the Clinical Audit Database to log and manage their local audits and to monitor the actions and outcomes of these.

National Audit			
Project Name	**Workstream name**	**Provider organisation**	Outcome
BAUS Data & Audit Programme	a) British audit of the investigation and referral of women with recurrent Urinary Tract Infection using recent Guidance (BOOMERANG)	British Association of Urological Surgeons (BAUS)	Compliant
BAUS Data & Audit Programme	b) Evaluating the Management Pathway for sudpected Testicular Cancer referrals (EMPAST)	British Association of Urological Surgeons (BAUS)	Compliant
Breast and Cosmetic Implant Registry		NHS England	Compliant
British Spine Registry		British Spine Registry	Compliant
Case Mix Programme (CMP)		ICNARC	Compliant
Child Health Clinical Outcome Review Programme		NCEPOD	Compliant
CRANE	Cleft registry And Audit Network	Royal College of Surgeons of England	Compliant
Emergency Medicine QIPs	Adolescent Mental Health	Royal College of Emergency Medicine	Compliant
	Care of Older People	Royal College of Emergency Medicine	Compliant
	Mental Health Self Harm	Royal College of Emergency Medicine	Compliant
	Time Critical Medications	Royal College of Emergency Medicine	Compliant
Epilepsy12 Audit		Royal College of Paediatrics and Child Health	Compliant
FFFAP	Fracture Liaison Service Database	Royal College of Physicians	No Service available
	National Audit of Inpatient Falls	Royal College of Physicians	Compliant
	National Hip Fracture Database	Royal College of Physicians	Compliant
LeDeR		NHS England	Compliant
Maternal, Newborn and Infant CORP		University of Oxford / MBRRACE-UK	Compliant
Medical and Surgical CORP		NCEPOD	Compliant
Mental Health CORP		University of Manchester / NCISH	N/A
National Adult Diabetes Audit	Core Audit	NHS England	Compliant
	DPP Audit	NHS England	Compliant
	Footcare Audit	NHS England	Compliant
	Inpatient Safety Audit	NHS England	Compliant
	Pregnancy in Diabetes Audit	NHS England	Compliant
	Transition & Young Type 2 Audit	NHS England	Compliant
	Gestational Diabetes Audit	NHS England	Compliant

National Audit			
Project Name	**Workstream name**	**Provider organisation**	Outcome
National Audit of Cardiac Rehabilitation		University of York	Minimum dataset produced
CVDPrevent		NHS Benchmarking Network	N/A
NACEL		NHS Benchmarking Network	Compliant
National Audit of Dementia		Royal College of Psychiatrists	Compliant
National Audit of Eating Disorders		Royal College of Psychiatrists	N/A (Community)
National Bariatric Surgery Registry		British Obesity & Metabolic Surgery Society	Compliant
National Cancer Audit Collaborating Centre (NATCAN)	Metastatic Breast Cancer Audit	Royal College of Surgeons of England	Compliant
	Primary Breast Cancer Audit	Royal College of Surgeons of England	Compliant
	Bowel Cancer Audit	Royal College of Surgeons of England	Compliant
	Kidney Cancer Audit	Royal College of Surgeons of England	Compliant
	Lung Cancer Audit	Royal College of Surgeons of England	Compliant
	Non-Hodgkin Lymphoma Audit	Royal College of Surgeons of England	Compliant
	Oesophago-Gastric Cancer Audit	Royal College of Surgeons of England	Compliant
	Ovarian Cancer Audit	Royal College of Surgeons of England	Compliant
	Pancreatic Cancer Audit	Royal College of Surgeons of England	Compliant
	Prostate Cancer Audit	Royal College of Surgeons of England	Compliant
National Cardiac Arrest Audit		ICNARC	Compliant
National Cardiac Audit Programme (NACAP)	a) Adult Cardiac Surgery Audit (NACSA)	NICOR	Compliant
	b) Congenital Heart Disease Audit (NNCHDA)		Compliant
	c) Heart Failure Audit (NHFA)		Compliant
	d) National Audit of Cardiac Rhythm Management (NACRM)		Compliant
	e) Myocardial Ischaemia National Audit Project MINAP		Compliant
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)		Compliant

National Audit			
Project Name	**Workstream name**	**Provider organisation**	Outcome
National Cardiac Audit Programme (NACAP) *continued*	g) UK Transcatheter Aortic Valve Implantation (TAVI) Registry		Compliant
	h) Left Atrial Appendage Occlusion (LAAO) Registry		Compliant
	i) Patent Foramen Ovsle Closure (PFOC) Registry		Compliant
	j) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry		Compliant
National Child Mortality Database		University of Bristol	Compliant
National Clinical Audit of Psychosis		Royal College of Psychiatrists	N/A (Community)
National Comparative Audit of Blood Transfusion	Major Haemorrhage Audit	NHS Blood and Transplant	Compliant
National Early Inflammatory Arthritis Audit		British Society for Rheumatology	Compliant
National Emergency Laparotomy Audit (NELA)	Laparotomy	Royal College of Anaesthetists	Compliant
	No Laparotomy		
National Joint Registry		HQIP	Compliant (CAH)
National Major Trauma Registry		NHS England	Compliant
National Maternity and Perinatal Audit		Royal College of Obstetricians and Gynaecologists	Compliant
National Neonatal Audit Programme		Royal College of Paediatrics and Child Health	Compliant
National Obesity Audit		NHS England	Compliant
National Ophthalmology Database	AMD Audit	Royal College of Ophthalmologists	Compliant
National Ophthalmology Database	Cataract Audit	Royal College of Ophthalmologists	Compliant
National Paediatric Diabetes Audit		Royal College of Paediatrics and Child Health	Compliant
National Perinatal Mortality Review Tool		University of Oxford / MBRRACE-UK	Compliant
National Pulmonary Hypertension Audit		NHS England	N/A (Primary Care)
National Respiratory Audit Programme	a) COPD Secondary Care	Royal College of Physicians	Compliant
	b) Pulmonary Rehabilitation		Compliant
	c) Adult Asthma Secondary Care		Compliant
	d) Children and Young People's Asthma Secondary Care		Compliant

National Audit			
Project Name	**Workstream name**	**Provider organisation**	Outcome
National Vascular Registry		Royal College of Surgeons of England	Compliant
Out-of-Hospital Cardiac Arrest Outcomes		University of Warwick	N/A Under Review
PICANet		University of Leeds / University of Leicester	Compliant
Perioperative Quality Improvement Programme		Royal College of Anaesthetists	N/A
Prescribing Observatory for Mental Health (POMH)	Valproate Prescribing	Royal College of Psychiatrists	N/A
	Use of Clopazine		N/A
	Use of medicines with anticholangeric		N/A
SSNAP		King's College London	Non-compliant on case ascertainment
SHOT		Serious Hazards of Transfusion	Compliant
UK Cystic Fibrosis Registry	Adults	Cystic Fibrosis Trust	Compliant
UK Cystic Fibrosis Registry	Children	Cystic Fibrosis Trust	Compliant
UK ILD Registry		British Thoracic Society	Compliant
UK Parkinson's Audit		Parkinson's UK	Compliant
UK Renal Registry CKD Audit		UK Kidney Association	Compliant
UK Renal Registry AKI Audit		UK Kidney Association	Compliant

3.3.4 Sharing Learning

3.3.4.1 Patient Safety Learning Hub

Background

The Patient Safety Learning Hub has been established since July 2024 enabling colleagues to learn from each other through conversation about issues impacting on patient experience and the quality of care.

There are 182 members of the hub representing 26 Clinical Service Units (including corporate services).

Key Achievements in 2025/26

- Continued growth of the Patient Safety Learning Hub membership.
- Eleven Learning Hub meetings fostering a brave space encouraging members to share experiences.
- Co-designed the Patient Safety Learning Hub "Reflection Tool" in collaboration with the Hub Patient Partner.
- Reflection Tool used during meetings aiding members to consider what has been presented, if there needs to be; action taken, alert other teams in the organisation and close the loop (ensuring changes are implemented and communicated).
- Hub members sharing learning from thematic reviews they have undertaken. Topics included central venous line events, swallow and nutritional safety, healthcare associated infection escalation clinics and antimicrobial stewardship.
- Second Patient Safety Road Map 2026 developed to enable a focussed monthly approach to key national awareness events.
- Collaboration and networking between members including across different Clinical Service Units.
- In-year Hub reflection session enabling members to consider what worked well in hub meetings, and contribute to the design of future hub meetings.
- Discussion of key patient safety issues e.g. medication filter lines, dying matters, civility and Just Culture, delay in stent removal, fluid balance.
- Sharing learning in clinical areas, acknowledging what teams are proud of and discussion about health inequalities.
- Launch of the Learning Loop and discussion of assurance verses reassurance to help members consider if learning has been embedded and how we evidence this.
- Presented at the Trust Patient Safety Conference promoting the hub and sharing reflections.
- Launched 2-minute learning videos targeting specific professional groups.
- Developed a Microsoft Teams space to enable resources to be shared with hub members including contact list to enable hub members to connect.

Aims for 2026/27

- Continue to increase hub membership and engagement within the medical workforce.
- Continue to gather information to enable a Hospital with a Memory guide to be published, sharing the learning and action taken following patient safety events and enable colleagues to understand the reason for changes made.
- Create a feedback loop to demonstrate how actions taken following hub meetings have impacted on patient safety.
- Revise stakeholder, forum and groups maps to reflect organisational changes and engagement.
- Create space within hub meetings for interactive exercises focussing on learning, actions and improvements following patient safety events.

3.3.4.2 Sharing Patient Experience Learning

Background

In addition to learning shared within the patient experience and involvement sections, we continue to review the ways in which we share learning arising from patient feedback and best practice across the Trust.

All our CSUs continue to present their patient experience findings at the Patient Experience Executive Group and the work they have taken forward to respond to these.

The CSUs also have established methods of sharing learning from patient experience within the CSU and share action taken to address the patients voice across the organisation through the Patient Safety learning Hub.

Complaint themes, learning and improving practice.

In 2025/26 the top four themes identified in complaints data were: communication, treatment, administration, access and patient flow and colleague interactions.

Clinical services report their improvements to the Patient Experience Executive Group, these are collated and included in the complaint reports that go to Trust Board.

Examples of improvements have included:

Urgent Care

Volunteer support has expanded at St James's, where 16 volunteers have been recruited to assist with tasks such as offering refreshments, monitoring patient waits and responding to queries enhancing communication and support for patients and relatives, particularly in the Emergency Department.

Adult Critical Care

There is a CSU Patient Experience Group that has representatives from each unit. It meets every six weeks to share good practice, improvement ideas and to review feedback.

The team have identified from feedback that many patients struggle with not knowing what has happened to them whilst they have been on the unit, as they have little recollection of it. The team have introduced an informal diary which colleagues fill in with notes about each day. This is given to the patient when they leave the unit. Feedback from patients has been excellent about this initiative. There is now a formal diary guideline advising what can be written in them.

3.3.4.3 Sharing Learning Regionally

The Trust participates in a number of regional and national learning forums and initiatives.

Background

The West Yorkshire Association of Acute Trusts (WYAAT) was established to share learning from patient safety events, particularly those meeting NHS England Never Event criteria. The group meets bi-monthly with senior representation from regional trusts and reports to the WYAAT Medical Director and Chief Nurse Group.

West Yorkshire Association of Acute Trusts

Key Achievements in 2025/26

- Adopted a WYAAT template for Patient Safety Incident Investigations.
- Shared six Early Learning alerts following Never Events.
- Exchanged Patient Safety Incident Response Plans.
- Shared templates for learning from safety events.
- Continued discussions on NHS England Never Event consultation outcomes.
- Shared learning from thematic reviews.
- Received a briefing on NHS England Patient Safety Training (Levels 3 & 4) and discussed supporting colleagues to undertake specialist training.

Aims for 2026/27

- Promote transparency and shared learning across WYAAT organisations.
- Identify emerging themes and agree shared actions.
- Review experiences aligned to the National Patient Safety Strategy.
- Share peer support in embedding the Patient Safety Incident Response Framework.
- Participate jointly in national consultations.
- Review and share implementation of National Patient Safety Alerts.

Part 4:

Statements of assurance from the Trust Board

4.1 Review of Services

During 2025/26 the Leeds Teaching Hospitals NHS Trust provided NHS services across 100 specialist areas, known as "Treatment Functions", and/or sub-contracted NHS services to a core population of around 845,000, and provided specialist services for 5.7 million people. The income generated by the NHS services reviewed in 2025/26 represents all of the total income generated from the provision of NHS services by the Leeds Teaching Hospitals NHS Trust for this period.

4.2 Information Governance and Data Quality

Background

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 colleagues 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 Data Security & Protection Toolkit requirements for 2025/26.

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.

Key Challenges in 2026/27

A key challenge for the Trust has been the change to the Data Security & Protection Toolkit (DSPT). This is an annual self-assessment produced by NHS England. However, in September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance.

The CAF provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed. This change sets out CAF-aligned requirements, these are segregated into five specialist areas known as 'objectives' as below:

- A – Managing risks
- B – Protecting against cyber-attacks and data breaches
- C – Detecting cyber security breaches
- D – Minimising the Impact of incidents
- E – Using and sharing information appropriately

There are 47 Principles which make up the five above objectives.

The DSPTv7 was no longer divided between mandatory or non-mandatory requirements. The DSPT has been divided into several contributing outcomes, each of which are supported by indicators of good practice grouped into levels of achievement:

- 'Not Achieved'
- 'Partially Achieved'
- 'Achieved'

Of the 47 contributing outcomes, 39 contribute from the CAF with a further eight contributing outcomes in a custom section on 'using and sharing information appropriately', to ensure that data protection, confidentiality, and other information governance disciplines are incorporated.

There are six contributing outcomes noted as requiring a 'not achieved' standard, these where formally known as 'non-mandatory' assertions in the previous DSPTs prior to the CAF alignment. However, following previous submissions, the Trust has completed all contributing outcomes to a partially achieved or achieved standard, including those detailed as a 'not achieved' standard.

During this year the Information Governance Team has made significant steps to implement robust Information Governance practices and ensured that a patient centred approach was maintained while ensuring patient confidentiality was not compromised.

NHS Data Security & Protection Toolkit Submission

The Trust was able to successfully submit its DSPTv7 Submission for 2024/25 by 30 June with all evidence items being successfully completed.

The Information Governance Work plan for 2026/27 will include:

- Developing an IG and data security culture throughout the Trust.
- Ensuring a consistent approach within the NHS with regards to information management.
- Support the Trust in the implementation of new systems and initiatives to enhance patient care.
- To adequately ensure the confidentiality, integrity and security of information in both physical and electronic formats.
- Support Cyber Security awareness.
- Support the "Digital Hospital".
- Support the Trust in successful completion of the DSPTv8.

The Information Governance Team's aim is to support the Trust in becoming a centre of excellence for Information Governance.

4.3 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 2025/26 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 2025 to March 2026 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

	LTHT %	National Average %	Above National Average %
Admitted patient	99.9	99.7	0.2
Outpatient	99.9	99.8	0.1
Accident and Emergency	98.2	99.0	-0.8

The percentage of records in the published SUS Data Quality Dashboard for the period April 2025 to March 2026 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 Registered GP

	LTHT %	National Average %	Above National Average %
Admitted patient	99.9	99.8	0.1
Outpatient	99.8	99.6	0.2
Accident and Emergency	99.7	99.7	0

4.4 Clinical Coding

Background

The Clinical Coding team records activity data for all inpatient discharges using nationally standardised formats. This data supports planning, finance, audit, statistical and benchmarking functions locally and nationally. A continuous programme of audit and training is in place, aligned to national specifications.

Key Achievements in 2025/26

- Continued collaboration with the Mortality Improvement Group, identifying coding errors and implementing improvements.
- Completed all mandatory training on schedule, alongside additional quality-focused training.
- Maintained 78% accredited coders within the team.
- Completed the mandatory DSPT audit, achieving improved results and meeting required standards:
  - Primary Diagnosis: 91.3% (target 90%)
  - Secondary Diagnosis: 86.1% (target 80%)
  - Primary Procedure: 95.8% (target 90%)
  - Secondary Procedure: 90.7% (target 80%)

Aims for 2026/27

- Continue working with the Mortality Improvement Group to monitor indicators and provide coding advice.
- Deliver mandatory training in line with national timescales.
- Maintain primary diagnosis accuracy in line with DSPT requirements.
- Improve consultant outreach and engagement to support coding quality and awareness.

4.5 Goals agreed with Commissioners (CQUINS)

The Commissioning for Quality and Innovation (CQUIN) framework designed to support improvements in the quality of services and the creation of new, improved patterns of care was paused in 2024. The scheme has not recommenced.

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 and Social Care 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. The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017. These added new mandatory disclosure requirements relating to 'Learning From Deaths' to quality accounts from 2017/18 onwards.

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;
- the Quality Account has been prepared in accordance with NHS England 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

25/06/2026 ..... Date ..... Chair

Antony Kildare

25/06/2026 ..... Date ..... Chief Executive

Brendan Brown

Appendix B: Statements from Local Stakeholders

Thank you for the opportunity to review the Leeds Teaching Hospitals NHS Trust Quality Account for 2025-26. The document provides a comprehensive overview of the Trust's priorities, activity, and performance, and reflects the scale and complexity of delivering acute and specialist services for the people of Leeds and the wider region.

It is positive to see the continued commitment to involving people and carers in shaping and improving services. The Quality Account highlights a wide range of engagement activity, including work with carers, use of national surveys, and the continued development of the Partner Programme. The reference to positive feedback from carers feeling welcomed and involved is particularly encouraging, as it the stated priority of complaint and feedback mechanisms, including Clinical Service Unit (CSU) reporting and subsequent actions, provides reassurance that people's concerns are taken seriously and acted upon.

We also welcome the system-wide, coordinated work described with Healthwatch Leeds, particularly in relation to complaints, Patient Advisory and Liaison Service (PALS) processes and the citywide How Does It Feel For Me programme. The references to the People's Voices Partnership, the use of the Insight Library, and the embedding of the 3Cs (Communication, Coordination and Compassion) demonstrate a growing maturity in how people's experience information is being gathered and used. We value our ongoing collaboration with the Trust in these areas and support the continued development of consistent, joined up approached to learning from people's experiences.

There are positive examples where feedback and learning have influenced service change, including work on access and waiting times, improvements to communication with people waiting for services, and targeted support for families navigating complex pathways such as pre-school autism services. These areas closely align with issues raised consistently by people across Leeds and it is helpful to see them reflected within the Trust's priorities and improvement activity.

However, while engagement and improvement processes are often well described, the Quality Account would be strengthened by clearer communication of the impact of this work for people, carers, and communities. In several areas, the report focuses on structures, processes, and volumes of activity, with less emphasis on what has changed as a result or how improvements have been sustained. More explicit links between insight, decisions made, service redesign and measurable outcomes would help demonstrate how people's voices are shaping delivery at both service and Trust-wide level.

The Trust's commitment to addressing health inequalities and improving equity is evident throughout the report. Positive areas include the focus on day- and night-time interpreting services, the continued development of Easy Read communications for people with learning disabilities and autism, and the Patient and Public Involvement team working with underserved communities through listening events. Reviews of initiatives such as the Patient Hardship Fund are also welcome. As with listening to people more broadly, this section would benefit from a stronger emphasis on outcomes, including how inequalities-focused projects are improving access and experience for different groups, how learning is shared across services, and how activity reflects the diversity of Leeds's population.

The Quality Account reflects an organisation increasingly focused on partnership working and neighbourhood-based and system approaches to care. As these models continue to develop, there may be further opportunities to strengthen co-production and co-design by involving people, carers, and communities at an earlier stage in service design, implementation, and evaluation, rather than primarily through feedback once services are established. Continued close working with Healthwatch Leeds, including clear feedback loops showing how local knowledge informs priorities and change, would support this ambition and help ensure that the voices of those most affected are meaningfully influencing strategic direction.

From a public accessibility perspective, the Quality Account is detailed and well laid out, with diagrams and visual elements that support navigation. However, the length, technical language and use of acronyms are likely to make it challenging for some members of the public to fully engage with the content. While we recognise that much of the format is prescribed, the inclusion of more case studies and clearer summaries of impact would help bring the report to life and demonstrate what the data means for people using services.

It was also reassuring to see emphasis placed on staff voice, psychological safety and initiatives designed to speak up and contribute to improvement, particularly in the context of ongoing regulatory scrutiny and system pressures. We recognise that building a supportive and open culture takes time, and we welcome the Trust's acknowledgement of this challenge.

Overall, this Quality Account presents a thorough picture of the Trust's activity, achievements, and areas for improvement during 2025-26. It demonstrates a genuine commitment to learning, partnership working and improving people's experience, alongside an honest reflection of the challenges faced. We look forward to continuing to work closely with Leeds Teaching Hospitals NHS Trust over the coming year, sharing experiences from people across Leeds and supporting the ongoing efforts to ensure services are safe, responsive, inclusive, and centred on people's experiences.

West Yorkshire
Health and Care Partnership

NHS West Yorkshire
Integrated Care Board

The Integrated Care Board in Leeds
Review of Leeds Teaching Hospitals NHS Trust Quality Account 2025/2026.

The West Yorkshire Integrated Care Board (WY ICB) acknowledges receipt of the draft 2025/2026 Quality Account from Leeds Teaching Hospitals NHS Trust (LTHT) and welcomes the opportunity to review the account and provide this statement.

The Quality Account was shared with key members of the ICB and reviewed by the ICB's Quality Team in Leeds. We acknowledge that the report is still in draft form and some additional information may still need to be added prior to final publication, so please accept our feedback on that basis.

With LTHT treating approximately 1.8 million patients, delivering 359,000 A&E attendances, and providing 109,000 inpatient admissions in the last year, alongside its role in delivering regional specialist services across Yorkshire and the Humber and nationally it is clear why the organisation is recognised as one of the largest and busiest NHS acute providers in Europe, employing around 22,000 staff.

The Quality Account provides a fair and accurate reflection of the Trust's performance in 2025/26, highlighting both successes and areas for improvement. It clearly reflects LTHT's strategic priorities and provides assurance that the focus remains on improving safety, experience, outcomes, and access for the diverse communities it serves.

The outcomes of Care Quality Commission (CQC) activity and assessment are directly acknowledged and the account provides a clear and transparent reflection of how the organisation is addressing the findings and demonstrates visible executive ownership of the improvement agenda.

Several examples within the Quality Account highlight the Trust's ongoing work with the CQC and NHS England and provide evidence of strengthened governance, system improvement and the embedding of organisational learning. This provides the ICB with increased confidence that the Trust is taking a systematic, organisation-wide approach to addressing regulatory findings, progressing the recommendations and improving the quality and safety of care.

Strategic Priorities and Progress

The Trust's 2025/26 strategic priorities and values centred on delivering safe, effective, and responsive care are firmly grounded in The Patient Safety Strategy 2024–2027, the Patient Safety Incident Response Framework (PSIRF), and the Patient Safety Incident Response Plan (PSIRP). Together, these continue to demonstrate a significant step forward in strengthening the organisation's learning culture and the wider programme of insight, involvement, and improvement.

- **Insight:** Progress over the last year shows a marked improvement in learning across the Trust, with clearer analysis of incidents and a more mature, system-wide safety culture reflected in reporting behaviours and thematic review.
- **Involvement:** The Trust's engagement with partner programmes has delivered strong results, including enhanced support for unpaid carers and a range of service improvement initiatives shaped by patient and staff listening events.
- **Improvement:** Notable achievements include the implementation of Martha's Rule to support early recognition of deteriorating patients and a sustained reduction in hospital-acquired pressure ulcers, an area of longstanding concern.

Quality Priorities for 2026/27

The ICB is supportive of the Trust's quality priorities for 2026/27, which are aligned with the NHS Patient Safety Strategy. These priorities will clearly underpin the Trust's focus over the next 12 months, with the ICB continuing to work closely with the Trust, CQC, and NHSE particularly in relation to the maternity and neonatal CSUs.

Insight

- Strengthen incident reporting through improved forms, clearer guidance, and enhanced colleague education.
- Embed PSIRF using specialist expertise to ensure consistent learning and improvement.
- Foster psychological safety so colleagues can raise concerns without fear.
- Increase Freedom to Speak Up Champions across all services.
- Boost colleague engagement by acting on feedback, promoting positive behaviours, and strengthening compassionate leadership.

Involvement

- Deliver the Complaints Improvement Plan and improve the timeliness and quality of responses.
- Embed patient partners across CSUs, expand the complaints panel, run listening events, and support projects addressing health inequalities.
- Launch a new Carer Passport and implement an updated Unpaid Carers Policy.
- Embed safeguarding learning and improve care for people with learning disabilities and autism through training, champions, and reasonable adjustments.
- Strengthen interpreting provision particularly in maternity services and enhance chaplaincy services.

Improvement

- Continue to design and support improvement programmes through quality improvement, audit, and research.
- Launch the RISE ward and department accreditation scheme.
- Embed improvement into daily management and frontline practice.
- Measure Trust-wide improvement using national indicators and benchmarking.
- Strengthen improvement collaboratives and develop more effective methods for sharing learning.

Celebrating Successes

The evidence presented within the Quality Account highlights many of the Trust's achievements during 2025/26, which the ICB warmly acknowledges. Given the significant operational pressures experienced over the past year and the continued challenges anticipated for 2026/27 it is essential that we recognise and celebrate staff morale and positive developments alongside areas for learning.

We particularly welcome:

- The opening of the Rob Burrow Centre for Motor Neurone Disease, a landmark achievement providing world-class specialist care and support.
- The Iris Award presented to an LTHT PALS officer for outstanding patient care a powerful reflection of the compassion and professionalism of Trust colleagues.

Patient Experience and Inclusive Practice

The ICB welcomes the Trust's continued focus on improving patient experience. The re-establishment of the Complaints Panel bringing together Trust Partners and colleagues to review the complaints process, patient experience, and opportunities for system learning is particularly positive. Initiatives such as this, alongside wider programmes including "How Does It Feel for Me", help to ensure more coordinated, person-centred care and reflect a broader culture of listening, learning, and acting on feedback from our communities, patients, and staff.

We also welcome the Trust's review of feedback on the 2024/25 Quality Account, which has informed improvements to this year's format. The decision to scale back supplementary videos and materials given low engagement demonstrates a pragmatic and evidence-based approach. The resulting document is comprehensive, well-structured, easy to read, and makes effective use of illustrations, although the language used on occasion could have been simplified.

The ICB looks forward to continuing to work alongside LTHT over the coming year, supporting its ongoing efforts to deliver safe, effective, and inclusive care for the people and communities of Leeds.

Your sincerely,

Sarah Wighton
Associate Director of Nursing and Quality
West Yorkshire Integrated Care Board

Appendix C: Glossary of Terms

A3 Thinking: a problem-solving, decision-making, and collaborative management tool. The name "A3" refers to the size of the piece of paper used to outline goals, ideas, problems, and solutions.
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.
Artificial Intelligence (AI): the theory and development of computer systems able to perform tasks normally requiring human intelligence.
Board (of Trust): the role of the Trust's Board is to take corporate responsibility for the organisation's strategies and actions.
BSL: British Sign Language.
BUFALO: blood cultures and septic screen, Urine output, Fluid Resuscitation, Antibiotics IV, Lactate measurement, Oxygen.
Care Quality Commission (CQC): the independent regulator of health and social care in England. Clinical Audit: clinical audit measures the quality of care and services against agreed standards, and suggests or makes improvements where necessary. Regulatory breach – occurs when a health or social care provider in England fails to meet the legal requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC Section 29A Warning Notice is a formal enforcement action flagging a need for significant improvement in care quality.
Clinical Service 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.
Data Security and Protection toolkit: the NHS Data Security & Protection Toolkit ensures necessary safeguards for, and appropriate use of, patient and personal information.
Datix: patient safety and risk management software for healthcare incident reporting and adverse events.
Digital Information Team (DIT): the Informatics Department in the organisation responsible for the management of Digital Information Technology infrastructure to support healthcare.
eMeds: an electronic system for prescribing and administration of medicines.
e-Obs: a digital method of recording the observations of patients' vital signs.
Enhanced Therapeutic Observation and Care (ETOC): (often referred to as enhanced care, enhanced therapeutic observations, 1:1s or specialing) is a set of interventions which contributes to safe and effective care of patients. ETOC interventions aim is to promote recovery, preserve safety & dignity of the patient/s receiving it.
Friends and Family Test (FFT): 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.
Healthwatch Leeds: Healthwatch is the independent consumer champion that gathers and represents the public's views on health and social care services in Leeds. It ensures that the views of the public and people who use the services are taken into account in health and care decision making.
HED - HED (Healthcare Evaluation Data): mortality refers to the use of an online benchmarking system to analyse, monitor, and compare hospital mortality rates across the NHS.

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. Hypoxic-ischaemic encephalopathy (HIE): this may be diagnosed if a baby's brain does not receive enough oxygen and/or blood flow around the time of birth.
Integrated Care: an organising principle for care delivery that aims to improve patient care and experience through improved coordination.
Integrated Care Board (ICB): clinically led NHS bodies responsible for the planning and commissioning of health care services for their local area.
Kaizen Promotion Office (KPO): established to drive the improvement work of the organisation in collaboration with the Virginia Mason Institute. Lean Methodology: a new national NHS service for the recording and analysis of patient safety events that occur in healthcare, this will replace NRLS.
Learn from Patient Safety Events (LFPSE): a methodology to ensure we provide the highest quality care for patients, whilst reducing inefficiencies and 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 Improvement Method (LIM): the method focusses on improving efficiency and flow of our services under the three key concepts: value, waste, and respect for people.
Leeds Place/Integrated Care Board (ICB): place-based partnership with an integrated care board committee to make decisions, NHS body responsible for the planning and commissioning of health care services for their local area. similar to the West Yorkshire integrated care board.
Medically Optimised For Discharged (MOFD): a patient who is medically fit for discharge, after a clinical decision has been made that the patient is ready to transfer.
Methicillin Resistant Staphylococcus Aureus bacteraemia (MRSA): a bacterial infection. Mortality Screening Tool: all patient deaths are screened to determine whether a further review of case notes should be considered.
Maternity and Newborn Safety Investigations (MNSI) programme: a national program in England, part of a strategy to improve maternity safety in the NHS, investigating certain patient safety incidents in maternity care and making safety recommendations.
MSSA related infections: infections as a result of methicillin-susceptible S. aureus (bacteria).
NHS England: the national leadership organisation that leads, oversees, and sets the strategic direction for the National Health Service (NHS) in England
NHS England Maternity Safety Support Programme (MSSP): a national initiative providing tailored, expert support to NHS trusts to improve the safety, quality, and culture of maternity and neonatal services.
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.

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 colleagues.
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.
Plan, Do, Study, Act (PDSA): A quality improvement tool to test an idea by trialling a small scale change and assess its impact, building upon the learning from previous cycles in a structured way before large scale implementation.
Patient Pathway Manager PPM+: This is the Trust's electronic health record, built on the latest web technology and benefitting from a programme of continuous development to deliver an agile, multi-functional record.
Patient Safety Incident Response Framework (PSIRF): Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
SPC chart: Statistical Process Control chart. Data is plotted chronologically to see changes over time.
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 Values of Leeds Teaching Hospitals Trust created by colleagues. 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.
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 Integrated Care Board: Committees made up of local health and care leaders, and they will also include independent people who do not work for health and care organisations.
WYAAT: West Yorkshire Association of Acute Trusts.

Appendix D: Performance against National Priority Indicators

Metric name	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
AE Attendances per day		1007	1012	1015	984	922	999	1037	1051	961	978	992	1012
Ambulance Handovers <15mins LGI	00:15:00	00:17:04	00:16:58	00:17:37	00:18:17	00:15:25	00:15:21	00:14:42	00:14:56	00:15:40	00:15:38	00:15:24	00:13:54
Ambulance Handovers <15mins SJUH	00:15:00	00:22:50	00:23:06	00:23:30	00:21:56	00:14:44	00:16:37	00:17:43	00:18:48	00:19:02	00:17:31	00:18:15	00:15:50
Last Minute Cancelled Ops		104	149	129	141	102	165	116	149	178	144	87	125
Cancelled Ops 28days		26	28	22	45	34	28	23	17	55	46	33	17
Cancer 28day FSD	75%	77%	72%	78%	75%	78%	78%	76%	73%	75%	75%	82%	84%
Cancer 31day	96%	94%	93%	93%	95%	94%	94%	95%	95%	95%	96%	97%	96%
Cancer 62 day	85%	63%	59%	55%	64%	63%	64%	61%	67%	69%	65%	66%	71%
Diagnostics	95%	83%	82%	84%	83%	83%	90%	93%	94%	93%	93%	94%	93%
DNA Rate		7%	6%	7%	7%	7%	7%	6%	7%	7%	6%	6%	6%
Outpatient DNA Volumes		8367	7790	8316	8721	7499	8599	8723	8091	7946	8296	7479	7928
ECS Monthly	78%	76%	76%	77%	79%	78%	76%	75%	74%	74%	74%	75%	79%
Elective LoS		4.36	4	4	4	4	4	4	4	4	4	4	4
Elective Readmissions		3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
Non-Elective LoS		7.53	7	7	7	7	7	7	7	8	7	8	8
Non- Elective Readmissions		11%	11%	12%	12%	12%	13%	11%	12%	12%	12%	12%	10%
OPFU3months		37653	37375	37429	38183	37370	37713	37801	39492	40073	40915	42035	42134
RTT Performance	92%	65%	66%	66%	66%	66%	67%	67%	67%	66%	66%	66%	67%
RTT Total Waiting list		89039	88184	88197	88146	88326	87667	87783	87103	85979	86915	85760	85125
RTT 52 Week Breach Backlog		2484	2708	2742	2316	1790	1525	1378	1334	1321	1343	1305	1294
RTT 78Week Breach Backlog		1	0	3	4	1	2	4	6	7	15	17	21
VTE	95%	97%	96%	97%	97%	96%	96%	97%	97%	96%	96%	96%	97%
CDI		17	17	11	16	15	13	16	10	11	13	15	19
MRSA		1	1	0	2	1	2	0	0	0	1	1	0
E. Coli		32	18	27	29	24	21	30	25	24	29	17	19
Pseudomonas		6	3	3	3	4	7	6	8	7	4	2	4
Klebsielalla		18	10	9	17	7	12	10	4	15	8	8	11
Patient Level Metrics Score	90%	95%	94%	95%	95%	95%	95%	95%	95%	94%	94%	94%	95%
Environment Level Metrics Score	90%	91%	93%	95%	94%	93%	90%	92%	93%	88%	93%	90%	94%
Falls		184	190	191	201	182	186	195	206	235	222	199	204
Falls Rate per 1000 Bed Days		3.27	3.40	3.42	3.53	3.29	3.34	3.30	3.63	3.99	3.58	3.63	3.49
Developed Pressure Ulcers		43	32	24	34	26	34	47	57	43	41	52	42
Developed Pressure Ulcer Rate		0.76	0.57	0.43	0.60	0.47	0.61	0.81	1.00	0.72	0.66	0.95	0.72
Admitted with Pressure Ulcers		313	322	314	269	319	305	327	303	325	361	304	289
Admitted with Pressure Ulcers Rate		5.53	5.70	5.65	4.73	5.77	5.47	5.65	5.32	5.47	5.83	5.54	4.95
2222 Calls		77	73	74	65	47	60	62	59	104	65	62	69
Cardiac Arrest Calls		21	20	23	18	10	18	18	18	28	16	15	13
SHMI		113.26	113.51	114.28	113.71	112.4	113.5	113.42	112.47	111.37	112.3	112.1	112.28

Metric name	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Still Births	5.2	3.92	3.45	3.56	3.51	3.4	4	4.1	4.5	4	4.7	4.2	4.3
Rolling Extended Perinatal mortality rate (all NND)		8.65	8.74	8.85	8.85	8.88	8.88	8.4	8.6	8.23	8.8	7.1	8.0
Number of MNSI Referrals		1	2	1	2	0	3	1	0	3	0	1	1
% Complaint Responses Sent Within Target Times (LR1 letters)	80%	49%	38%	34%	33%	35%	23%	37%	19%	26%	23%	33%	35%
% CSU Draft Comments Received Within Target Times (LR1 letters)	80%	57%	64%	56%	59%	46%	54%	52%	54%	44%	41%	49%	45%
PHSO Referrals		0	7	2	1	2	2	2	2	2	3	2	5
Response Lead Time (WDs)		41	49	49.5	49.5	47	55.5	48.5	70	59.5	60	54	54
Defect Rate	15%	2%			5%			7%			1%		
PALS Concerns - % Patients contacted in 2 w/days	80%	80%	79%	74%	78%	80%	75%	73%	78%	80%	77%	74%	82%

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