NHS
The Leeds Teaching Hospitals
NHS Trust

Annual Report and Accounts

2017/18

Incorporating the Annual Quality Account

Contents

Overview

This section introduces the work of Leeds Teaching Hospitals NHS Trust. It sets out the Trust's core vision and values and highlights some of our strategic developments and achievements over the 2017/18 financial year. It also summarises our performance over the year and the key risks we faced in achieving our vision to provide the best possible specialist and integrated care for patients in Leeds and the wider region.

Chair and Chief Executive's statement

We would like to welcome everyone who has an interest in our Trust to this annual report. On behalf of colleagues from Board to Ward, throughout our hospitals, we are very pleased to present the story of our collective year. We would like to begin by setting the scene for a report that presents the very significant progress we are making, as well as recognising where challenges remain.

It is a great privilege indeed to be able to step back and review our performance over the course of a year. Our fantastic staff are working extremely hard day by day to provide outstanding care for our patients, so it is important that there is an opportunity to look upwards and outwards to think about our priorities and to recognise our achievements.

Trust Board members work together consistently throughout the year at Board meetings and at Board committees, where Executives are held to account for meeting our objectives as well as local and national standards through constructive challenge from our highly skilled Non-Executives. So again, it is crucial to review our work at the end of the year.

Financial sustainability

Ensuring that our finances are sustainable is a crucial part of delivering health care, so we are delighted to have achieved a financial surplus of £18.9 million this year. This is the first surplus the Trust has made in four years and the biggest ever in the 20 years since the Trust was created to embrace all acute hospitals across the city.

This surplus was enabled by Sustainability and Transformation Funding (STF), a joint initiative between NHS Improvement and NHS England, in return for meeting agreed financial targets. We were able to meet this target thanks to the really great work that has been done on waste reduction and other financial improvements across the organisation without impacting on patient care or safety.

The new financial year does, of course, present another big challenge for us as we need to deliver an additional £75 million in waste reduction. As more teams continue to embrace the Leeds Improvement Method and look at how they can work more efficiently, we will be able to make continuous improvements that lead us to financial sustainability.

Collaboration and integrated care

Of course, developing sustainable care and providing integrated services also means working closely with partners and one of the key areas we continue to strengthen is our relationships and networks with other parts of the health and care system i.e. with commissioners and other health and social care providers not only within the NHS but also within Leeds City Council.

We work closely with members of the Adult Social Care, Public Health and NHS Scrutiny Board to keep them up to date on developments and challenges in our hospitals, as well as decisions we take to improve the services we provide. We are also a member of the Health and Wellbeing Board for Leeds.

Once again, we have seen unprecedented levels of demand locally and throughout the NHS as a whole. Pressures that used to be most intense through the Winter months are now sustained for a much longer period, putting great pressure into the health and social care system, and especially at the front door. There has been a consistently high number of people attending our Emergency Departments (EDs) and we aim to see, treat, discharge or admit 95% of patients within the four hour target throughout the year.

We are seeing an increase in patients requiring a higher level of care as they have more complex clinical needs and are staying in hospital longer. Together with the higher numbers of patients who are ready to be discharged but for whom no suitable care is available, we have experienced sometimes severe difficulties with patient flow through our organisation. As a result, we have worked more closely than ever with our partner organisations in Leeds.

Through regular formal meetings, like the System Resilience Assurance Board (SRAB), and our more informal regular contact, we try to ensure that we are providing the best possible care for patients in our city and beyond.

In an operational context, we held our first ever Perfect Week in October 2017, a national initiative which is designed to test ourselves and our ability to solve operational problems quickly and effectively to unblock barriers that have developed and 'reset the system' to optimise patient flow. We used the outcomes of the Perfect Week to inform a Multi-Agency Discharge Event (MADE) in February 2018. MADE is an NHS Improvement organised event bringing together senior clinical and operational staff from the local health system to further support improved patient flow, recognise and unblock delays, while challenging, improving and simplifying complex discharge processes.

Our ward teams really embraced MADE, which occurred during a particularly challenging week, and a colleague from one of our partner organisations commented: "The passion you all have for making sure each patient receives the best possible care really comes through". This is just a snapshot of how our teams care for patients in challenging circumstances every single day.

Strategically, we are part of the West Yorkshire and Harrogate Health and Care Partnership, which brings together all health and care organisations in six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. This collaboration aims to develop and transform health and care by creating sustainable organisations, systems and partnerships. In February 2018, the Partnership published 'Our Next Steps to Better Health and Care for Everyone' which describes the progress made across the partnership and sets out ambitions for the next 12 months and beyond. You can read the document at www.wyhpartnership.co.uk/next-steps.

We are also a key partner in the West Yorkshire Association of Acute Trusts (WYAAT). This group of hospital provider Trusts is effectively the delivery mechanism for acute provider aspects of the health and care partnership. WYAAT enables hospitals in West Yorkshire and Harrogate to work more closely together to give patients better access to services, facilities and expert care. There are a number of different work areas that help to ensure more streamlined decision-making across the region and improve how we deliver services for our patients.

Patient safety and high quality care

Ensuring our patients receive the safest and highest quality care is at the centre of everything we do at the Trust. We are rated as a 'Good' hospital trust by the Care Quality Commission

and our Friends and Family Test shows that 92% of patients would recommend us to their loved ones if they needed hospital care.

The increasing growth in demand for health care means it is a challenge for us, and across the NHS as a whole, to consistently achieve against national performance standards. However, we couldn't do any of what we do without our dedicated teams who have worked extremely hard in very difficult circumstances. The Leeds Way continues to be an integral part of how we do things at Leeds Teaching Hospitals. More than ever, our five values - patient-centred, accountable, collaborative, fair and empowered - underpin every decision we make and every action we take.

The commitment of our teams to providing the very best care for our patients shines through every single day. We are pleased to take this opportunity to acknowledge the dedication shown by everyone throughout our hospitals to developing our services and making improvements in our systems to cope with growing demand, especially at times of extreme pressure.

Throughout the year we did a number of things to help us manage the extra demand on our services with the result that fewer patients needed to be admitted into our hospitals this year. We continue to work closely with our partner organisations across the city to ensure that patients receive the most appropriate care for their needs.

Ensuring our patients are safe and improving quality across all of our services is a strategic goal and through really great practical initiatives such as our multi-disciplinary safety huddles, our pressure ulcer collaborative, and our deteriorating patient initiative, we have seen fantastic, statistically significant reductions in harm and in falls, and a Trust-wide decrease in cardiac arrest calls. Our teams have been invited to share this good practice at conferences across the UK which shows that they're really leading the way in improving care for patients.

Support from our Charitable Foundation

This year, we welcomed David Welch in a newly created role of Chief Executive of Leeds Cares, formerly the Leeds Hospital Charitable Foundation. We are working even more closely with them to make a positive impact on the care and wellbeing of patients, their loved ones and staff. The charity continues to provide fantastic support to the Trust. This year, more than £10 million has been spent across the Trust, including the supply of portable ultrasound scanners, the funding of the Leeds Children's Clinical Research Facility and sponsoring our annual Nursing, Midwifery and Allied Health Professionals conference.

Building The Leeds Way

Our exciting plans to redevelop the Leeds General Infirmary (LGI), known as Building The Leeds Way, have made great progress this year. If we are successful in getting national support to go ahead with the scheme it will be both as a result of the financial success we have achieved this year and which we aim to deliver in future years. It is also one of the ways we will achieve our long term aims of financial sustainability and improved services.

In November, we presented our plans for a new healthcare building at the LGI and a remodel of the Leeds Children's Hospital. The event at the House of Commons was attended by the Minister of State for Health Philip Dunne, Lord Carter of Coles who is leading the efficiency work across the NHS, NHS England, some of the Leeds MPs and a number of other partners from Leeds and the wider region. There was a great deal of support and a lot of excitement in the room.

Since then we have begun work on an Outline Business Case that will be submitted later this year. It's important that we know what our patients and the public think about the plans and to have their views on what they want from the development and so we will be raising awareness of the work and engaging with stakeholders and members of the public in the coming months.

We know that our teams provide truly world-class treatment and care at Leeds Teaching Hospitals, and we are looking forward to having the most up-to-date facilities from which to do this.

The Leeds Improvement Method (LIM)

The Leeds Improvement Method aims to reduce variation and waste, using small scale tests of change to continuously improve. Quality improvement works best when those involved directly in the work are empowered to make changes and use local measurement to make further improvements. The LIM approach is that everyone working in our hospitals is empowered to make improvements in their daily work, bringing the benefits of a safe, high quality experience for every patient and member of staff.

During 2017/18 we continued to grow, scale up and spread implementation of the Leeds Improvement Method, working with the prestigious Virginia Mason Institute in Seattle, US. Our education, training and development programme is fully integrated into our leadership development and core induction for all staff. We have engaged with over 6,000 staff helping them to use the method in their work. We have also invested in developing 200 leaders with more specialised skills in the use of the management method, known here as Lean for Leaders.

Our year-long leadership education programme supports leaders in our organisation, enabling them to develop a deeper knowledge and more explicit understanding of our improvement method. The programme requires that they learn and use lean tools in applying a daily management approach to know their business, run and improve it through their teams. Each participant identifies a value stream; a specific focus area for them and their team to deliver improvement.

The following are examples of improvements produced by our leaders through the programme:

- Reducing pathology sample defects from over 16% to less than 1%.
- Releasing eight hours of time in outpatient cancer services for the team to use on direct patient care.
- Over 70% increase in the number patients receiving physiotherapy rehabilitation sessions three times each week, the national best practice standard.
- Releasing 40 minutes every day from handover for nursing teams to focus on direct patient care and to be able to leave on time after a night shift.
- Reducing time in weekly access meetings from 60 minutes to 20 minutes.
- Eliminating up to 45 minutes of waiting for patients in ante-natal clinic
- Standardising the Daily Operations meeting
- Reducing the duration of medicine rounds by 50% from 120 to 60 minutes.
- Improving clinic outcome coding accuracy by over 90% across outpatient services.

To date our training and education in the Leeds Improvement Method have included:

- 6146 members of the Trust have received an introduction to the Method.
- 192 Leaders representing all areas of the Trust have taken part in the Lean for Leaders Programme.
- 24 leaders have taken part in Advanced Lean Training.

Engaging and developing our staff

Our amazing team continues to grow to meet demand for services and we have nearly 18,000 staff working at Leeds Teaching Hospitals. Once again their expertise and dedication are the real driving force behind us being able to achieve our ambitions.

The results from this year's Staff Survey showed another increase in those reporting positively about working at the Trust, and our scores are among the best in the country. This is a huge improvement and is undoubtedly down to our staff and their commitment to embedding The Leeds Way into everyday working life.

We are the most improved trust nationally for our work on staff engagement, which we are particularly pleased about as studies show that higher staff engagement is linked to improved patient experience.

The Leeds Way is also about recognising and sharing the successes of our teams. Once again we held two events to recognise long-serving staff members and began our third trust-wide staff awards campaign, Time To Shine.

We are particularly fortunate in Leeds to not only have staff that are experts in their fields improving services in West Yorkshire, but that also work nationally and internationally. We have staff from all across the organisation, doctors, nurses, therapist and scientists along with senior managers who hold senior leadership positions in Royal Colleges, professional bodies, Universities, working groups and forums.

We are also conscious that we have a huge responsibility as a teaching hospital to develop clinical leaders of the future by helping junior doctors to develop their careers across our hospitals. We have a vision as a Trust for how we engage with our junior doctors and have made a strong commitment to make their experience the very best it can be. Having engaged with junior medical staff to understand their needs, we have committed to delivering as many of their recommendations as possible, including improving communication, making sure they get protected teaching time and are involved in various clinical groups. We want to ensure that all of our junior doctors feel valued and are able to train in a safe, supportive and enriching environment so that they feel able to recommend LTHT as a place to work.

We recognise that having a workforce that can plan and work as part of an integrated system means training and developing those people to work across boundaries. We are, key partners in the Leeds Health and Care Academy which will bring together the planning, coordination, resource and delivery of learning and development for around 57,000 Leeds health and care professionals, offering them greater opportunities to experience and practise in different workplace settings and disciplines. Throughout the year we have continued to make progress with this initiative and look forward to its implementation.

Research, education and innovation

We are pleased to be a world-leader in clinical research and innovation and we work closely with the academia, in particular the University of Leeds. Research, Innovation and Education are fundamental to our goals and strategy. We are a key partner in the Leeds Academic Health Partnership, a group that brings together expertise from universities, NHS organisations and the local council in Leeds to attracts inward investment and implement innovation across the city to improve health and care, and reduce health inequalities.

It is well-evidenced that where hospitals are active in research, patients get better treatment and these facilities will help us consolidate and improve our impressive performance in clinical trials and other vital research. In 2017/18, more than 19,000 of our patients were recruited onto 440 research studies. We were among the top three trusts in England for research projects recognised by the National Institute of Health Research (NIHR).

In September, we launched the new Research and Innovation Centre at St James's. The centre provides a real focus for research and innovation across our hospitals and in a collaboration with our partners in academia and industry. In December, we officially opened the NIHR Biomedical Research Centre (BRC) at Chapel Allerton Hospital. There are only 20 NIHR BRCs in the country and Leeds is the only one dedicated to musculoskeletal research.

We continued to run one of the largest medical education programmes in the NHS. Last year we welcomed over 2000 undergraduate and postgraduate medical students to our hospitals as part of their training. In addition, more than 1200 nursing, midwifery and allied health professional students completed clinical placements with us and nearly 600 apprentices across a number of different roles. We are delighted to be playing such a vital role in training the healthcare professionals of the future.

We are the second largest provider of specialist services in the country with half of our income coming directly from NHS England. This year we have become the lead provider for the West Yorkshire Hepatitis C network, the congenital heart disease network and we are the regional provider for the HIV service.

We have also worked with the Department of Health's 'Getting It Right First Time' programme to benchmark our services against other providers. In some departments we have been shown to be exemplary and others are learning from us, whereas in others we are taking on board feedback to improve.

Strengthening our Leadership

Throughout the year we saw changes in our leadership team, which gave us the opportunity of bringing new expertise to existing challenges. At the beginning of the year we welcomed Simon Worthington as Director of Finance for the Trust. Simon joined us from Bolton NHS Foundation Trust where he has delivered, in the words of the then Chief Executive of NHS Improvement, Jim Mackey, 'the most impressive financial turnaround in the NHS'. His financial leadership has helped us achieve our impressive performance this year.

We are also delighted to have appointed into the new post of Chief Digital and Information Officer, Richard Corbridge, formerly Chief Executive Officer for eHealth Ireland, and a globally recognised expert in healthcare technology strategy. Richard has already made an impact by raising the priority of digital and information projects and accelerating progress with our strategy.

Richard will be working with Jasmeet (Jas) Narang, who joins us for one year as an Associate Non-Executive Director. This is a new role for the Board which aims to provide greater breadth of expertise, especially in IT, digital and information systems. Jas is currently Governance Director and Transformation Leader at Santander UK and has over 20 years' experience in global finance services. He will be the Non-Executive Director with lead for our digital development.

Non-Executive Directors

We would like to introduce our other new Non-Executive Directors, replacing those whose terms of office expired during the year.

Bob Simpson joined the Trust Board with experience as a senior executive manager and has extensive experience in building development and construction. A key part of Bob's role will be to seek assurance with the Board in all aspects of Building the Leeds Way and be the lead Non-Executive for this exciting work.

Professor Moira Livingston has worked in a variety of roles within the NHS for over 30 years, and brings a wealth of experience in patient safety and quality improvement from her clinical background.

Chris Schofield is a lawyer who joins us from a role as a Non-Executive Director for the Leeds West Clinical Commissioning Group, so will bring strong experience of the wider NHS, and local commissioning in particular, to his role.

Together they bring key strengths to the Trust Board and we look forward to working with them all. With almost 18,000 other colleagues, our aim is to ensure that in 2018/2019 we will see even more progress towards our strategic ambitions and continuing operational achievements in the face of what we expect to be consistently increasing demand for our services.

Our workforce are central to everything we do here at Leeds Teaching Hospitals and our reputation for specialist care, research and academic training is down to their hard work and dedication. We are committed to delivering the highest quality compassionate care for all of our patients and it is thanks to our teams living The Leeds Way that we are in the best possible position to do this.

Linda Pollard *CBE DL Hon.DLL*
Chair

Julian Hartley
Chief Executive

About us

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

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

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

- Leeds General Infirmary
- St James's University Hospital (including Leeds Cancer Centre)
- Seacroft Hospital
- Wharfedale Hospital
- Chapel Allerton Hospital
- Leeds Children's Hospital
- Leeds Dental Institute

Our services

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

Our services include:

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

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

We are one of the largest providers of specialist hospital services in the country, covering over 100 specialties, many of which are delivered across the region. Around 50% of our patient care income of around £1.2 billion comes from our specialised commissioners, NHS England.

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

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

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

1. Specialist children's services

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

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

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

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

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

2. Cancer, blood and genetics

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

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

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

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

3. Neurosciences and major trauma

We are the regional tertiary centre for Neurosciences, which includes services for spinal surgery, neurosurgery, neurology, neuro-rehabilitation, neurophysiology and stroke.

The Leeds Major Trauma Centre (MTC) was created at the Leeds General Infirmary in 2013 as part of a network set up across England to improve care for patients with life-threatening multiple injuries. In the 5 years since the launch of our MTC we have treated more than 7000 seriously injured adults and children.

The MTC is one of only 12 combined paediatric and adult trauma centres in the country and takes adult patients from across West Yorkshire as well as from the Harrogate and York district, and children from across the wider region. We have one of only two paediatric MTC's in Yorkshire and the only centre with vascular and liver trauma capability.

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

4. Cardiac services

In cardiac surgery, Leeds has the largest single centre Percutaneous Coronary Intervention (Primary PCI) services across the UK and was one of the national pilot sites for this service. PCI services such as coronary angioplasty are used to treat the narrowed coronary arteries of the heart and angina in patients. In Leeds they are provided to more than 1,000 patients each year admitted acutely with a heart attack.

We have also developed the largest Transcatheter Aortic Valve Implantation (TAVI) service in the UK, with over 1,000 patients benefitting from this service. TAVI is a procedure that involves inserting a new artificial heart valve inside the old tight valve using a balloon catheter.

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

5. Specialised transplantation and other specialised surgery

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

Our vision and values

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

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

To achieve this vision, we developed a five year strategy which is now fully integrated within the Trust. Our staff helped to define the values and behaviours that we all work to and that form the foundations of our culture, our ethos and how we will work for the benefit of patients for years to come. This is known as The Leeds Way and is described below.

Over the last four years we have worked hard to embed The Leeds Way as the way we do things across the Trust. During this time we have had positive recognition for its impact from the CQC and this work is also reflected in our staff survey results where in the period 2012 - 2017 we were the most improved trust nationally.

The Leeds Way – our values

We are patient-centred

We consistently deliver high quality, safe care
We work around the patient and their carers and focus on meeting their individual needs
We act with compassion, sensitivity and kindness towards patients, carers and relatives

We are fair

We treat patients how we would wish to be treated
We strive to maintain the dignity and respect of each patient, being particularly attentive to the needs of vulnerable groups

We are collaborative

We are all one team with a common purpose
We include all relevant patients and staff in our discussions and decisions
We work in partnership with patients, their families and other providers so they feel in control of their health and care needs

We are accountable

We act with integrity and are always true to our word
We are honest with patients, colleagues and our communities at all times
We disclose results and accept responsibility for our actions

We are empowered

We empower colleagues and patients to make decisions
We expect colleagues to help build and maintain staff satisfaction and morale
We celebrate staff who innovate and go the extra mile for their patients and colleagues

Highlights of the year

We've had another fantastic year which reflects the outstanding work taking place every day in our hospitals. Our staff have been part of world firsts, groundbreaking research and advancements in care, all while putting patients at the centre of everything they do. Below are just a few of the hundreds of successes we've celebrated over the past year. You can read more about our work on the Trust website, www.leedsth.nhs.uk, or by following us on social media.

April 2017

A garden designed in a collaboration between the team at the Yorkshire Brain Research Centre and our gardening team won a Silver Gilt award at the Harrogate Spring Flower Show.

The idea was to raise awareness and discussion about the brain as well as to raise the profile of the vitally important work of the brain research charity appeal. It has now been installed outside the Research & Innovation Centre at St James's Hospital.

The milestone 1000th TAVI procedure took place. This is a specialist cardiovascular procedure that enables an aortic valve to be replaced without the need for open-heart surgery.

The provides better outcomes for patients and significantly reduces their recovery time. TAVI, which is Transcatheter Aortic Valve Implantation, was first carried out in 2008 and LTHT is now one of the largest centres for the procedure. Leeds also has the highest survival rates amongst patients undergoing the TAVI procedure, both in the immediate period post-surgery and longer-term.

Chris King visited the Trust to share his progress since he received the UK's first double hand transplant.

Chris was able to demonstrate some of the everyday tasks he has now been able to start doing again, such as making a cup of tea, holding a book and writing a thank you letter to his surgeon.

May 2017

Wards at the Leeds Children's Hospital welcomed their second intake of Bedside Buddies.

The Bedside Buddies are a group of 40 students from the University of Leeds who volunteer to spend time with younger patients while in the hospital.

The students are all accredited volunteers and work in conjunction with and guided by our ward play leaders. They make a big difference to the amount of play and individual attention youngsters receive, so they are a very popular addition to the wards and help extend play into the evenings.

The Crohn's & Colitis UK Leeds and District Network opened the new Inflammatory Bowel Disease (IBD) clinic at St James's Hospital.

The charity funded the refurbishment of the clinic in Lincoln Wing to provide a purpose built office space for the IBD clinical nurse specialists, but also a waiting area and three consultation rooms. This dedicated space allows the nurses to run their telephone clinics in a more suitable environment, but also gives them the opportunity to bring patients in for examination in between their scheduled appointments should they need to be seen.

The pathology team celebrated a world first which is improving care for diabetes patients.

The thermo track is the first in the world to exclusively test blood samples to diagnose and monitor diabetes. The equipment has been brought to Leeds thanks to our partnership with Siemens, reducing turnaround time for tests, enabling better control of the condition as doctors can identify treatment plans more quickly and help to avoid admissions to hospital.

June 2017

The fantastic work of the Leeds Children's Hospital featured in the national BBC documentary series 'The Secret Life of the Hospital Bed'.

The show told the stories of patients in beds from Ward 49, Children's Day Surgery and was filmed over a two week period, as well as three other hospitals. It captured the fantastic support the staff provide to patients and their families at what can be an anxious time pre and post-surgery.

Working in partnership with Leeds City Council, Leeds Teaching Hospitals launched its first electric vehicle.

The new electric vehicle, a Nissan e-NV200 van, is used for a range of tasks, including delivering post and small goods around the different hospital sites in the city.

As well as being more environmentally friendly and reducing emissions, the van also allows the Trust to benefit from fuel savings.

Leeds Teaching Hospitals was the first NHS trust in West Yorkshire to sign up to the Trades Union Congress (TUC) Charter, for terminally ill workers.

The charter's aim is to support employees who become terminally ill at work. Under the Charter employees have the security of work, peace of mind and the right to choose the best course of action for themselves and their families which helps them through a challenging period with dignity and without undue financial loss.

July 2017

As part of his role as patron of the WellChild charity, we were pleased to welcome Prince Harry to Leeds Children's Hospital, where he met LTHT's WellChild nurse Helen Tooby and a group of children and families who have been her patients.

Helen is a Tracheostomy Nurse Specialist and she is the main point of contact for all children with a tracheostomy and their families at Leeds Children's Hospital.

The Leeds Transplant Games Teams competed in the Westfield Health British Transplant Games in North Lanarkshire.

23 adult transplant recipients and 39 children from LTHT competed in a range of disciplines, from cycling to swimming and snooker to bean bag throwing. Their ages range from 3 to 79 and all have received life-saving organ transplants in Leeds.

August 2017

A new Frailty Unit opened at St James's Hospital providing dedicated care for older people who come into hospital.

A multi-disciplinary team work on the unit, providing medical and holistic care for patients over the age of 80, or from 65 if they have particular frailty needs.

When a patient is admitted to the unit they are quickly assessed by a specialist team, including a Consultant Geriatrician, Nurses, Advanced Practitioners and Allied Health Professionals. This means that treatment and any packages of care can begin sooner and, in many cases, patients are able to go home the same day, and avoid an unnecessary stay in hospital.

An edible food trail launched as part of the Sustainability GRASP campaign.

Each food garden is part of the St James's Way, a trail of raised beds across the grounds of St James's hospital, working with local charity Back to Front. The raised beds provide an area for staff and patients to tend to and forage from, and also form a walking trail across the site. Each food garden is themed, and following a great response, they were created using feedback from the public.

The very first nurse-led sedation for Transcatheter Aortic Valve Implantation (TAVI) took place.

The procedure was performed without an anaesthetist or ODP in the room and went smoothly - with minimal sedation the patient was wide awake but entirely comfortable throughout. This highlights how collaborative working can make a real difference to the care we provide. It is also a big step forward for the TAVI service, and would not have been possible without the huge amount of time, effort, and expertise that the anaesthetics team provided.

A celebration and commemoration of the life of brave Leeds nurse, Nellie Spindler, who was killed in action 100 years ago at the Battle of Passchendaele was held at St James's Hospital Chapel.

Nellie qualified as a nurse in 1915 at St James's (then known as Leeds Township Infirmary) before joining Queen Alexandra's Imperial Military Nursing Service as a staff nurse. She was critically wounded by shrapnel whilst posted at a casualty clearing station just behind the British front line. During the service a wreath was laid at Nellie's plaque in the Chapel by her niece and the Last Post was sounded in tribute.

September 2017

The Sleep and Non-invasive Ventilation Centre became the first centre in the world to prescribe a potentially life changing drug for patients with Duchenne Muscular Dystrophy outside the clinical trial setting.

Idebenone has been shown to slow down the decline of respiratory function in this condition.

Marking the start of Organ Donation Week, Be A Hero, Yorkshire's dedicated organ donation campaign, launched a 24 hour cycling event.

It saw two hundred volunteers pedalling seven static bikes through the day and night to generate enough power to constantly inflate a giant seven foot inflatable heart. The event was part of Yorkshire's ambitious challenge to inspire 50,000 new sign ups to the organ donor register in just six months. Launching the event was British Cycling Head Sprint Coach and liver transplant recipient, Justin Grace, along with Team GB's Katy Marchant. They were accompanied by courageous transplant patients, the families of organ donors and specialist nurses and clinicians in organ donation. Over 50,000 people signed up to the Organ Donor Register which is a fantastic achievement.

The Yorkshire Heart Centre celebrated its 20th anniversary.

The event commemorated the move of cardiac services from Killingbeck Hospital to Jubilee Wing of the LGI in 1997.

Since then, we have performed more than 25,000 heart surgery operations, more than 100,000 cardiology interventional catheter procedures and more than 1,100 Transcatheter aortic valve implantation (TAVI) procedures.

Trust Chair Linda Pollard officially opened the new Research and Innovation Centre at St James's Hospital.

Its location near the main entrance to the St James's site puts Research and Innovation at our front door, making an important statement about our strategic intentions. The centre provides a real focus for research and innovation throughout our hospitals and collaboration with our partners in academia and industry. Find out more about our research on page 46.

The First Baby Box Programme in Yorkshire launched during Leeds Baby Week.

New parents across Leeds now receive a free Baby Box to support safer sleeping for their new arrivals. The Baby Box Co. provided the kit, which doubles as an infant sleeping space and contains useful information and products for families. The aim of the programme is to encourage early engagement with maternity services and access to care for all pregnant women.

October 2017

Teams in both Emergency Departments celebrated 50 years of Emergency Medicine in collaboration with the Royal College of Emergency Medicine.

They taught CPR as part of a world record attempt, visited local primary schools and businesses, as well as in our hospitals. Mr Maurice Ellis, a Consultant at the LGI, set up the Casualty Surgeons Association in October 1967- this later became the Royal College of Emergency Medicine (RCEM) - marking the start of Emergency Medicine as a specialty. Mr Ellis became the first A&E consultant in the UK so we're proud to think that Emergency Medicine all started in Leeds.

The Trust received an Employer Recognition Scheme Silver Award from the Ministry of Defence for their support of the Armed Forces.

The Trust has developed a dedicated Reservist Procedure, in addition to increasing leave for staff who are reservists, to help facilitate training attendance. Previously holders of a Bronze Award, the Trust has received a Silver Award in recognition of these further achievements.

The Neonatal Intensive Care Unit became the first in England to use video updates to connect parents and babies.

The vCreate web-based application lets nurses record video updates for parents when they are not able to be by their baby's cot side. The nursing team now use secure video messaging to ensure that parents of premature babies don't miss out on any special moments in their baby's care journey, as well as ensuring that the wider family unit feels more involved in the care of their own baby.

We welcomed the first newly qualified physician associates to the Trust.

As a new professional group, physician associates are there to assess and diagnose patients, initiate investigations and management, and oversee treatment. Their role is designed to support our doctors and medical teams.

A timeline of Leeds General Infirmary's 250 year history launched, officially beginning a year of celebration.

The timeline, generously funded by the Leeds Hospital Charitable Foundation, is displayed along the blue bridge in Jubilee wing, bringing historic imagery to a modern healthcare building and showing LGI's important contribution to the development of modern healthcare as we know today. Over the past 250 years the LGI has been at the forefront of the development of medicine and surgery in the UK, developing many techniques ranging from aseptic surgery to the UK's first kidney transplant and the UK's first hand transplant and first double hand transplant.

November 2017

The 'Sit Up, Get Dressed, Keep Moving' campaign launched, to encourage patients to get out of bed, wear their own clothes and stay mobile during their time in hospital.

This simple idea can support a faster recovery and enable patients to go home sooner. This initiative comes on the back of the national 'End PJ Paralysis' campaign and encourages a collaborative approach between staff on the ward, patients and their families.

Seriously ill or injured patients from across Yorkshire are now benefitting from extended air ambulance flying hours thanks to a donation from the HELP Appeal.

The donation has been used to fund important lighting and fire fighting equipment on the helideck at the Leeds General Infirmary, which is enabling air ambulances to land later into the evening, therefore increasing access to the Major Trauma Centre.

NHS England confirmed that the Leeds Teaching Hospitals NHS Trust will continue to deliver congenital heart surgery services from the Leeds General Infirmary.

NHS England confirmed that it is satisfied with the Trust's progress against meeting the standards for congenital heart disease services which were introduced in 2016. The service will continue to be commissioned by NHS England and patients will benefit from the excellent care and expertise of the teams in Leeds.

December 2017

Our first ever day-case aortic aneurysm repair was completed.

Aortic aneurysm repair is undertaken to prevent aortic rupture, an event that is nearly always fatal. Traditionally this required a major open operation with a 5-10 day post-op hospital recovery. Endovascular aneurysm repair (EVAR) has revolutionised this, by using image guidance to re-line the aorta from the inside through tiny incisions in each groin. Having performed EVAR as a one night stay, the pioneering Leeds Vascular Radiology and Vascular Surgery teams have now pushed the boundary to complete the operation as a day-case for the first time.

January 2018

Our volunteer Sheila Miller was awarded a British Empire Medal (BEM) for the difference she has made to patients and staff as a Spiritual Care volunteer.

For over twenty years, she has been volunteering at LTHT and St Gemma's Hospice supporting patients and their families.

Ian Bailey, a patient at Leeds Cancer Centre was the first patient in the world to receive viral immunotherapy as part of an early phase clinical trial to enhance his treatment for an aggressive brain tumour.

The clinical trial, run by Susan Short, a consultant clinical oncologist at Leeds Cancer Centre and Professor of neuro-oncology at the University of Leeds, is investigating whether the use of a virus could improve treatment of glioblastomas, a type of brain tumour that is extremely hard to treat.

The Parkinson's Quality Improvement Collaborative won a UK Parkinson's Excellence Network Award for their work creating an intervention bundle for patients with the disease.

This work involved partnership working with a carer, which demonstrates how we engage and listen to patients to make improvements. The bundle consists of resources such as an alarm clock and the Get It On Time laminated clock as well as a 6 monthly educational masterclass day. The team have seen some great results, with the delay of the first medication on admission going down from over 7 hours to below one hour. The average percentage of Parkinson's medication doses omitted over a 24 hour period has also fallen from 15% to 5%.

The groundbreaking ceremony for the new Maggie's Yorkshire centre took place on the St James's Hospital site.

The centre will complement the excellent clinical care provided at Leeds Cancer Centre and offer practical, emotional and social support for people with cancer and their family and friends.

February 2018

Work started on a new children's cardiac hybrid theatre and intra-operative MRI facility.

This new development will create a dedicated environment at Leeds Children's Hospital for paediatric cardiac surgery and paediatric neurosurgery, supporting the internationally recognised work of these expert teams.

PPM+ won the 'Using technology to improve efficiency' award at the Academic Health and Science Network (AHSN) Yorkshire and Humber 'Innovation, Improvement, Impact' conference.

The PPM platform powers the Leeds Care Record, 100,000 Genomes and regional Oncology, connecting over 35 systems across health and social care in the Leeds area. This provides a local integrated care record for 2.8 million patients over the last five years. PPM+ also serves as Leeds Teaching Hospitals own in-house Electronic Health Record (EHR).

The theatre team put on the first elective caesarean section surgery lists at St James's and LGI.

Before, the daily lists included both elective and emergency sections, which has meant women coming in for elective surgery may find themselves waiting longer than expected whilst fasting due to unplanned emergencies. Thanks to this dedicated list, elective patients are enjoying a streamlined service. This has also had the effect of increasing the number of electives that can be planned for a given day, whilst patients can benefit from the care of a dedicated team of anaesthetists, ODPs, theatre staff, midwives and obstetricians.

A new cardiac suite opened at Leeds General Infirmary, thanks to £500k of funding from the charity Take Heart.

The suite, based on ward L14, enables elective and day case cardiac patients to receive their treatment in a comfortable location. It also includes a large waiting area with new furniture, lockers and a refreshment area, separate toilets and two consent rooms for patient confidentiality.

DigiBete landed in the Children's Hospital, providing much needed support for parents of children with Type 1 Diabetes.

It has been designed and created by parents Maddie and Rob Julian, whose son Otis has Type 1 Diabetes, in partnership with the children's hospital.

DigiBete is a digital platform that provides additional support to parents and means that schools, extended family and the child's community can also access vital training in order to keep children safe and ensure that their condition is better understood and managed effectively.

March 2017

The Family Integrated Care team at Leeds Children's Hospital were named Team of the Year in the national Bliss Neonatal Excellence Awards.

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

The Think Drink campaign launched, aimed at reducing excessive fasting which increases dehydration and other adverse effects to our surgical patients.

It's a fantastic advancement to our fluid fasting protocol and will dramatically improve patient experience and outcome.

The campaign has been funded and supported by The Leeds Hospital Charitable Foundation.

A new state-of-the-art Radiotherapy CT Scanner was officially launched in Bexley wing.

The scanner offers an "ambient patient experience" which is lighting, sound, and media all designed to ensure the patient experience is as relaxing and non-clinical as possible.

Notable visits

Our groundbreaking work attracts attention from influential figures and experts from around the world. We have been privileged to welcome a number of them as guests into the Trust to showcase the innovation and patient centred work that happens every day in our hospitals. Here are just a few of them:

We were delighted to welcome HRH Prince Harry to Leeds Children's Hospital to meet Helen Tooby, our tracheostomy nurse specialist funded by the charity WellChild. Helen explained how she is on hand for families from the point of diagnosis with training and advice, helping them to learn to care for their child and gain the confidence they need to support them at home. It was fantastic for him to hear directly from the families how much of a difference Helen has made and helped them get home from hospital sooner.

We welcomed the Chair of NHS Improvement, Baroness Dido Harding who heard about our exciting plans around Building the Leeds Way. Dido also visited our Breast Care Unit to see the innovative technology we are using to improve patient care through Scan4Safety, an innovative technology which allows us to track products from supplier to patient. She met the team on our Chemotherapy Day Unit to hear about the difference they have been making to patient waiting times by using the Leeds Improvement Method.

Cecilia Anim, Royal College of Nursing (RCN) President, and Richard Deacon, Senior RCN Officer also visited the Trust. Their comments included: "we thoroughly enjoyed the visit and were really impressed at the innovation and enthusiasm that we saw. It is truly a breath of fresh air with all the negative press at the moment to see happy and genuinely engaged nursing staff – both registered and non-registered staff alike."

Lord Carter visited the Trust to hear about our progress using the Model Hospital tool that he has been instrumental in helping set up. This is a benchmarking tool from NHS Improvement which allows us to measure the Trust's performance against that of other NHS trusts across the country. This has been really helpful for us in identifying which areas we are leading in and which areas we could be pushing more towards the national average.

We were honoured with a visit from Dr Christopher Tufton, the Minister for Health in Jamaica, who was pleased to hear about the post-registration education available for Registered Nurses in Adult Critical Care settings. He discussed some of the challenges Jamaica is facing with nursing retention and post-registration skills development and education and was keen to explore avenues for future co-operation between the Trust and hospitals in Jamaica to improve this.

Philip Dunne, Minister of State at the Department of Health was warmly welcomed to the Trust where he met some of our Freedom to Speak Up Guardians and visited the maternity team, where he heard about our vision to create personalised care and choice for women. He also met the teams in our Emergency Department, who discussed our on-going preparations for winter.

We also hosted a visit by Lord Kerslake, Chair of Kings College Hospital, who attended a Leeds Improvement Method Report Out session where he heard about work on developing 7-day services and on our national work to standardise chemotherapy drugs.

Top row, left to right: Baroness Dido Harding, Cecilia Anim, Lord Carter
Bottom row, left to right: Dr Christopher Tufton, Philip Dunne, Lord Kerslake

Key risks to delivering services in 2017/18

In 2017/18 we identified a number of key risks that could affect the delivery of our services. These are outlined below:

- Achievement of national performance standards, including the Emergency Care standard, cancer waiting times, cancelled operations not rebooked within 28 days and the 18-week Referral to Treatment target.
- Ensuring that we rigorously monitor our costs and reduce wasteful practices without compromising patient safety. This includes working with colleagues across West Yorkshire to introduce new payment mechanisms which reduce unnecessary visits to hospital and encourage better pathways of care for our patients through "aligned incentive contracts".
- Monitoring investment in IT infrastructure and resilience to manage the risk of cyber attacks.
- Manage the risk of power failure and work with NHSI colleagues to find solutions for other infrastructure priorities. Manage the condition of the estate and backlog pressures throughout the year to ensure services have suitable facilities.
- Manage safety and quality including nurse staffing levels, the reduction in the supply of doctors in training, C. difficile and MRSA targets and violence towards staff.
- Work with our partners in other agencies to reduce the number of unplanned admissions to hospital and improve the arrangements for discharging medically optimised patients to non-hospital based services to improve hospital bed availability.
- Ensuring we constantly horizon scan the benefits and risks associated with local and regional policy changes to the health and social care system. This includes the financial arrangements linked to any such changes and the funding implications of other national policy initiatives.

The Trust's risk register is reviewed regularly by our Board and senior leaders as part of our governance processes. Further information on our risks and our monitoring and reporting of them can be found in the Annual Governance Statement, on page 68.

Section 1
Operating and Financial Review

Operating and Financial Review

1.1 Achieving quality, efficiency and financial sustainability

An important part of our approach in 2018 will be to build closer links with colleagues in our partner agencies. All health and social service bodies are increasingly aware how much we rely on each other to treat patients' illnesses and, where we can, prevent people getting ill in the first place.

We are therefore working with our partners to look beyond our respective organisations to see how a patient's whole pathway of care can be improved. An example of this is this introduction of the Aligned Incentive Contract which makes it easier for us to treat patients using technological links with their homes or their local GP practices, rather than asking them to attend hospital outpatients.

A summary of our approach to 2018/19 is set out below against each of our Trust goals.

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

We will implement our Quality Improvement Strategy which, for 2018/19, includes falls prevention, the care of deteriorating patients, ward-led safety huddles, acute kidney injury, pressure ulcer prevention, sepsis, Parkinson's disease, end of life care and improving the patient experience. This is described in the Trust's annual Quality Account. Further work will also take place in providing services for our patients seven days a week.

Trust goal: To be the best place to work

We will invest in our staff to help us achieve continuous quality improvement, focusing on our values and behaviours set out in The Leeds Way. There will be an on-going review of roles and skill mix, with a focus on attracting and retaining key clinical and non-clinical staff.

We will continue to engage and involve our staff in all the work of the Trust. This approach includes our Leeds Improvement Methodology, our appraisal programme and the use of our crowd sourcing tool. We are employing apprentices across our hospitals and creating a range of new roles to support patient care. We will continue to work with health and social care colleagues in Leeds and across West Yorkshire and Harrogate to make the best use of our workforce, including progressing the Leeds Health and Social Care Academy.

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

We will work with the West Yorkshire Association of Acute Trusts to understand how our hospitals can collectively support clinical services as close to patients' communities as possible, where possible sharing support services.

We will also work closely with Leeds Medical School and the city's universities to provide high quality education and skills training for staff, and progress the plans for improving the Leeds General Infirmary site, including the Leeds Children's Hospital.

Trust goal: To offer seamless, integrated care

We will continue to work closely with health and social care partners, particularly in Leeds. We have system wide actions agreed for 2018/19 to ensure safe and appropriate care facilities are available for our patients when they are medically fit to leave hospital.

There are some specialties where there are pressures on services across West Yorkshire such as paediatric surgery, spinal surgery and dental specialties. We also have our own areas of high demand and capacity constraints. We will continue to discuss these issues with our commissioners to ensure that we manage our patients in the best way possible.

Trust goal: To be financially sustainable

We will continue to work with our colleagues across Leeds and West Yorkshire to use our collective resources wisely, ensuring patients are directed to care that best meets their needs and minimising the costs of transactions between us. We have agreed a sustainable financial plan with our commissioners and regulators which includes engaging with our staff to improve our efficiency and reduce waste.

1.2 Our performance

In 2017/18, the Trust saw and treated 1,180,687 outpatients, 114,104 inpatients, 103,640 day case patients, with 212,856 patients attending our Emergency Departments.

We also delivered NHS services for a population of around 751,500 and provided specialist services for more than five million people.

The Trust's performance is assessed externally against a range of national targets and standards. In 2017/18, overall, we reduced the numbers of patients attending our emergency departments and our admissions from A&E, however the numbers of acutely unwell patients who stayed in our care for longer than needed rose significantly. This further impacted on our capacity to undertake planned patient operations and presented difficulties and at times extreme pressures with patient flow across the Trust.

We continued to strive to balance the provision of care for our patients alongside dealing with the increased challenges of discharging medically fit patients, while achieving significant efficiency savings and ensuring financial sustainability.

Despite the pressures, we continued to provide safe, high quality care, with excellent clinical outcomes and a high level of patient satisfaction. The City of Leeds Winter Plan and our performance in key areas is outlined below.

The Leeds System Winter Plan 2017/18

The Leeds System Winter Plan for 2017/18 was one integrated plan for the city aligned to the national nine point plan for action on A&E. Based on the nine national initiatives the following work streams were established on a city wide basis:

- A&E Streaming
- Patient Flow
- Community Capacity
- Mental Health
- NHS 111 service developments
- Primary Care including GP access
- Care Homes
- Urgent Treatment Centres
- Ambulance Response Programme

In addition to the above work streams three additional areas were identified as priority areas and these included:

- Public Health
- Communication
- System Management, Escalation and Mutual Aid

The delivery of the plan by each partner organisation was reported and managed through the Operational Resilience Group and the System Resilience Assurance Board (SRAB / Local A&E delivery board) chaired by Phil Corrigan, Chief Officer of Leeds CCG.

Areas of focus internal to Leeds Teaching Hospitals

Learning from previous winters, combined with analysis undertaken to understand capacity and demand through the year, allowed us to focus our internal operational response. The key internal developments undertaken through the course of the year included:

- **A revised Operational Response Document which described the:**
  - Daily Operational Performance (DOP) process
  - Operational Performance Escalation Levels (OPEL) Level
  - Full capacity plans
  - Non-designated area and surge escalation process
  - Staffing escalation process
  - Winter room established and operational until April 2018

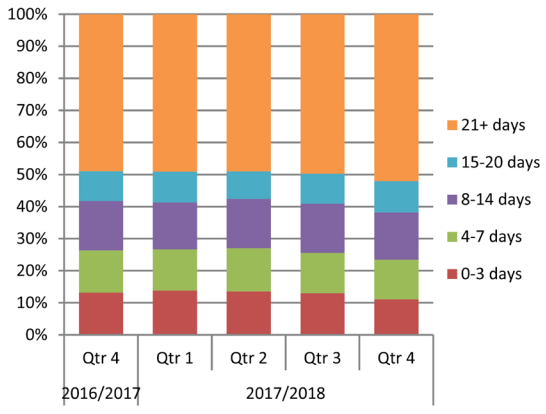
- Front Door
  - GP in A&E available on both sites for 12 hours per day seven days a week since November 2017.
  - Ambulatory Care - Relocation of JAMA (Acute Medical Assessment and Ambulatory Unit at St James's) from J27 to A&E in January 2017 - this service is available seven days a week.
  - Increased JONA (Oncology Assessment Unit at St James's) capacity through estates work from four to six cubicles allowing more patients to be managed through the unit.
  - Frailty Unit - Opened November 2017 at the St James's site
- Inpatient Flow
  - Inpatient bed capacity
    - Increase of beds at Wharfedale Hospital (WGH) for Medically Optimised For Discharge (MOFD) patients on the Heather and Bilberry Wards (52 beds) opened in January 2017 and March 2017.
    - Ward J16 transferred to J11, allowing an increase of nine beds over the winter period (release of staff from WGH to support)
    - Creation of an additional seven beds on J27 as a result of the relocation of JAMA to A&E
    - J30 MOFD ward 30 beds management of patients via private provider to allow release of our nursing staff into the acute wards
    - Ward J31 and J32 opened as MOFD wards staffed by private provider - this allowed a further 47 beds.
    - J24 - 8 beds for medical patients
    - L28 staffed on a seven day basis providing 20 beds
    - CAH - C02 and C03
    - Five day wards expanded to seven day opening e.g. J43, L14, David Beevers Day Unit
- Perfect Week undertaken October 2017
- MADE Event held February 2018

Despite all the actions taken the escalating pressure being experienced associated particularly with increasing numbers of MOFD and Stranded patients meant that the performance against key metrics such as ECS, RTT (Emergency Care Standard, Referral to Treatment) and Cancer were adversely impacted. Recommendations from MADE (Multi- Agency Discharge Event) and themes emerging from the Winter room require a city wide response with a particular focus of ensuring that patients are no longer cared for in a hospital setting once deemed medically fit. The plan for 2018/19 is focussed on delivering against the key recommendations highlighted by the MADE event.

Flow pressures

During 2017/18 we experienced unprecedented acute bed pressures, primarily due to our inability to discharge patients out of hospital who no longer required our level of hospital care.

This resulted in increased numbers of patients staying longer in hospital when they didn't need to and had a significant impact on the number of patients in A&E waiting to be admitted to a ward. It also impacted on our planned levels of elective care. This occurred from November 2017 to March 2018 and included no routine operating, other than for cancer and urgent cases, from mid-December 2017 to end of January 2018.



The number of patients with a length of stay of seven days or more in the Trust during 2017/18 was one of the highest within England and will require a significant step change in our hospital outflow during 2018/19 to address.

Teams across the Trust continued to provide high-quality care to our patients during this period, with a focus on a number of ways to reduce pressure in A&E. These include:

- the use of GPs in A&E to see those patients who need primary care
- opening of a new frailty unit
- establishing more ambulatory care pathways
- supplementing our existing two 'Optimised for Discharge' wards (opened in 2016/17) with three more opened in 2017/18, giving a total of 152 additional system supporting beds

We have continued to work with system partners across health and social care and during 2017/18 we ran a Perfect Week - a national initiative which is designed to help optimise patient flow and 'reset the system' unblocking barriers.

We introduced a Winter Room to support the management of winter pressures and maintain the safety and standards for patients and staff by working with partners, internal and external to the Trust, to improve the overall flow of patients.

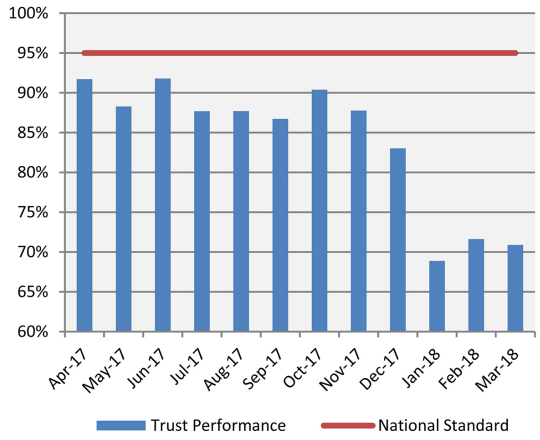
During March we hosted a Multi Agency Discharge Event (MADE) on our wards. The event brought together local health partners to improve patient flow across the system, unblock delays, and simplify complex discharge processes. Senior clinical and operational staff from partners across the city - including from Clinical Commissioning Groups, community services, social care and primary care - came together to identify patients most susceptible to delays in their care pathway. Each patient participating in the event had their case reviewed to understand what next steps were required to reach discharge and to make sure critical interventions happened without delay.

We will continue to refine our internal approach and work with commissioners and partners to improve the areas identified throughout 2018/19.

Emergency Care Standard (ECS)

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

Percentage of patients treated within four hours in ED

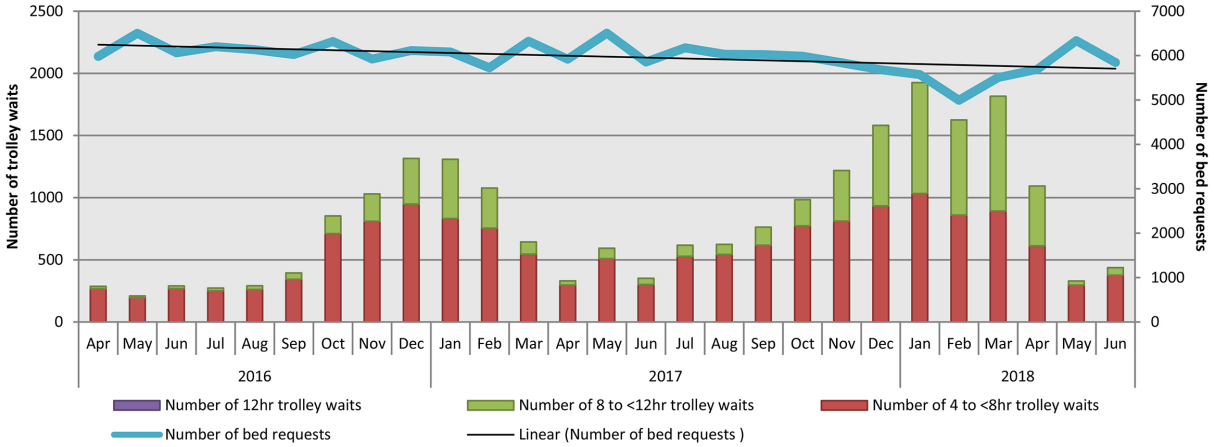


In 2017/18, performance in our Emergency Departments remained below the 95% standard and on a declining trend throughout the year due to the continuing acute bed pressures described above. This resulted in significant levels of Emergency Department congestion, despite the multiple internal schemes and actions put in place to try and avoid this, described above. We finished the year with an ECS of 82.79%.

We maintained a position of reporting no over 12 hour trolley waits, despite our flow issues, but we recognise that the level of congestion resulted in much longer waits for our patients in the Emergency Department than we would wish.

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

Trolley waits (exc. 15min - <4hrs)

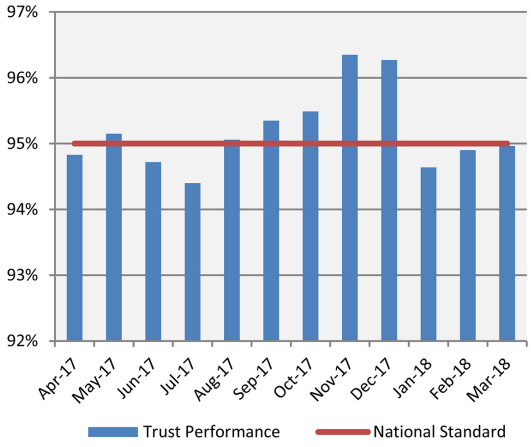


This resulted in us not achieving the requested NHSE trajectory to reach 90% performance by September 2017 and 95% performance by March 2018.

Harm-free care

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

Percentage of patients experiencing harm free care



We continued to see positive improvements in the reduction of falls and pressure ulcers in the Trust during 2017/18. In November 2017 we launched the Pressure Ulcer Collaborative on 16 pilot wards, which have already shown a statistically significant reduction in pressure ulcers.

Trust wide we have continued to maintain the step reduction seen in cardiac arrests in 2016/17 and we remain significantly lower than the national average.

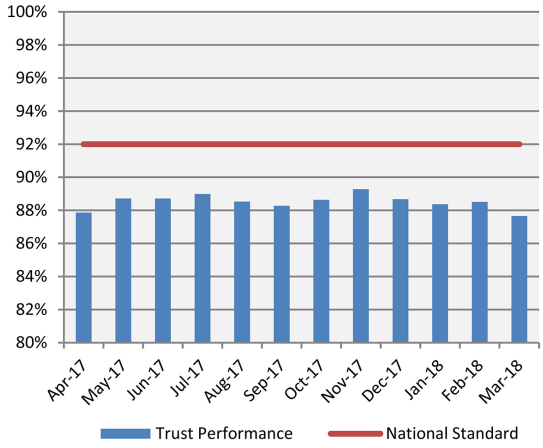
Our goal is to provide harm-free care to every one of our patients. This year, 95.2% of our patients received harm-free care and this has been largely sustained across 2017/18. Our priority for 2018/19 is to continue achieving this level of harm-free care in a more sustained way and identify areas for further improvement.

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

The RTT standard is for patients to wait no longer than 18 weeks from referral to start routine NHS consultant-led treatment, unless a patient chooses to wait longer or it is clinically appropriate to do so.

This standard is to ensure that 92% of patients on our waiting list for routine (elective) care have waited less than 18 weeks.

Percentage of patients on incomplete pathways waiting over 18 weeks



The Trust experienced a number of challenges in meeting this target during 2017/18. These included:

- the volume of acute admissions across our hospitals throughout the year, which continued to significantly affect routine surgical activity
- the increased impact of the inability to discharge patients who no longer needed our care - this continued to significantly reduce our elective bed capacity
- the requirement by NHS England to cancel all elective operating, excluding cancers and urgents between mid-December 2017 and end of January 2018 to better support acute care pressures
- smaller issues with increased pressures across our more specialised elective service, ie Children's surgery, Spines, ENT and Dentistry.

During 2017/18, the Trust reported 52 week waiting patient breaches for the first time in over two years. The first patients were reported in July 2017, with 153 patients reported in total as having waited over 52 weeks by the end of March 2018.

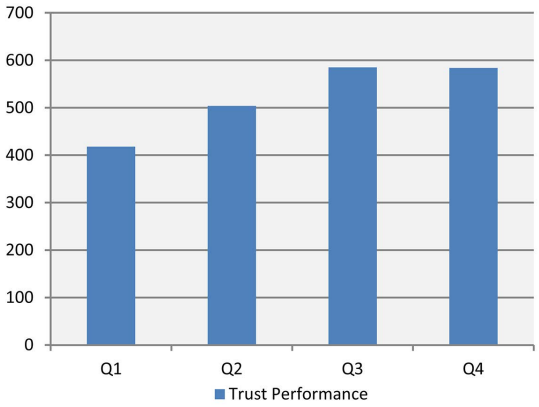
For 2018/19 we are required to reduce the level of over 52 week waiting patients by 50% throughout the year (from March 2018 position), as well as maintain the RTT waiting list at current levels.

Our performance requirements for 2018/19 will be challenging, though a system wide approach to deliver this has been agreed with all system partners across health and social care.

Cancelled operations

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

Number of last-minute cancelled operations

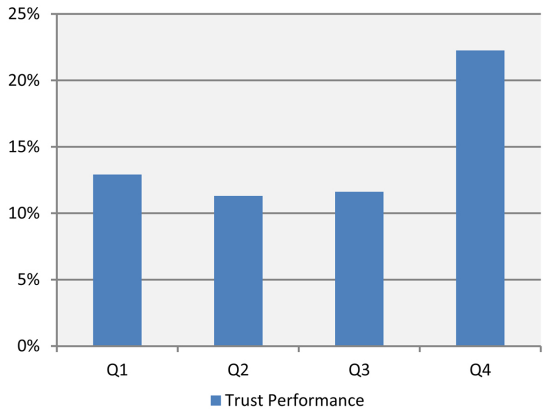


We recognise that last-minute cancelled operations are a distressing experience for patients and we apologise for this. We worked hard to reduce the number of these during 2015/16, however, during 2016/17 and again in 2017/18 this progress has continued to be significantly affected by the volume of medical patients in our beds waiting to leave hospital for their on-going care. This has resulted in insufficient space for our patients requiring routine operations.

When patients' operations are cancelled at the last minute there is a requirement to offer them a new date within 28 days.

In 2018/19, achieving no last minute cancelled operations not rebooked in 28 days will again be challenging. A system wide approach to deliver improved hospital outflow agreed with all system partners across health and social care should support an improved performance position.

Percentage of patients not treated within 28 days of cancellation

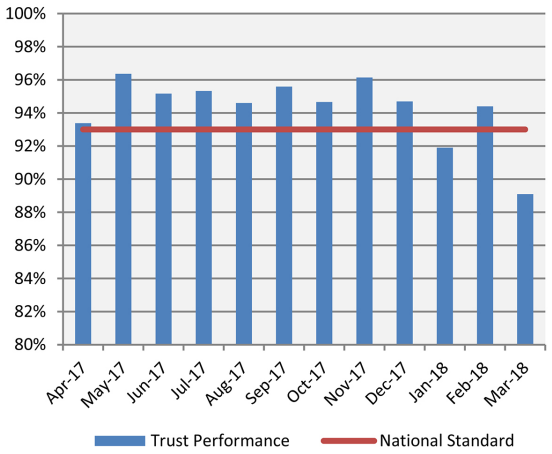


Cancer waiting times

The National Institute for Health and Care Excellence (NICE) sets out four main cancer standards:

- Patients who are urgently referred to a specialist with a suspicion of cancer are seen within two weeks
- Patients who are diagnosed with cancer must then receive first treatment within 31 days of a consultant's decision to proceed
- Patients who have been referred by their GP on a two-week wait and receive a diagnosis of cancer are treated within 62 days of the date of receipt of the referral.
- All subsequent treatments (surgery, radiotherapy, drug therapy or palliative care) must be delivered within 31 days of the decision to treat being agreed with the patient.

Cancer target: urgent GP referrals seen within 2 weeks

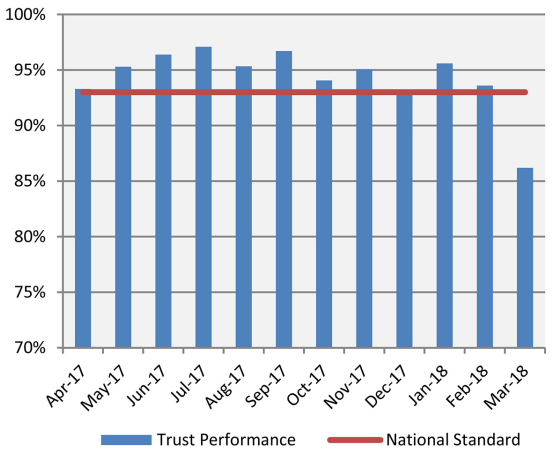


The standard to see urgent GP referrals for patients with suspected cancer within two weeks is 93%.

Due to patient choice of deferring their appointment over the Christmas and New Year period performance was affected. This was further exacerbated by the poor weather conditions in late February and early March which affected the two week wait cancer clinics.

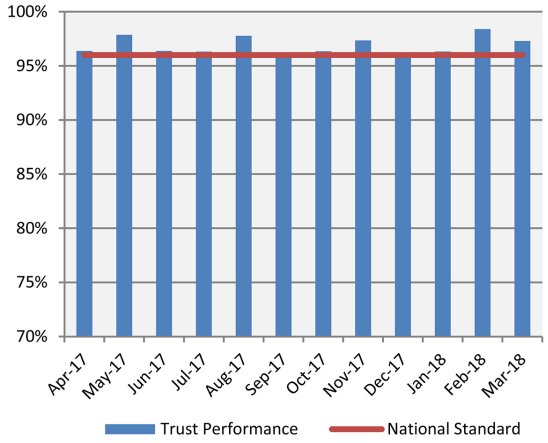
Whilst performance was restored for February, the snow in late February and early March also affected two week wait performance in March as the three days of bad weather occurred on our most busy days of the week for two week wait cancer clinics.

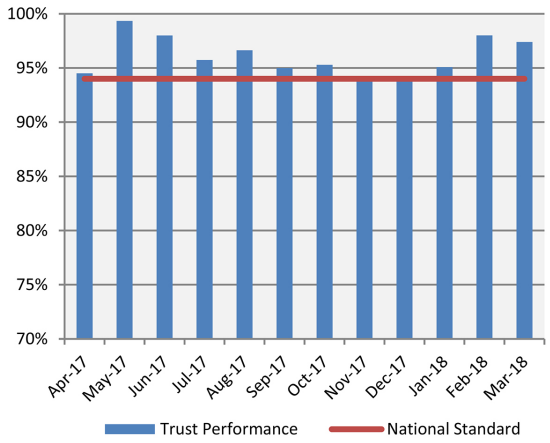
Cancer target: breast referrals seen within 2 weeks



The requirement to see patients referred with breast symptoms within two weeks was consistently achieved in 2016/17, although was affected by the snow issues in March 2018.

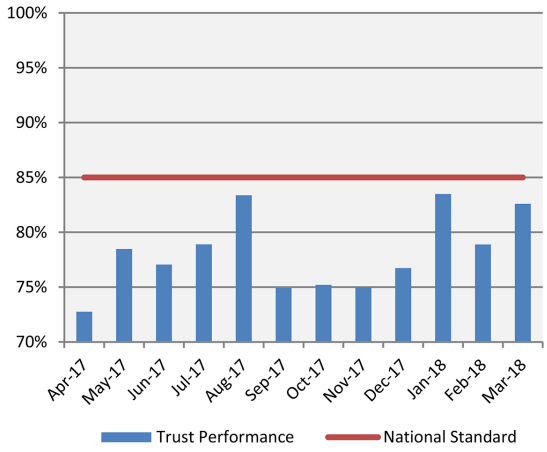
Cancer target: first treatment within 31 days of Decision to Treat





During 2017/18, we consistently achieved the target to treat patients with cancer who needed first and subsequent treatments of any type within 31 days of a decision to treat.

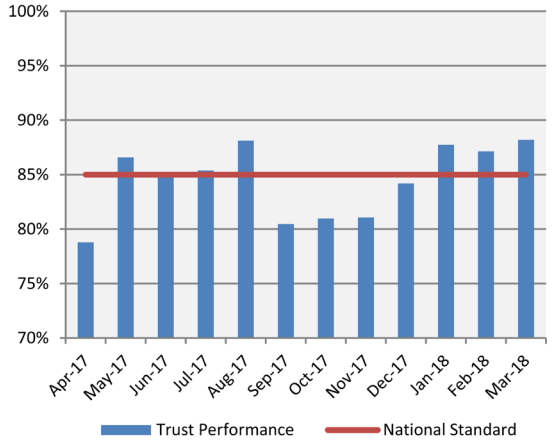
Cancer target: first treatment within 62 days of an urgent GP referral



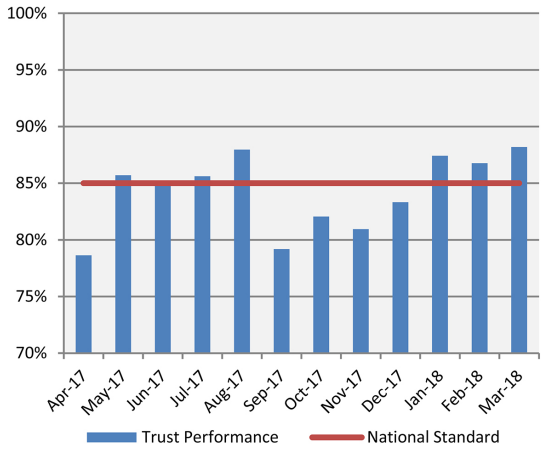
This standard refers to the total number of days from a referral for suspected cancer to the first treatment. This is a shared responsibility with other hospitals that refer their patients to our services for specialist care that they do not provide, which forms a significant part of our 62 day cancer treatment workload (36%).

In order to achieve the overall 62 day standard, we remain reliant on other Trusts to refer their patients to us within 38 days. Despite significant on-going work with our referring Trusts, current referrals by day 38 remain at 50%, with 15-20% of patients arriving after day 62.

Cancer target: treatment by 38 days



Cancer target: treatment within 62 days (internal)

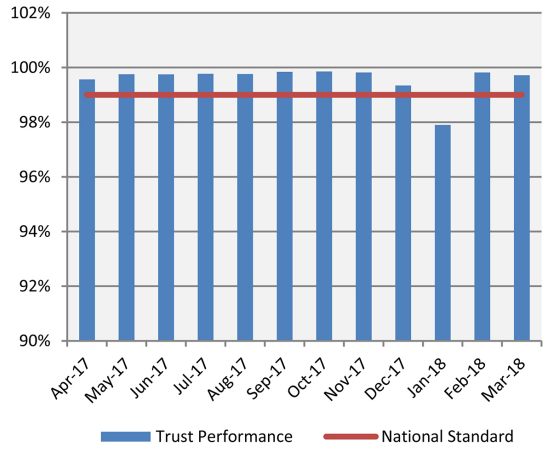


During 2017/18 we saw our internal performance around 62 day treatment improve in line with our Trust Board agreed recovery plan and our NHS Improvement trajectory, with LTHT achieving internal performance and for those patients that were referred to us by day 38 for six out of the 12 months of 2017/18.

Diagnostic waiting times

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

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



During 2017/18 we continued to sustain our diagnostic waiting times performance, with the exception of January 2018 where there was a short term issue which was resolved to ensure performance was restored for February and March.

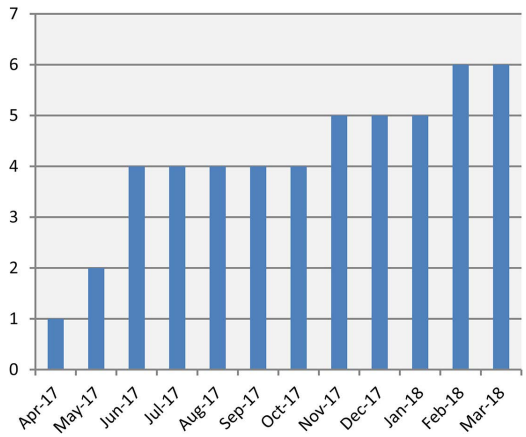
It is expected that during 2018/19 this performance level will be maintained, however there are risks in relation to MRI scanning. There will be reduced capacity in summer 2018 when one of our scanners is replaced and MRI demand pressures are expected to continue. This will continue to be mitigated by the use of capacity at other providers and mobile facilities until the scanner is replaced and internal capacity can be increased, currently planned for during 2018/19.

Hospital acquired infections

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

We are committed to reducing the levels of hospital acquired infections and have continued to work to implement measures and initiatives to support this.

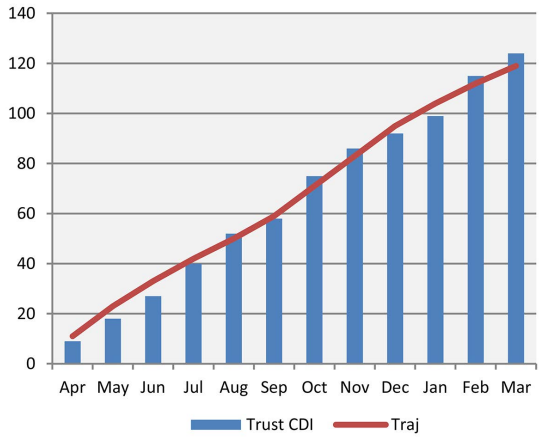
Number of MRSA cases attributed to the Trust (cumulative)



Reducing the rate of MRSA infections is a key national target and indicates the degree to which hospitals prevent the risk of infection by ensuring the cleanliness of their facilities and good infection control compliance by staff.

During 2017/18 six cases of MRSA bacteraemia were recorded against a zero tolerance standard, which is a decrease of four when compared to the 2016/17 position. We will continue to strive to improve in this area as we focus on keeping these infections to a minimum.

Number of CDI cases attributed to the Trust (cumulative)



There were a total of 124 cases of C difficile for 2017/18, against a trajectory of 119. This is an increase of nine cases from 2016/17 levels, although 28 of these cases were not attributable to any lapse of care at LTHT and so our trajectory was achieved. Infection prevention actions remain in place to support our aim to continue to reduce the risk for our patients and staff.

Factors likely to affect performance in 2018/19

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

Emergency care

Delivering the four-hour target for patients in the Emergency Department was not achieved this year in light of the number of patients waiting for alternative care outside of hospital. To achieve increased levels of performance in 2018/19 will remain challenging with the continued pressure on beds and levels of stranded patients due to lack of patient flow out of the Trust at required levels.

Our aim is to ensure patients receive care in the right place at the right time and are discharged from the Trust in a timely and appropriate way. We will continue to work with our commissioners and health and social care partners to address the current outflow issues in line with our MADE event action plan, which will need to have significant impact ahead of winter 2018/19.

18-week referral to treatment (RTT)

There are two new contractual requirements in relation to the delivery of RTT during 2018/19:

- to reduce the level of over 52 week waiting patients by 50% throughout the year (from 26 March 2018 position)
- to maintain or reduce the RTT waiting list from March 2018 levels (52,076 patients).

Performance will continue to be challenging whilst actions to reduce bed pressures with partners are addressed.

For LTHT, all of the current patients waiting over 52 weeks and those who have currently waited over 40 weeks are patients requiring inpatient care and are concentrated over a small number of fairly constrained Clinical Service Units. These are:

- Abdominal Medicine and Surgery - General Surgery (Lower GI and Urology)
- Neurosciences - Spines
- Head & Neck- Paediatric ENT
- Children's - Surgery and Urology

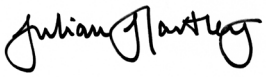
There are plans in place with other providers to increase spinal operating capacity outside Leeds Teaching Hospitals and focus on surgical capacity in the first half of the year to address patients waiting for routine general surgery and paediatric ENT.

We will continue to focus on reducing first outpatient waits and increasing the number of patients we treat as daycases, flagging any areas of increased demand above trigger levels to our commissioners to ensure we jointly address those areas as quickly as we can.

Cancer waiting times

We will continue to work closely with our referring organisations and the Cancer Alliance to put in place the changes required in order to improve the issue of late referral of patients on 62 day pathways from surrounding units. The focus in 2018/19 will remain on maintaining internal LTHT performance and assessing the impact of the new amendments to the Cancer Waiting Times reporting standards due to take effect from July 2018.

Signed



Julian Hartley

Chief Executive Date: 24 May 2018

1.3 Improving quality

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

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

- Our nationally acclaimed ward safety huddles - short, ward-based meetings involving all staff - continue to make a real impact on patient safety and care. These have been embedded in more than 91% of wards. We have seen a 25% reduction in cardiac arrest calls Trust-wide and falls with harm have seen a reduction of 62%. Our ward health check, an initiative that helps wards to identify areas where they are performing well and those where they can improve, is showing excellent results.
- Our work with the prestigious Virginia Mason Institute in Seattle on a five-year programme known in our hospitals as the Leeds Improvement Method. The programme aims to advise and coach staff how to make the best use of their skills, time, systems and resources to deliver the most efficient and effective care possible to our patients. Now in its third year, the Leeds Improvement Method has achieved some exciting results, including reducing the waiting time for orthopaedic surgery, improving theatre turnaround times and ensuring certain patients who have had prostate surgery are discharged quickly and safely. We have continued to scale up and spread this work across the Trust through our Lean for Leaders programme. In 2018/19 this will be underpinned by continuing the development of the education and training curriculum, particularly focussing on practical work with the tools and techniques and coaching staff to work effectively with them.

- Our work to use patient and public feedback to support service and Trust developments is continuing to influence how we offer patients the best possible experience. We have also made great progress in learning from what patients and families tell us by implementing 'Always Events', which are also contributing to improving the patient experience.

We have worked with clinicians, managers and local partners at Leeds West Clinical Commissioning Group (CCG) and Healthwatch Leeds to identify the following priorities for 2018/19:

Patient safety

To continue our Patient Safety and Harm Free Care Improvement Programme which includes: Acute Kidney Injury, Sepsis, Pressure Ulcers, Antimicrobial Stewardship, Falls, Deteriorating Patient, Safety Huddles, Parkinson's, Maternity Services, and Medication without Harm.

Clinical effectiveness

Leeds Improvement Method (LIM) Value Streams:

- Chapel Allerton Orthopaedic Centre - Total hip and knee replacement patients
- Abdominal Medicine and Surgery - Discharge, followed by Inpatient and Day Case
- Adult Critical Care step down
- Outpatient Services - Ophthalmology
- Emergency and Speciality Medicine - improved patient flow from Emergency Department
- Adult Cardiac Surgery
- Reducing the numbers of patients in medicine and elderly wards who have been assessed as being medically fit for discharge who remain in hospital for longer than 21 days

Patient experience

- Measuring and reporting the impact of two 'Always Events', which aim to:
  - Improve the night time experience for patients
  - Improve the anaesthetic / theatre experience for patients
- Reporting how we have obtained public and patient feedback and taken this into account, in our planning of 'Building the Leeds Way'.
- Each bed holding CSU undertaking two new patient and public involvement activities and reporting how using the feedback obtained has influenced patient care.
- Caring the Leeds Way
- Research & Innovation Ambassadors

Further information on key improvements in our quality of care and patient safety, the Trust's performance against national targets in 2017/18, goals agreed with commissioners and our plans for 2018/19 can be found in our Quality Account, published on page 108.

1.4 Financial review

The Trust's plan for 2017/18 was to report a surplus, after technical adjustments and receipt of Sustainability and Transformation Funds, of £9 million compared to a deficit of £1.9 million in the previous year. The table below shows not only that a surplus of almost £19 million was achieved in 2017/18 but that the Trust is in surplus for the first time in four years. The surplus delivered represents a record in the Trust's 20 year history and means that the statutory breakeven duty has been achieved.

	2014/15 Actual £000	2015/16 Actual £000	2016/17 Actual £000	2017/18 Actual £000	2018/19 Plan £000
Operating income	1,086,638	1,115,720	1,172,927	1,238,267	1,245,465
Gross employee benefits	(632,102)	(651,993)	(679,552)	(702,958)	(707,976)
Operating expenses excluding employee expenses	(452,179)	(468,472)	(520,710)	(549,644)	(536,052)
Net finance costs	(22,568)	(22,530)	(9,557)	(20,311)	(20,172)
Gains / (losses)	223	44	96	(149)	-
Retained surplus / (deficit) for the year	(19,988)	(27,231)	(36,796)	(34,795)	(18,735)
Technical adjustments	(4,398)	(2,963)	34,895	53,675	47,609
Adjusted retained surplus / (deficit)	(24,386)	(30,194)	(1,901)	18,880	28,874

In a period of challenging financial pressure for the NHS the significance of this surplus is difficult to overstate. It represents a major step towards achieving the Trust's goal of financial sustainability. Looking ahead to 2018/19, it gives the best possible baseline for delivering the £28 million surplus which the Board has agreed as part of the financial plan it approved in March 2018. Crucially, it generates confidence across the organisation that while the challenges and risks to delivering an even greater surplus are no less daunting than they were in 2017/18 the Trust has the means to succeed. Finally, the cash generated by the improved surplus last year will help fund the record level of £69 million in capital investment planned for 2018/19.

Income Summary

The table below shows the principal sources of our income.

	2014/15 Actual £000	2015/16 Actual £000	2016/17 Actual £000	2017/18 Actual £000	2018/19 Plan £000
NHS England - Specialist Services	439,566	460,543	476,132	498,293	512,098
Clinical Commissoning Groups	456,501	462,945	486,784	522,806	525,889
Non-NHS: Private Patients	4,832	4,715	5,593	5,857	6,843
Other income from patient care activities	24,615	15,180	7,039	7,266	6,851
Other operating income	161,124	172,337	197,379	204,045	193,784
Total operating income	1,086,638	1,115,720	1,172,927	1,238,267	1,245,465

- The principal sources of income to the Trust are from commissioners (NHS England and CCGs) and other income in support of trust activities such as Research and Innovation, Education and Training, and services provided by the Trust to other bodies. Since 2016/17 the Trust has also received Sustainability and Transformation funding.
- Each year the Trust has been able to successfully respond to increasing demands for healthcare, working in partnership with commissioners to ensure that additional work is paid for. This can be seen in the table above with year-on-year increases in income from NHS England and CCGs.
- For 2018/19 onwards the Trust has again worked closely with commissioners to help develop an Aligned Incentive Contract with both Leeds CCGs and NHS England. This will promote a more collaborative approach to addressing the cost of patients' needs in the future, as well as being more responsive to changing treatments which current payment mechanisms can sometimes struggle to cope with.

Every year the Trust benefits from a number of grants and charitable donations. These help us to invest in capital schemes, provide items of equipment, enhance the patient environment, provide training and undertake research. During the year the Trust received the following sums towards its capital and revenue expenditure.

Capital Grants and Donations	£000
Leeds Teaching Hospitals Charitable Foundation	2,120
Take Heart	310
Yorkshire Air Ambulance	108
University of Leeds	57
Total	**2,595**

Charitable Donations Revenue	£000
Leeds Teaching Hospitals Charitable Foundation	11,341
Candlelighters Trust	256
Wheatfield's Hospice	136
Children's Heart Surgery Fund	69
The Burdett Trust for Nursing	68
Cancer Research UK	58
Macmillan Cancer Support	49
Wellchild	43
Kidney Research Yorkshire	34
Other	12
Total	**12,066**

We are immensely grateful to all of the charities who support us in delivering patient care.

2017/18 was an exciting time in terms of our relationship with our key charity partner, the Leeds Teaching Hospital Charitable Foundation. The Charity is legally and managerially independent of the Trust but exists to receive donations and raise funds on our behalf. The Boards of both the Charity and the Trust are building an entirely new strategic partnership which will see a much closer alignment between their respective objectives, mutual support towards achieving those objectives and a growing number of areas of joint funding aimed at delivering the best patient care. We expect this to bring about significant benefits for our patients. This stronger partnership working began to bear fruit in 2017/18 with the Charity supporting a range of important services and developments across the Trust including Interpreting, specialist play, youth and frailty support.

Expenditure Summary

The table below shows our main heads of expenditure

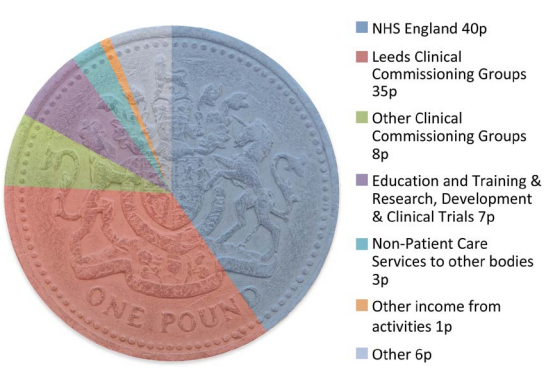
	2014/15 Actual £000	2015/16 Actual £000	2016/17 Actual £000	2017/18 Actual £000	2018/19 Plan £000
Employment related costs	632,102	651,993	679,552	702,958	707,976
Drug costs	148,710	152,410	173,284	178,445	186,934
Clinical supplies and services	153,477	156,673	152,001	155,889	144,882
Premises	37,807	34,310	38,975	42,348	38,865
Other operating expenses	112,185	125,079	156,450	172,962	165,371
Total operating expenses	1,084,281	1,120,465	1,200,262	1,252,602	1,244,028

- Despite the Trust needing to deliver on-going savings from year to year, it has still been able to increase staffing numbers every year to ensure it continues to deliver the best, patient-centred care it possibly can. It plans on further increases in the coming years.
- Every year drugs costs continue to rise, partly due to increased prices but principally due to the increased effectiveness in the treatment of patients. This trend is expected to continue into the future, and the Trust will continue to work closely with commissioners help deliver these on-going improvements for patients.
- The Trust has had a very successful savings programme over the last few years which has resulted in either a reduction or just a small increase in clinical supply costs each year, with no adverse impact on the availability of supplies to patients, and aims to deliver on-going savings in this area next year.
- Other increases in non-pay expenditure are based on a combination of different factors - ranging from expenditure to support more complex patient needs, through to the costs that all Trusts incur each year on things like insurance.
- During 2017/18 the Trust implemented a new financial performance framework which has underpinned our identification, monitoring and delivery of waste reduction. Taken alongside our Leeds Improvement Method which is becoming deeply embedded in our culture the Trust has mechanisms in place to help deliver its 2018/19 financial target.

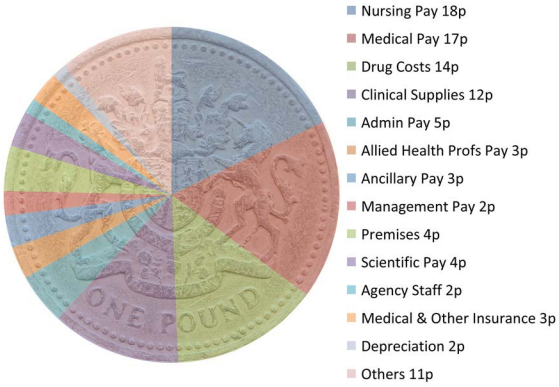
To meet its 2017/18 financial target the trust had to make waste reduction savings of £64 million. Of this, £29 million was made through various central and technical schemes such as our estate valuation, but £35 million had to be delivered by Clinical Service Units and corporate departments. A wide range of schemes were identified which achieved the required elimination of waste without reducing or risking patient care. This approach to waste reduction will carry over into 2018/19 and help deliver the £75 million needed to meet our financial target. By March 2018 almost 100% of the schemes necessary to achieve the £75 million waste reduction had been identified, a fact picked up and acknowledged by our external auditors when forming their unmodified opinion on the Trust's Use of Resources arrangements. It is the first time this has been achieved since 2013.

The two charts below give some further information on where our income comes from and how we use it to deliver our full range of services to our patients

Where each £1 came from



How each £1 was spent



Capital Investment

Capital investment in our estate, medical equipment and informatics was £23 million in 2017/18. The table below shows this to be at a lower level than recent years.

	2014/15 Actual £000	2015/16 Actual £000	2016/17 Actual £000	2017/18 Actual £000	2018/19 Plan £000
Building and Engineering	15,522	14,506	17,776	10,633	47,327
Medical and Surgical Equipment	17,152	7,308	8,698	7,286	10,399
Information Technology	9,667	6,261	6,212	5,210	11,502
Total	**42,341**	**28,075**	**32,686**	**23,129**	**69,228**

In part the reduction in capital expenditure arose from delays on our project to re-plant the Generating Station Complex at LGI and install our new Children's 3t/MRI Intraoperative Hybrid Theatre in Clarendon Wing. It is pleasing to note that in early 2018/19 both of these important installations are well underway with the Children's 3T/MRI Hybrid Theatre due to open in February 2019.

Inevitably, three consecutive years of financial deficit have constrained our ability to invest capital in 2017/18. With financial recovery on course, the fact that a surplus has been delivered in the year and an even larger surplus planned for 2018/19 we are able to look to the future with much greater confidence. The cash generated by a revenue surplus is available to fund capital projects. Receipt of our 2017/18 bonus in 2018/19 will help to fund our planned record level of capital investment in that year. Funding will come from:

2018/19 Sources of Capital Funding	£m
Internal Resources inc. surplus cash	40
PFI Funding	15
Loans	9
Grants and Donations	5
Total	**69**

The plan to fund and spend £69 million on capital projects does carry a number of challenges and risks. It will be noted that a proportion of funding will come from loans. Approval to borrow will be required from the Department of Health and Social Care if the schemes associated with that funding are to proceed. The Trust will have to fulfil its plan to deliver a revenue surplus in 2018/19 to meet its full capital programme but as described elsewhere it has the mechanisms in place and the confidence to make that happen.

Cash

The year-end cash balance of £15 million represents an improvement of £7 million on our planned position at that point. During the course of the year the Trust did draw down £7.5 million of short term borrowing to help meet its payment obligations but all of that plus a further £7.5 million of short term debt carried over from 2016/17 was repaid in-year. Other borrowing fell by £10 million. In overall terms therefore the Trust began to see an underlying improvement in its cash position to reflect the improvement in revenue.

The cash position, combined with the fact that the Trust delivered a surplus, has a plan to achieve a larger surplus in 2018/19 which in turn is underpinned by the certainty of agreed Aligned Incentive Contracts with our principal commissioners has given the trust directors full confidence that we are a going concern. In the NHS, going concern status derives from the certainty that services will continue to be provided in the foreseeable future. There are national mechanisms in place to ensure that this will always be the case but it is reassuring nevertheless that the Trust is able to prepare its annual accounts as a going concern in its own right and with a strong financial position to support that decision.

1.5 NHS Constitution

NHS bodies like Leeds Teaching Hospitals NHS Trust are required by law to comply with the NHS Constitution, a document that establishes the principles and values of the NHS in England. The Constitution sets out rights to which patients, the public and staff are entitled and pledges that the NHS is committed to achieve. It also describes the responsibilities that patients, staff and the public owe to one another to ensure the NHS operates fairly and effectively.

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

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

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

1.6 Future direction

Each year the Trust produces a plan setting out how we will spend the money that has been allocated to us and how we will improve our services. We make our plans in conjunction with our partners in other health and social service organisations and with our local universities. We know that we all contribute to the care of our patients and that we are dependent on each other's work.

We coordinate this through the West Yorkshire and Harrogate Health and Care Plan. The purpose of this plan is to ensure that we collectively use our staff and resources to their best effect. For example, we do not wish to undertake duplicate tests on people or ask patients to travel from their local town for treatment unless it is unavoidable. Our current plan is initially focussed on a series of priority areas, particularly Mental Health, Learning Difficulties, Cancer Services and Emergency Care.

As well as planning our services with agencies across West Yorkshire, we work particularly closely with our colleagues in Leeds where we provide local hospital services. Priorities for this joint work include promoting the prevention of illness and the self-management of care, as well as the provision of high quality hospital care when it is required. Most people do not wish to come into hospital unless they need to and our aim is to support our primary and community colleagues in undertaking as much care as we can out of the hospital environment. Examples of the work that has taken place in 2017 include the provision of GPs in our accident and emergency units, to stream patients to the most appropriate doctors, and the increasing use of telephone consultations and digital images from GP surgeries to alleviate the need for patients to attend hospital. Underpinning this work is the piloting of a new funding mechanism with our commissioners which moves away from payments linked to hospital attendances and concentrates more on funding the best care for patients, wherever they are treated.

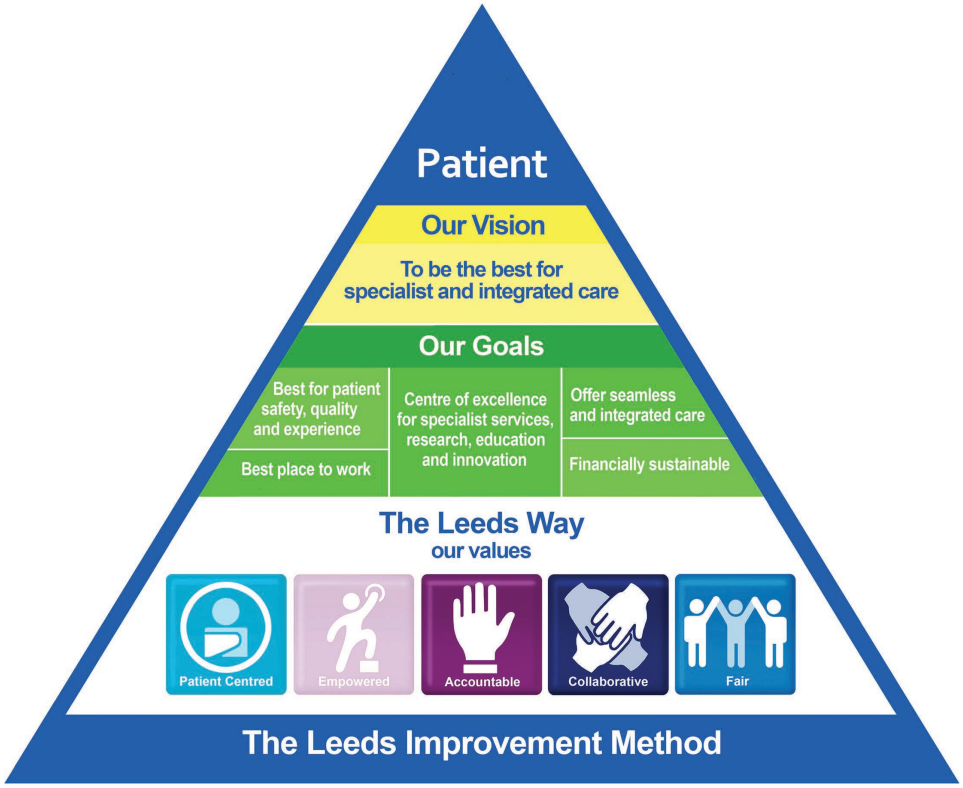
Much of the planning of our clinical services is carried out by our Clinical Directors. Our Clinical Directors are experienced doctors who are in charge of a group of our hospital specialties, called Clinical Service Units or CSUs. In 2017 our Trust Board met all 18 of our CSUs to discuss their plans for the next five years. The CSU teams work with all the clinical staff in our Trust as well as specialty colleagues from other hospitals across West Yorkshire. We work together as a West Yorkshire Association of Acute Trusts (WYAAT) to ensure that district general hospitals can continue to provide a wide range of medical specialties locally and patients get the best possible access to specialist care, such as vascular surgery units for example. Similar collaborative arrangements feature in the way we deliver services from the Leeds Cancer Centre (based on the St James's site) and the Leeds Children's Hospital (based at the Clarendon Wing in the Leeds General Infirmary).

Our role is to work with partner agencies to provide high quality specialist hospital services for adults and children across our region, and to provide local care that is effectively integrated with the services provided by GPs and social services staff. Quality and safety will continue to be key goals for our Trust. We must also ensure that we can attract and retain the best staff in a competitive healthcare market and make the best use of the public money. Our aim is to constantly improve our service and always act within the set of values our staff have adopted, namely The Leeds Way.

Each of our CSUs has completed a set of plans for their services in line with the approach outlined above. This involves building on the things that we do well and critically examining instances where we believe that our service has fallen behind the standards that we expect. This includes taking into account both good and bad comments from our patients and carers, and through the analysis of quality indicators that we produce for every ward in our hospital.

One of the more significant developments that we are working towards is the potential redevelopment at the Leeds General Infirmary. The plan, called 'Building the Leeds Way', is to replace old buildings with a much needed new purpose built facility that will include day care, outpatient, critical care, endoscopy, imaging and operating theatres. The plan requires a significant investment of public money and we are currently putting together our case in conjunction with partner health agencies and the Leeds City Council.

Overall we believe that our future direction is a positive one. The West Yorkshire and Harrogate Health and Care Plan and WYAAT give us the mechanisms to work more closely with colleagues across Leeds and West Yorkshire to improve the care we offer to the public. Our Clinical Directors will continue to work with other clinical teams at specialty level to maintain hospital care in people's local communities and provide high quality specialist care for people who need it. To support this approach we are seeking to reduce the size of our estate and replace old buildings that we cannot currently use, with facilities that are fit for the future.



1.7 Managing risk

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

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

Risk management is a core component of governance across the organisation and is a fundamental step towards continuing to build a 'safety culture' across the Trust. During 2017/18, work has continued to strengthen the risk management processes supporting delivery of the Trust's objectives and our continued journey of improvement. Our governance committee structure is now fully embedded and operating well. Any risks that may impact on the Trust's ability to deliver its strategic objectives are escalated from 'ward to board'.

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

We have a full web-enabled risk management information system that captures issues and learning from incidents, complaints and PALS queries. We also use the system to support the Trust Risk Register.

This has given our Clinical Service Unit (CSU) management teams greater flexibility around the production of reports to enable focussed reviews of themes and trends. It also allows for the linking of issues raised from these reviews directly into the risk register. We continue to rollout the Datix actions module across the Trust. This supports the CSUs in monitoring the implementation of action plans following incidents, complaints and claims. We will continue to embed this over the coming year.

This year, we have been working to improve the online incident reporting and review process for users. Following consultation with users from across the Trust we have simplified and shortened the online incident report in order to promote more reporting. We have also made changes to the incident reviewer's form to make the review process flow more logically and improve data quality.

These changes were rolled out in in July 2017 and have been received with great enthusiasm.

In June 2017 we held our first Risk Management conference entitled Beyond Incident Reporting. This was an event to showcase incident investigation at the Trust and focused on all the work that goes on once an incident has been reported to identify key learning and how we do this in The Leeds Way.

The event was attended by over 80 staff members from across the Trust and the wider Yorkshire region. The programme included a powerful video demonstrating the impact of serious incidents on patients and staff and how the most tragic circumstances can be a powerful agent for change. Delegates also heard from local clinical teams on how they had made changes and improvements as a consequence of incidents. The conference evaluated really well from the delegates and as a result we have been able to secure funding for a follow-up event later this year.

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

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

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

1.8 Research and innovation

We are committed to developing and supporting world-class research and innovation. It is central to our vision to be the best for specialist care and ensure we secure our future as a leading clinical research centre in the UK.

The Trust has an ambitious strategy for research and innovation, aimed at harnessing the significant advances in clinical science for the benefit of Trust patients by improving access to world-leading research studies.

We are among the top three hospital trusts in England for research projects recognised by the National Institute for Health Research (NIHR), involving more than 19,000 patients in 440 high quality research studies last year.

In 2017 we opened the new Research and innovation Centre on the St James's University Hospital campus, bringing together the core Research & Innovation team and a number of the Trust's other core research functions under one roof.

Taking over from the NIHR Leeds Diagnostic Evidence Co-Operative (DEC), the NIHR Leeds In Vitro Diagnostic Co-operative commenced in January 2018 with a focus on supporting the development of In Vitro Diagnostics across cancer, Infectious Disease, Musculoskeletal Disease and Renal Medicine. There is a particular focus on supporting the development of clinical and economic evidence to help accelerate the deployment of technologies into NHS practice.

The NIHR Surgical MedTech Co-operative succeeds the NIHR Colorectal Therapies Health Technology Co-operative (HTC) and will focus on the development of medical devices for use in Colorectal, Vascular and Hepatopancreatobilliary (HPB) surgery. The Co-operative works with patients and clinicians to identify unmet needs in surgery, bringing them together with technical partners from engineering, nanotechnology and biotechnology backgrounds to develop and evaluate solutions to the challenges.

The Trust was awarded funding for the NIHR Leeds Bioresource Centre in December 2017, which is part of a national network. The Bioresource centre aims to create a national register of patients (particularly those with "rare diseases") who can be recalled for participation in future clinical trials.

The NIHR Leeds Clinical Research Facility continues on an impressive trajectory of work. The facility comprises a hub and spoke model, with spokes in Bexley Wing, Jubilee Wing, Chapel Allerton Hospital and the Dental Hospital and conducts early phase research with leading-edge medicines and technologies across a range of diseases.

NIHR Leeds Biomedical Research Centre

The centre is a partnership collaboration between the Trust and the University of Leeds. It is a world leading centre for translational research into individually targeted, patient focussed therapies across musculoskeletal diseases. The new £7m funding over five years started in April 2017 to support the centre which is based at Chapel Allerton Hospital. In addition to groundbreaking research, its facilities include dedicated MRI and ultrasound imaging.

Rapid Infection Diagnostics to Manage Antimicrobial Resistance@ Leeds (RID-AMR@Leeds)

Antimicrobial Resistance (AMR) is an increasingly serious threat to global health that requires action across all government sectors and society. Without effective antibiotics, the success of major surgery and cancer chemotherapy would be compromised. One of the major causes of AMR is antibiotic misuse and rapid point-of-care diagnostic tests are a central part of the solution to this problem.

RID-AMR@Leeds is a large multidisciplinary research programme bringing together healthcare, engineering and bionanotechnology to advance infection diagnostics and optimise antimicrobial use. It is composed of 16 scientists led by Professor Christoph Walti from the University of Leeds with co-investigators from the Trust. The research funded by the Medical Research Council commenced in October 2017 and aims to generate a disposable single use chip that can be used in GP surgeries to determine if a patient has bacterial or viral infection. It will help with appropriate antibiotic prescribing and could make a real difference to care both in hospitals and in the community.

Finding Evidence to Treat or Reassure in Appendicitis (FETOR)

Although appendicitis is common and easily treated if spotted in time, children often present with unusual symptoms, making diagnosis difficult. The condition also progresses more quickly in younger people, increasing the risk of perforation, which can result in emergency surgery and a longer stay in hospital.

This piece of research will investigate whether changes in certain gasses found in children's breath - called volatile organic compounds or VOCs) - can be used as a reliable markers for the condition.

The proof of concept study, funded jointly by the NIHR HTC and Roboscientific, will look at whether analysers can collect sufficient breath from children to identify VOCs at a high enough density to provide a reliable diagnosis. The study will test VOC analysers with children presenting with suspected appendicitis at Leeds Children's Hospital over a six month period. If shown to be effective, the technology can then be developed for full clinical trials.

1.9 Sustainability report

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

Environmental Impact Performance Indicators 2017-18

Area		Non-financial Metric	Non-financial Metric		Financial data (£,000)	Financial data (£,000)
		2017/18	2016/17		2017/18	2016/17
Finite resources	Water / sewerage	684,715	818,913 m3	Water / Sewerage	£1,333	£1,419
	Electricity	24.70 GWh	20.35 GWh	Energy	*£12,367*	*£8,431*
	Gas	262.87 GWh	*274.4* GWh			
	Oil	1.07 GWh	*0.02* GWh			
Waste minimisation and management	Clinical HTI	501 Tonnes	1,836 Tonnes	Total Waste Cost	£1,657	£1,426
	Clinical - Alternative	2052 Tonnes	1,970 Tonnes			
	Landfill disposal	1655 Tonnes	1,209 Tonnes			
	Recycling / Recovery diverted from landfill	2323 Tonnes	2,850 Tonnes			

The drop in high temperature incineration is following an audit where a new type of clinical waste bag has been implemented. Improved clinical waste segregation has also seen that medical packaging is now being put in to the general waste stream as opposed to clinical waste.

The GRASP campaign

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

The Trust hosted the first ever GRASP champion networking event in November which was an opportunity for champions to showcase best practice across the Trust, learn about current and future sustainability initiatives and network with colleagues. The champion network, with over 70 members across the Trust, is acting as an effective tool in spreading knowledge, generating enthusiasm and encouraging sustainable behaviour change.

Sustainability was rated as one of the most important issues to our staff during the IFactor staff engagement campaign and consequently the board had the opportunity to hear about the work of the GRASP campaign and the important role that the champions carry out. The executive team was very impressed with the campaign and gave their full endorsement to it.

Green Spaces

On the back of a very successful organic vegetable garden, the sustainability team developed a further green spaces project; a series of food gardens across the St James's hospital site.

Each food garden is part of the St James's Way, a trail of raised beds across the grounds of the hospital, working with local charity Back to Front. Each garden is for staff, patients and visitors to enjoy and look after.

Back to Front is a charity that works in the community to promote the planting of front gardens for food to eat, admire and talk about. It has also worked with the Thackray Medical Museum on a number of projects.

The raised beds provide an area for staff and patients to tend to and forage from, and also form a walking trail across the site. Each food garden is themed, and following a great response, they were created using feedback from the public.

The final chosen themes were:

1. Colourful foods
2. Edible flowers
3. Herbs
4. Scented
5. Thackray herbs
6. Organic vegetable garden
7. Grows well in Yorkshire
8. Bee & butterfly friendly
9. Nutritious foods
10. Pick me up for lunch

The garden benefits the environment by providing an urban habitat for local wildlife and is also somewhere for patients and staff to enjoy. The project has been deemed as pioneering for an acute teaching hospital and has been published as a best practice case study by the national Sustainable Development Unit.

The project cost £2000 to develop and deliver. The positive impact on patient, staff and community wellbeing is being evaluated on a qualitative basis outlined below:

- The raised beds have been well received by staff, patients and the local community with over 350 people voting on the themes.
- The Trust physiotherapy department has incorporated the raised beds into patient treatment plans.
- A food growing education session has been scheduled which will further enhance community cohesion, promote a healthy eating message and improve the food growing skills of staff, patients and local residents.
- The project has improved staff morale, with themes such as the 'pick me up for lunch' encouraging people to get out of the office or ward and talk to other staff whilst enjoying some healthy free food. Future staff wellbeing surveys will incorporate questions around the gardens helping to further quantify the contribution they have made
- High profile flagship projects, such as this, can help to re-energise environmental champion networks and rally them behind a shared, focused objective.
- Engaging a local organisation with community development objectives helps to understand the needs and priorities of local communities.

Waste Management

We have continued to deliver comprehensive environmental training which has delivered significant improvements to our environmental performance and compliance with legislation.

- Achieving for the first time 100% compliance on an external sharps waste audit demonstrating our clear procedures for the handling of this waste stream to minimise risks and environmental impacts associated with it
- One of the areas targeted for improvement, theatres, was singled out for their significant improvement by winning an award within the Trust Time to Shine competition

Transport

In 2017/18, working in partnership with Leeds City Council, the Trust launched its first electric van.

The new electric van, a Nissan e-NV200, is used for a range of tasks, including delivering post and small goods between the St James's Hospital and Leeds General Infirmary sites. Leeds Teaching Hospitals has around 30 vehicles which are essential to delivering many of its services in the city and this is an important step forward in making the fleet more sustainable.

The van took its first trip on Clean Air Day, a nationwide campaign where the public are encouraged to leave their cars at home or switch off the engine where possible. As well as being more environmentally friendly and reducing emissions, the van allows the Trust to benefit from fuel savings.

It is one of six new vehicles supplied by Leeds City Council to the Trust, the remaining five of which are diesel. The security and pathology teams at Leeds Teaching Hospitals have also trialled the use of electric vehicles and this has seen great success, with more vehicles set to be implemented in the future.

Introducing low carbon fleet is one of a range of measures implemented as part of the Trust's highly ambitious GRASP campaign which aims to reduce the carbon footprint of hospitals in Leeds and save money through steps like improving recycling and saving energy.

Future plans

Sustainable Development Management Plan (SMDP)

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

Energy Generation

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

Pollution and Health

We actively supported the national Clean Air Day campaign. As a major healthcare provider as well as a major employer in Leeds we recognise the role that we can play in educating people on how to minimise both their emissions and their exposure. We held training sessions for health professionals working with groups that are most vulnerable to the effects of air pollution, including respiratory, cardiac and maternity wards and held a stand on the day, helping to promote sustainable travel.

1.10 International partnerships

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

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

Department for International Trade (DIT)

Working with DIT through Healthcare UK and other professional contacts, our networking activity has ensured a steady flow of commercial leads. In October 2017, we were pleased to host a delegation of Trade Advisors from UK embassies around the world, as a result of which, we have received a number of enquiries. The growing demand for health services in countries such as China, India and across the Middle East offers numerous opportunities, some of which we are exploring.

Ministry of Health, Malta

Over the last four years we have developed a relationship with health authorities in Malta through the training of medical physicist students and the commissioning of complex equipment and patient pathways at their new oncology hospital. To further develop that relationship we have signed an agreement with the Medical School of Malta which will see qualified doctors from Malta working at Leeds Teaching Hospitals whilst undergoing specialist training. This will provide many benefits to the Trust including increased staffing levels.

King Hussein Cancer Center, Jordan

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

Section 2
Accountability

Accountability

We have 17,760 people working across our hospitals in a variety of different roles. This year we have recruited more nurses, midwives and support staff and reduced the amount we spend on agency administrative staff. This is a saving that can be directly invested into patient care. The commitment and achievements of our people is key to the success of our Trust.

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

2.1 Members of the Trust Board 2017/18

During 2017/18, the Board met bi-monthly at locations across the Trust; St James's University Hospital, Wharfedale and Chapel Allerton Hospitals. Between the public meetings, informal workshops were held to address such issues as strategy, planning and training and development.

Our lead link to Healthwatch has observed some of our Board meetings and the chair of the staff council is also present at the public meetings. The media attend and report on proceedings in the local press. Any member of the public is welcome to attend the formal meetings. These are advertised on the Trust's website at the address below.

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

Changes in membership of the Trust Board

Jenny Ehrhardt was Acting Director of Finance from April through to start of July with Simon Worthington commencing in post as Director of Finance from 3 July 2017.

A new Executive position was created in year; Chief Digital and Information Officer, with Richard Corbridge commencing in post on 20 November 2017.

On 1 February NHS Improvement confirmed the appointment of three new Non-Executive Directors and supported the appointment of an Associate Non-Executive Director to the Trust Board. This followed the stepping down of two Non-Executive Directors from their posts - Caroline Johnstone, and Allison Page, and the appointment to the longer term vacancy the Trust had held.

Mark Chamberlain, Non-Executive Director, took over the role of Vice Chair and Senior Independent Director from Caroline. Allison Page left her role as Non-Executive Director but continues to use her expertise to support the Trust in its ambitious plans to redevelop the Leeds General Infirmary site and Leeds Children's Hospital, known as Building the Leeds Way.

Carl Chambers stood down as Chair of Finance and Performance Committee and became Chair of the Audit Committee, with Mark Ellerby becoming Chair of the Finance Committee.

Professor Moira Livingston joined for three years. Moira sits on the Remuneration Committee and Quality Assurance Committee and she is the named Non-Executive lead for CQC, Safeguarding and Duty of Candour.

Robert Simpson (Bob) also joined for a tenure of three years. A key part of Bob's role is to seek assurance with the Board in all aspects of Building the Leeds Way and he is the lead Non-Executive for this exciting work. Bob also sits on the Remuneration Committee and Finance & Performance Committee.

Jasmeet (Jas) Narang joined for one year as an Associate Non-Executive Director. Associate Non-Executive is a new role for the Board appointed by Leeds Teaching Hospitals which aims to support the Board and provide a greater breadth of expertise, especially in IT. Jas sits on the Audit Committee as well as being the Non-Executive Director with lead for our digital development.

Chris Schofield joined for three years from 1 April. Chris sits on the Audit Committee, Remuneration Committee and Quality Assurance Committee.

Dean Royles, Director of Human Resources & Organisational Development tendered his resignation in January and will leave the Trust at the end of July.

Appointment of Non-Executive Directors

The Non-Executive Directors have been appointed by NHS Improvement (NHSI) who set the defined term of office for each appointment. Re-appointments can be made, but Non-Executive Directors will not normally serve more than six years to ensure independence and to comply with the regulators Code of Governance, any exception to this by NHSI.

Termination of the term of office of the Chair would be carried out by the Chair of NHS Improvement. All Board Directors comply with the 'fit and proper person test' that was introduced from November 2014, with reconfirmation at a public Board meeting in March 2018.

Measuring the performance of the Board members

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

The Chair has in turn appraised each of the Non-Executive Directors during the year, set objectives for the coming year and undertaken mid-year reviews. Should the Chair have any concerns about their performance, this would be discussed with NHSI and their term of office would be terminated.

The Chief Executive has appraised Executive colleagues during the year, which was reported to the Remuneration Committee in June 2018. His own appraisal by the Chair was also reported at this meeting without his presence and all Executive Directors had clear objectives set for the year. The Board refined the corporate objectives at their meeting on 30 March 2017 and these were used to underpin the objectives for the Chief Executive and the executive team for 2017/18.

The various committees reported their work plans to the Trust Board at the beginning of the financial year, and against these have given an annual report to the Audit Committee at the year-end, which were received at the May Public Board meeting. These reports provide a summary on their progress and an evaluation of their performance during the year.

The Board has continued with its development programme during the year. It commissioned an externally facilitated 360° evaluation process, which reported back to the Board in June 2016, and was reviewed in detail. This included feedback from external stakeholders. The Chair is currently reviewing a range of externally facilitated development tools to source the best programme for the Board to embed the skills, knowledge and changes to both the Non-Executive and Executive Directors.

Register of interests

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

http://www.leedsth.nhs.uk/about-us/trust-board/board-register-of-interests

Non-Executive Directors of the Board during 2017/18

Dr Linda Pollard CBE DL Hon.DLL

Chair

From 1 February 2013

Linda is a successful entrepreneur and highly experienced chair who has worked in the public and private sector in a number of high profile and successful organisations.

She is currently Chair of the Trust where she has led the organisation to a number of significant successes including a 'Good' rating from the CQC; the first financial surplus (£18.9m) for the organisation in four years and the biggest in its 20 years history; and an innovative international partnership with the Virginia Mason Institute in Seattle to introduce a culture of continuous quality improvement into the organisation. She continues to set ambitious targets for the Trust and is currently leading a £300 million plus investment plan to build a new hospital and improved Children's Hospital facilities on the site of Leeds General Infirmary in the heart of the City's new Innovation District.

Linda is a huge advocate of partnership working and leads a number of successful high level partnership groups bringing together leaders from across the region, and beyond, to focus on range of important issues including the closer working between health and social care, building economic investment into Leeds and the wider City region, the appropriate representation of women on Boards, community cohesion and improving the local environment and public realm to name a few.

She is involved in a wide range of advisory and working groups and frequently influences at ministerial, senior civil servant and department head level on national issues.

With a personal passion for supporting women in business, Linda acts as a business angel and mentor to women forming start-ups and until recently was the chair of An Inspirational Journey, an organisation supporting women into the boardroom. Linda is also an active Deputy Lord Lieutenant for West Yorkshire and was awarded a CBE in 2013 for her work in the business community and an OBE in 2003 for her work in Bradford. She was also awarded an Honorary doctorate by the University of Leeds.

Caroline Johnstone

Vice-Chair, Senior Independent Director, Non-Executive Director and Chair of the Audit Committee

From 1 January 2013 (Vice-Chair/Senior Independent Director from 1 February 2015) until 31 January 2018 (term of office expired)

Caroline is a Chartered Accountant and has had a career of over 30 years working in professional services, based in Leeds, London and Edinburgh. As a partner with PricewaterhouseCoopers (PwC) until 2009, she worked at senior board level, supporting some of the largest organisations in the UK and internationally implementing significant change including turnaround, mergers, cost reduction, culture and people change. She also sat on the Board of PwC's assurance division with responsibility for people.

Among her other roles, Caroline is Non-Executive Director and Chair of the Audit Committee of Synthomer plc, a Non-Executive Director and Chair of the Audit Committee of Shepherd Group Limited, she provides consulting services to a range of global chemical industry organisations and is a member of the governing Council of the University of Leeds. She is also Chair of BARCA - Leeds, a community-based charity in the City.

Caroline was a member of the Finance & Performance Committee and was Chair of the Audit Committee until the end of January 2018.

Mark Chamberlain

Non-Executive Director and Chair of the Quality Committee

Vice-Chair, Senior Independent Director from Feb 2018

From 4 January 2010

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

Mark holds a number of additional lead duties as a Non-Executive Director within the Trust under the collective title of Chair of Corporate Affairs; Raising Concerns (Freedom to Speak Up NED Guardian role), Medical Staff in difficulty, oversees the lay representatives for AAC panels, volunteering, mortality and during the year had Chaired the Shadow Board programme (an internal programme to develop staff towards future executive positions).

Carl Chambers

Non-Executive Director and Chair of the Audit Committee

From 1 February 2015

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

He is currently Non-Executive Chairman of CNG Ltd, a gas supply business. He has previously held a number of senior roles including Non-Executive Chairman of Task International Ltd, Chief Financial Officer of Spice plc and Chief Executive of Team Telecom. During the year Carl became a Council Member of the University of Bradford.

Carl was Chair of the Finance & Performance Committee until the end of January and is now Chair of the Audit Committee. He remains a member of the Finance & Performance Committee. He is the Trusts named Non-Executive lead for Procurement, Emergency Preparedness and is a Board member of the Integrated Sexual Health Board representing the Trust.

Professor Paul Stewart

Non-Executive Director

From 1 October 2013

Paul is the Dean of the Faculty of Medicine and Health and Dean of the Medical School at the University of Leeds and an Honorary Consultant Endocrinologist at the Leeds Teaching Hospitals NHS Trust. He received his medical degree from Edinburgh Medical School in 1982 and was awarded an MD from Edinburgh University with Honours and a Gold Medal in 1988 and undertook postgraduate training in Endocrinology, Diabetes and Internal Medicine in Edinburgh, Birmingham and Dallas. As a Clinician Scientist Paul has led an active Endocrinology research group that has uncovered new mechanisms of disease and developed novel therapies for patients with disorders of the Pituitary and Adrenal glands and Obesity-Metabolic syndrome. In 2017 he was elected Vice-President of the Academy of Medical Sciences. Due to the close working relationship between The University of Leeds and the City's hospitals, the Dean of Medicine has a key role on the Trust Board.

Allison Page

Non-Executive Director

From 1 January 2014 until 31 January 2018 (stood down from the Board

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

She was a member of the Audit Committee and Quality Assurance Committee.

Mark Ellerby

Non-Executive Director

Chair of the Finance & Performance Committee (from 1 February 2018)

From 1 December 2014

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

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

Robert Simpson (Bob)

Non-Executive Director

From 1 February 2018

Bob is an accomplished senior executive manager and has extensive experience in building development and construction. He is a Director of Hexstall Consultancy Limited.

Using his extensive skill set Bob will seek assurance with the Board in all aspects of Building the Leeds Way and be the lead Non-Executive for this exciting work.

Bob is a member of the Finance & Performance Committee.

Jasmeet (Jas) Narang

Associate Non-Executive Director

From 1 February 2018

Jasmeet (Jas) Narang is currently Governance Director and Transformation Leader at Santander Operations UK. He has over 20 years' experience in global finance services and has worked in India, Japan and the US in the past. He is a qualified Six Sigma 'Master Black Belt' and has held roles leading large operational teams, commercial portfolios and also project/ digital transformation and supplier functions.

Jas is an Associate Non-Executive, a new role for the Board which aims to support the Board and provide a greater breadth of expertise, especially in IT.

Jas successfully completed the Insight Programme, which supports senior level managers to develop the skills they need to become a Non-Executive in the NHS.

He has over 20 years experience in global finance services and will sit on the Audit Committee and also be the Non-Executive Director with lead for our digital development.

Professor Moira Livingston

Non-Executive Director

From 1 February 2018

Moira has worked in a variety of roles within the NHS locally, regionally and nationally for over 30 years. Clinically her background is as an older age psychiatrist and most recently she was a Director at NHS Improving Quality, leading on building capacity and capability in improving quality across the NHS. She is Chair of the charity Dementia Care. Moira is a member of the Quality Assurance Committee and she is the named Non-Executive lead for CQC, for Safeguarding and Duty of Candour.

Chris Schofield

Non-Executive Director

From 1 April 2018

Chris Schofield joined the Trust on 1 April, and during January, February and March has carried out his induction programme; which included observing Board and Committee meetings. Chris, a qualified lawyer, is the founding partner of Schofield Sweeney LLP Solicitors, and a Trustee of the Leeds Hospital Charitable Foundation and a number of other local charities. Chris was a Non-Executive Director for the Leeds West Clinical Commissioning Group and has strong experience of the NHS. Chris is member of the Audit and Quality Assurance Committee.

Executive Directors of the Board

Julian Hartley

Chief Executive

From 14 October 2013

Since joining Leeds Teaching Hospitals in 2013 Julian has focussed on creating a patient centred culture, fostering high levels of staff engagement, and ensuring frontline teams have the skills to improve care for patients. The Leeds Way has led to a step change in staff engagement meaning that Leeds Teaching Hospitals is now among the best performing Trusts in the national staff survey. Over 3,000 of our staff have so far engaged with The Leeds Improvement Method leading improvement projects across a wide range of clinical and non-clinical areas. Julian also plays a key leadership role in the local and regional health economy acting as the Chair of the West Yorkshire Association of Acute Trusts which is a collaboration of the six hospital trusts across West Yorkshire and Harrogate to work together to deliver the best possible services for patients. Julian is also a core part of the leadership team for the West Yorkshire and Harrogate Care Partnership.

Professor Suzanne Hinchliffe CBE

Deputy Chief Executive / Chief Nurse

From 20 May 2013, commenced as Deputy Chief Executive 5 January 2015

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

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

Suzanne has extensive experience in acute NHS services and has also been a member of a number of national advisory committees involved in regulatory inspection and has led Board governance reviews across acute, primary care and ambulance service organisations. Working at Executive level over the past 20 years, Suzanne has had experience in Chief Operating Officer and Chief Nurse positions with two periods as interim Chief Executive.

She is also responsible for Operational Services. Suzanne is a Member of National Clinical Reference Board.

Dr Yvette Oade

Chief Medical Officer

From 1 June 2013

Yvette joined Leeds Teaching Hospitals in June 2013 as Chief Medical Officer. Her portfolio includes responsibility for Quality Improvement and Patient Safety in the trust. She is also the lead for Medical Education and Research in the Trust.

She was previously the Chief Medical Officer of Hull and East Yorkshire Hospitals NHS Trust and Deputy Chief Executive, a role she undertook for two years, focussing on quality improvement and patient safety. She was closely involved in the development of the Yorkshire and Humber Academic Health Science Network.

Originally trained as a doctor in Leeds, Yvette became a Consultant Paediatrician in Calderdale and Huddersfield Foundation NHS Trust.

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

Dean Royles

Director of Human Resources and Organisational Development

From 8 October 2014

Dean Royles has been a leading figure in Human Resources (HR) within the NHS for nearly two decades. Former Chief Executive of NHS Employers, Dean joined Leeds Teaching Hospitals in 2014. Other notable positions have included Director of Workforce and Education at NHS North West and Deputy Director of Workforce for the NHS at the Department of Health.

Dean has an MSc in Human Resources and is a member of Sheffield Business School's Advisory Board as well as a visiting fellow at Newcastle Business School. He is former Chair of the Board of the Chartered Institute of Personnel and Development (CIPD) and was awarded Companionship of the CIPD in 2015. He is also Chair of the Advisory Board for the Institute for Organisational Development. He has an Honorary Doctorate from the University of Bradford for his contribution to health services management.

He is a regular conference speaker, has published in a number of journals, and is a member of the editorial board of HRMJ and the International Journal of Human Resources Development. Dean is a huge advocate for social media and provides expert opinion in the national media. He was voted UK's Most Influential HR Practitioner for three years running. His book with Oxford University Press on Human Resource Management was published in February 2018.

Simon Neville

Director of Strategy and Planning

From 1 May 2014

Simon joined us from Salford Royal NHS Foundation Trust, where he was Director of Strategy and Development. He has worked in the NHS since 1983 in a variety of general management and planning roles in London and the North West, specialising in major service change and capital investment.

Here in Leeds Simon has led the development of the Trust's strategic direction and established a comprehensive clinical service planning process with the Clinical Service Units. He has developed a partnering approach to joint service development in Leeds, West Yorkshire and, for more specialist services across Yorkshire & Humber and the North East. In support of clinical strategies Simon is leading the Building the Leeds Way Programme, a major capital investment programme to redevelop the LGI and Leeds Children's Hospital. Once completed there will be an opportunity to re-develop the old part of the LGI site as part of the Leeds Innovation District.

Simon is also the Executive Lead for Estates and Facilities and has supported the continuous improvement of these services. In 2017 he led the team that re-negotiated the Bexley Wing PFI Agreement generating a saving of over £50m for the Trust.

Jenny Ehrhardt

Acting Director of Finance

From 1 April to 2 July 2017

Jenny joined us from Harrogate and District NHS Foundation Trust in May 2014, where she was Deputy Director of Finance. She has worked in the NHS since 2000 in a variety of roles within Finance, with extensive experience in financial management and acute trusts. She is substantively our Deputy Director of Finance, and was Acting Director of Finance from April - July 2017. Her portfolio includes responsibility for negotiating healthcare contracts with our commissioners, as well as leading the team delivering all aspects of a high quality Finance service for the Trust, including Financial Management, Costing and Financial Accounts.

Simon Worthington

Director of Finance

From 3 July 2017

Simon joined the Trust from Bolton NHS Foundation Trust, where he was Director of Finance from 2013 and Deputy Chief Executive.

He was awarded the HFMA's Finance Director of the Year in 2015, recognising his contribution to the successful turnaround of the financial position at Bolton. He left Bolton in a strong financial position.

Prior to this he held roles at the Yorkshire Ambulance Service, including one year as acting Chief Executive, South Huddersfield Primary Care Trust and South London Healthcare NHS Trust. Simon started his NHS career as a trainee accountant at the Leeds General Infirmary in 1988.

Richard Corbridge

Chief Digital and Information Officer

From 20 November 2017

Richard has specialised in IT development, procurement and implementation across national and local health care arenas in the UK for more than 20 years. He has a wealth of experience, and joined the Trust from the Health Service Executive in Ireland where he was the Chief Information Officer (CIO).

He led the delivery of many solutions: a health identifier for the whole population (similar to an NHS number); the first digital hospitals in Ireland; genomic sequencing in specific disease areas; a full digital referral process (referrals made online rather than by post or fax); and the creation of the Chief Clinical Officers Council.

In his early career Richard led the delivery of a wide range of systems and processes in the NHS with a focus to aid the provision of healthcare and clinical research. These ranged from the first primary care messaging system in the NHS, to the modernisation of the information systems' infrastructure for the delivery of clinical research throughout England.

In 2017 Richard was named the number one CIO for the UK in the EDG CIO Magazine CIO100, was listed in Hot Topics global CIO100 and in 2018, was Ireland's first CIO100. He was named the eGovernment Visionary of the year in Ireland and was named as the most disruptive talent in digital by Sir Richard Branson and Steve Wozniak.

2.2 Attendance tables

Board of Directors

Name/Date	25 May		27 Jul		28 Sep		30 Nov		25 Jan		29 Mar		
Members:	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	W'shop	Pu	Exord Pu
Linda Pollard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Carl Chambers	✓	✓	✓	✓	✓	✓	Apols 2	Apols 2	✓	✓	✓	✓	✓
Mark Ellerby	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Caroline Johnstone	✓	✓	✓	✓	✓	✓	✓	✓	Apols				
Simon Neville	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Yvette Oade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dean Royles	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols 1		
Paul Stewart	✓	Apols 3	✓	✓	✓	✓	✓	Apols 3	✓	✓	✓	✓	✓
Allison Page	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mark Chamberlain	✓	✓	Apols 4	Apols 4	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Ehrhardt	✓	✓											
Simon Worthington			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Corbridge							✓	✓	✓	✓	✓	✓	✓
Jasmeet Narang									Obs		✓	✓	✓
Bob Simpson									Obs	Obs	✓	✓	✓
Moira Livingston											✓	✓	✓
Chris Schofield											Obs	Obs	Obs
In Attendance:													
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

W'shop - Workshop Pu - Public Obs- Observing

1	Annual leave - family wedding	3	Commitments at University of Leeds
2	Family funeral	4	Annual leave

Board Time-Outs

Name/Date	27 Apr	22 Jun	28 Jun	12 Oct	13 Oct	20 Dec	08 Mar	28 Mar
Linda Pollard	Changed to Exec only meeting	✓	✓	✓	✓	✓	Full Board meeting cancelled due to weather conditions A conference call was arranged for one item. New date of 28th March was scheduled.	✓
Carl Chambers		✓	✓	✓	✓	Apols		✓
Julian Hartley		✓	✓	✓	✓	✓		✓
Suzanne Hinchliffe		✓	✓	✓	✓	Apols 1		✓
Yvette Oade		✓	Apols 2	✓	✓	✓		✓
Dean Royles		✓	✓	✓	✓	✓		Apols 2
Paul Stewart		Apols 3	Apols 3	Apols 3	✓	✓		✓
Simon Neville		✓	✓	✓	✓	✓		✓
Allison Page		✓	Apols	Apols	Apols	Apols		
Mark Chamberlain		✓	✓	✓	✓	✓		Apols
Mark Ellerby		Apols 1	✓	Apols 1	✓	✓		✓
Caroline Johnstone		✓	✓	✓	✓	Apols 1		
Simon Worthington				✓	✓	✓		✓
Richard Corbridge						✓		✓
Moira Livingston						Obs		✓
Chris Schofield						Obs		
Jasmeet Narang								✓
Robert Simpson								✓
In Attendance:								
Jo Bray		✓	✓	✓	✓	✓		✓

W'shop - Workshop Pu - Public Obs- Observing

1	CQC unannounced visit	3	Commitments at University of Leeds
2	Annual leave		

Chairs of Committees Committee

Name/Date	22 Jun	14 Dec
Linda Pollard	✓	✓
Carl Chambers	✓	✓
Julian Hartley	✓	✓
Mark Chamberlain	✓	✓
Yvette Oade	✓	✓
Caroline Johnstone	x	✓
Mark Ellerby		✓
In Attendance:		
Jo Bray	✓	✓

Audit Committee

Name/Date	04 May	24 May	14 Sep	07 Dec	07 Mar
Members					
Caroline Johnstone	✓	✓	✓	✓	
Allison Page	✓	✓	Apols	✓	
Carl Chambers	✓	Apols	✓	✓	✓
Jasmeet Narang					✓
In Attendance:					
Jo Bray	✓	✓	✓	✓	✓
Jenny Ehrhardt	✓	✓		For SW	Apols
Simon Worthington		✓	✓	Apols 1	✓
Attendance for Specific Issues					
Julian Hartley	✓				✓
David Hay	✓	✓	✓		✓
Dean Royles			✓		
Richard Corbridge				✓	
Simon Neville	Apols 2	✓		✓	✓
Mark Chamberlain					✓
Mark Ellerby					✓
Observing					
Linda Pollard	✓				✓

1	HFMA Conference	2	Leeds GSC Project Board Meeting

Finance and Performance Committee

Name/Date	26 Apr	24 May	28 Jun	26 Jul	30 Aug	27 Sep	25 Oct	29 Nov	20 Dec	24 Jan	28 Feb	28 Mar
Members												
Carl Chambers	✓	✓	✓	✓	✓	✓	✓	Apols 7	✓	✓	✓	✓
Linda Pollard	✓	✓	✓	✓	Apols 1	✓	✓	✓	✓	✓	✓	✓
Caroline Johnstone	✓	✓	✓	✓	Apols	✓	✓	✓	Apols	✓		
Mark Ellerby	✓	✓	✓	✓	✓	✓	Apols	✓	✓	✓	✓	✓
Bob Simpson											✓	✓
In Attendance:												
Jo Bray	✓	✓	✓	✓	Apols 1	✓	Apols 1	✓	✓	✓	✓	✓
Jenny Ehrhardt	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Simon Worthington			✓	✓	✓	✓	✓	✓	✓		✓	✓
Julian Hartley	✓	✓	✓	✓	✓	✓	Apols 2	✓	✓		✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	✓	Apols 4	Apols 3		✓	✓
Simon Neville	✓	✓	✓	✓	Apols 1	✓	✓	✓	✓		✓	✓
Dean Royles	✓	✓	✓	✓	Apols 1	✓	✓	Apols 5	✓		✓	✓
Richard Corbridge									Apols 6	✓	Apols 1	✓
Open Invitation to Board Members for Specific Item:												
Mark Chamberlain			✓									
Paul Stewart			✓									
Yvette Oade					✓				✓			

1	Annual Leave	5	Compassionate Leadership & Care Conference
2	Future Vision Leadership Course	6	EHR & Clinical Engagement
3	System Resilience Board meeting	7	Family funeral
4	CQC unannounced inspection		

Quality Assurance Committee

Name/Date	25 Apr	12 Jul	11 Oct	07 Feb
Members				
Mark Chamberlain	✓	✓	✓	✓
Allison Page	✓	Apols	Apols	
Paul Stewart	Observe	✓	✓	✓
Moira Livingston				✓
In Attendance:				
Jo Bray	✓	✓	✓	✓
Suzanne Hinchliffe	✓	✓	✓	✓
Yvette Oade	✓	✓	✓	Apols 1
Richard Corbridge				✓
Observing:				
Linda Pollard	✓		✓	

1	Annual Leave

Research, Education and Training (RET) Committee

Name/Date	02 May	01 Aug	07 Nov	06 Feb
Members				
Yvette Oade	✓	✓	✓	Apols 2
Suzanne Hinchliffe	✓	✓	Apols 1	✓
Paul Stewart	✓	✓	Apols	✓
Dean Royles	✓	✓	✓	✓
Observing:				
Linda Pollard		Observe		

1	CQC visit
2	Annual Leave

Risk Management Committee

Name/ Date	06 Apr	04 May	01 Jun	06 Jul	03 Aug	07 Sep	05 Oct	02 Nov	07 Dec	04 Jan	01 Feb	01 Mar
Members												
Julian Hartley	Apols	✓	Apols 1	✓	Apols	✓	✓	Apols 1	✓	Apols	✓	Meeting cancelled due to adverse weather conditions & operational pressures
Simon Neville	Apols	Apols	✓	✓	✓	Apols	Apols 2	✓	Apols 4	Apols	✓	
Dean Royles	✓	✓	✓	✓	✓	✓	Apols 2	✓	✓	✓	Apols	
Yvette Oade	Apols	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	
Jo Bray	Apols	✓	Apols 1	✓	Apols	✓	✓	✓	✓	Apols	✓	
Suzanne Hinchliffe	✓	✓	✓	✓	✓	✓	Apols 2	✓	Apols	✓	✓	
Andy Thomas	Apols	✓										
Jenny Ehrhardt	Apols	✓	✓						For SW			
	Period acting as Director of Finance											
Simon Worthington				Apols 1	✓	✓	Apols 2		✓			
Richard Corbridge									✓		Apols	
In Attendance:												
David Hay					For SW							
Observing:												
Linda Pollard					✓							
Caroline Johnstone		✓	✓	✓		✓				✓		
Carl Chambers											✓	

1	Annual Leave	3	Perfect Week
2	Sickness absence	4	Pathology Clinical Workshop

Signed

Julian Hartley

Chief Executive Date: 24 May 2018

2.3 Governance

Annual Governance Statement (2017/18)

1. Scope of responsibility

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

2. The purpose of the system of internal control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Teaching Hospitals NHS Trust (LTHT), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in LTHT for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 The Board of Directors provides leadership on the overall governance agenda. The Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control; such Committees include; the Audit, Quality Assurance and Finance & Performance. The Risk Management Committee and Research, Education and Training Committees are executive Committees reporting to the Board of Directors. The Committees have all provided an annual report with attendance of the respective Committee Chair at the Audit Committee meeting on 7 March 2018. The Risk Management Committee focusses on all high or significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. The Risk Management Committee is chaired by myself as Chief Executive and comprises of all Executive Directors. Senior managers and specialist advisors routinely attend each meeting. The Trust has kept under review and updated risk management policies during the course of the year. Whilst the Risk Management Committee reports directly to the Board through me, it also works closely with front line Clinical Service Units (CSU's) and all Committees of the Board in order to anticipate, triangulate and prioritise risk, working together to continuously enhance risk treatment.

3.2 Training and support is provided to relevant staff on risk assessment, incident reporting and incident investigation. In addition, the Board has set out the minimum requirements for staff training required to control key risks. A training

needs analysis informs the Trust's mandatory training requirements and has been kept under review; this sets out the training requirements for all members of staff and includes the frequency of training in each case. During the year we have added PREVENT training to the suite of mandatory training for all our staff.

3.3 Incidents, complaints, claims and patient feedback are routinely analysed to identify lessons for learning and improve internal control. Lessons for learning are disseminated to staff using a variety of methods including Quality and Safety briefings, Learning Points Bulletin and personal feedback where required. The Quality Assurance Committee provides oversight on this process, with an annual report to the Board of Directors each July and six month update in January.

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

3.5 The Board of Directors regularly scans the horizon for emergent opportunities or threats, and considers the nature and timing of the response required in order to ensure risk is kept under prudent control at all times. Collectively the Board reviews the Board Assurance Framework (BAF) and our risk management appetite statement in year.

3.6 During the year I created and appointed to a new role of Chief Digital and Information Officer. This will strengthen the Trusts position with strategic leadership, resilience and management of IT systems and infrastructure moving forward. Noting there remains a significant capital funding required to address years of historic poor investment, funding loans will be required in year from NHS Improvement. The role of the Chief Digital and Information Officer provides the trust with a clearly defined Board level owner for Cyber Security and the risks associated to this. The Trust is working towards and is well prepared for the implementation of the new requirements under GDPR from 25 May 2018 and has been able to return a positive outlook through the Information Governance Tool Kit returns.

4. The risk and control framework

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

(i) Determine priorities

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

(ii) Risk Identification

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

(iii) Risk Assessment

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

(iv) Risk Response (Risk Treatment)

For each risk, controls are ascertained (or where necessary developed), documented and understood. Controls are implemented to avoid risk; seek risk (take opportunity); modify risk; transfer

risk or accept risk. Gaps in control are subject to action plans which are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk, and reviewed its risk appetite to guide the management of risk throughout the Trust.

(v) Risk Reporting

Significant risks are reported at each formal meeting of the Board of Directors and Risk Management Committee. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management Policy, which was revised in March 2016. The risk report to the Board of Directors also details what action is being taken, and by whom, to mitigate the risk and monitor delivery. The Audit Committee and Board of Directors have reviewed assurance on the effective operation of controls to manage potential significant risk as set out in the Corporate Risk Register and supporting report to each Board meeting and regular reviews of the Board Assurance Framework. This is supported by a recent Internal Audit Report No. 2017/27 'Framework of Assurance', where Full Assurance was reported.

(vi) Risk Review

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

b. Incident reporting and investigation is openly encouraged as a key component of risk and safety management to help us learn and take action in response to patient safety incidents. An electronic incident reporting system is operational throughout the organisation and is accessible to all staff. Incident reporting is promoted through induction and training, regular communications, leadership walk rounds or other visits and inspections that take place. A programme to support staff who have been involved in an incident has been established, Leeds Incident Support Team (LIST) and a process for sharing lessons across the organisation is established, overseen by the lessons learned group. In addition, arrangements are in place for staff to raise any concerns at work confidentially and anonymously if necessary.

5. Significant risks facing the Trust

5.1 As at 31st March 2018, Leeds Teaching Hospitals NHS has identified a range of significant risks, which are currently being mitigated, whose impact could have a direct bearing on requirements within the NHS Improvement Accountability Framework, CQC registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Currently, the significant risks relate to the following areas:

- **National Standards** 18-week RTT standard, 62-day Cancer, 6-week diagnostic wait, 28 day cancelled operations and Emergency Care target
- **Finance** Aggregate effect of income volatility, non-delivery of the Waste Reduction Programme in 2018/19, insufficient liquidity and cost pressures and capital equipment replacement, IT infrastructure and the risk of cyber-attack and inadequate storage space on Oncology servers.

- **Fundamental Standards of Safety & Quality** Nurse staffing levels, reducing supply of doctors in training, C. difficile and MRSA targets, violence due to organic, mental health or behavioural reasons, patient flow, bed capacity and emergency admissions, unsustainable levels of medical outliers, inability to deliver a cardiac surgery service and length of time patients with mental health conditions wait in the ED
- **Performance & Regulation** Corroded pipes in Clarendon Wing, LGI, power failure at LGI and a combination of demand and capacity factors giving rise to unsustainable levels of medical outlying and delayed discharges.

5.2 Detailed risk registers are proactively used throughout the organisation. These set out arrangements for risk treatment, risk appetite thresholds and further mitigating actions planned. We have established arrangements to allow a review of significant risk exposures by the full Board at each formal meeting; , the process for this is examined by the Audit Committee to underpin this Statement.

5.3 Equality impact assessments are integrated into core Trust business. All reports to Trust Board follow a standard reporting template, which includes an 'Equality Analysis' section where authors of the report are required to set out any negative equality-related impacts along with mitigation, and all Trust policies require sign off of an equality impact assessment by the Trust's Equality and Diversity Team before Executive Team approval. In organisational change projects, Senior HR Officers support Line Managers in undertaking their duty to prepare equality impact assessments on the proposed change and to then take this into consideration in implementing that change.

6. Care Quality Commission (CQC) Registration

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

- Reporting and keeping under review matters highlighted within the Care Quality Commission's Intelligent Monitoring Report and inspections;
- Self-assessment against the Key Lines of Enquiry defined within the criteria of the Well-led review, and prepare for external review
- Liaising with the Care Quality Commission and local Clinical Support Units to address specific concerns;
- Engaging with the Care Quality Commission on the inspection process, co-ordinating the Trust's response to inspections and recommendations/ actions arising from this;
- Analysing trends from incident reporting, complaints, and patient and staff surveys to detect potential non-compliance or concerns in Clinical Service Units;
- Reviewing assurances on the effective operation of controls;
- Receiving details of assurances provided by Internal Audit, and being notified of any Clinical Audit conclusions which provide only limited assurance on the operation of controls; and
- Challenging assurances or gaps in assurance by attending meetings of Risk Management Committee, Quality Assurance Committee, and Audit Committee.

6.2 The Trust is registered with the Care Quality Commission, has no compliance actions in force and is fully compliant with the Fundamental Standards. There

was a follow-up inspection undertaken by the Care Quality Commission in May 2016; relating to the inspection that took place in March 2014. The Trust received an overall Good rating when the final report from the follow-up inspection was published in September 2016. The Board of Directors welcomed the report and the significant improvement in the ratings. Progress continues to be made in accordance with the plan, which is monitored through the Quality Assurance Committee. The Trust is fully complaint with the registration requirements of the Care Quality Commission.

6.3 The CQC undertook an unannounced inspection visit at St James's Hospital on 20 December 2017 focusing specifically on the care of patients in non-designated areas on medical and older people's wards, which is a consequence of the sustained operational and patient flow pressures across our health care system. We continue to work with our partners to address this; the care of patients in non-designated areas continues to be monitored daily through our operational processes to ensure our patients continue to receive safe care. The final report was received by the Trust on 29 June 2018, which included seven areas for improvement linked to five Regulations (Requirement Notices). The Trust will produce an action plan in response to the recommendations. The report will be publicly available on the CQC website. The action plan will be monitored through the Quality Assurance Committee, joint quality meeting with Commissioners and engagement meetings with the CQC.

6.4 The Trust Chair holds and maintains the 'Fit and Proper Persons Test Register' for the Board. Annually checks are carried out to ensure all those listed are fit and proper against the requirements defined by the CQC.

6.5 The CQC has published its new regulatory framework, including the Well-led review, focusing on eight Key Lines of Enquiry. This has been reviewed with the Board of Directors and an initial self-assessment undertaken. The Board has also considered the use of resources assessment that will be undertaken by NHS Improvement.

7. Pensions

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

7.2 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

8. Carbon Reduction

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

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

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

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

9.2 The Trust submitted its Operational Plan for 2017/19 in December 2016 with a further submission in March 2017 to NHS Improvement, incorporating a financial plan approved by the Board of Directors. The update to the original submission was required by NHS Improvement and was submitted 30 April 2018 which included updates to our operational, financial, workforce and strategic plans. These submissions contain a variety of technical documents prepared by members within the Trust and an overall narrative which describes these submissions and their associated risks. This informs the detailed operational plans and budgets which are also approved by the Board. The Trust actively engages Commissioners, regulators (NHS Improvement), staff and others as necessary to develop and agree detailed financial and operational plans. Prior to approval the Board takes the views obtained from stakeholders into account. Work is currently underway working with local and regional stakeholders towards the delivery of five year Integrated Care System for both the West Yorkshire and Harrogate 'footprint' and the City of Leeds.

The Trust is a key member of the West Yorkshire Association of Acute Trusts (WYAAT) which during 2016/17 established a Committee in Common for the governance and accountability of work streams to support transformation across West Yorkshire and Harrogate. Throughout 2017/18 this group has established a number of projects looking at how some clinical and support services can be provided more effectively across the region. It is expected that this work will continue in 2018/19.

The Trust established the inaugural Leeds Health and Social Care Board to Board meeting, during 2016/17 which has continued to meet in 2017/18.

9.3 The Board agrees annually a set of corporate objectives which are communicated to colleagues. This provides the basis for performance reviews at CSU level. Operational performance is kept under constant review by the Executive Team, Finance & Performance Committee and the Board of Directors. In order to keep under review the delivery of the corporate objectives, the Board reviews at each formal meeting a Quality & Performance Report covering patient safety, quality, access and experience metrics, and a Finance Performance Report. Since my appointment as Chief Executive, the Board has approved a Quality Improvement Strategy (with a refresh at the March 2018 meeting setting out the strategy for 2017-2020) with progress reports to the Quality Assurance Committee and Board, and published within the Quality Account.

9.4 Assurances on the operation of controls are commissioned and reviewed by the Audit Committee and, where appropriate, other Committees of the

Board of Directors as part of their annual cycle of business. The implementation of recommendations made by Internal and External Audit is overseen by the Audit Committee. Due to the changes in the rules around appointment of external auditors for NHS Trust, the Board of Directors appointed the External Auditors for the first time, with an extension to the contract by one year.

9.5 The Trust has a good record on the management of Information Governance and has acted as advisor to the Local Authority and CCG on the subject of data sharing as well as assisting Leeds Academic institutions on the creation of their own Information Governance Frameworks.

Information Governance incidents at the Trust are managed through rigorous and standardised processes with an appointed Caldicott Guardian and Deputy, qualified Senior Information Risk Owner and Data Protection Officer.

In 2017/18 no risks at level 2 occurred, one was reported but after further investigation was deemed to not be a level 2 incident and the Information Commissioners Office closed this incident report with no further action required.

10. Annual Quality Account

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

10.2 The Trust has continued to embed strong clinical leadership for the development of the Quality Account during 2017/18 and this has been provided by the Chief Medical Officer in close collaboration with the Chief Nurse / Deputy Chief Executive and the wider Executive Team.

Assurances relating to the outcomes highlighted within the Annual Quality Account were provided to the Quality Assurance Committee (QAC), a formal committee of the Trust Board, which is chaired by a Non-Executive Director. The Quality Assurance Committee is responsible for overseeing the production of the Quality Account and for overseeing monitoring indicators and data quality. The Trust has engaged with partner organisations, including Leeds Healthwatch and Commissioners at NHS Leeds CCG to agree priority quality goals for the year ahead, relating to the key quality domains: safety, effectiveness, experience. A limited scope assurance report is provided by External Audit on the content of the quality account and selected key performance indicators.

11. Review of effectiveness

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

12. The Board of Directors

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

12.2 The Board commissioned an independent review into Board governance and Committee effectiveness during 2014/15. The review found no material concerns, but outlined a range of opportunities to advance governance arrangements. With external support, the Board devised a set of proposals to further develop the Committee structure alongside a new and innovative approach to Board governance and assurance using the 'three lines of defence' model. These new arrangements came into effect in May 2015 and all actions from the independent review have been delivered.

The Board is currently preparing its Self-assessment against the CQC Key Lines of Enquiry defined within the criteria of the Well-led Review, and has agreed to commission and external review in Autumn 2018.

The Board commissioned an independent 360° review which included feedback from external stakeholders and was reported and considered in detail at a Board timeout session during June 2016. The Trust Chair is currently meeting external facilitators to commission a new independent 360° review, to support future Board development, and integration of new members of the Board. We anticipate this to take place during the summer or early autumn.

12.3 The Board assign high importance to risk management and internal control. The effectiveness of the Board's risk management and internal control framework is subject to independent review by Internal Audit on an annual basis. Progress continued to be made during the year culminating in a 'significant assurance' opinion by the Head of Internal Audit, in line with the previous year. As a result of their work in 2017/18, the internal auditors have provided significant assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and / or inconsistent application of controls, put the achievement of particular objectives at risk.

13. Internal Audit

13.1 With respect to the internal audits concluded during 2017/18, there was one (out of 28) assignments for which Internal Audit reported the level of assurance as limited for the year ended 31st March 2018. This audit provided limited assurance as a result of weaknesses in the design and/or operation of controls. Management action plans are developed and implemented, or in the process of being implemented, to address identified weaknesses. Progress is reviewed by the Audit Committee.

13.2 Moving forward for 2018/19 the Trust will implement a new model of service provision to the Internal Audit Service which will be co-sourced with an external supplier.

14. External Audit

14.1 External audit provides independent scrutiny on the accounts, annual report, Annual Governance Statement, reporting by exception if the Trust fails to comply with the guidance and as defined by NHS Improvement, limited assurance on the Annual Quality Report.

15. Clinical Audit

15.1 The Quality Assurance Committee, at the October 2017 meeting, received and were assured by the Clinical Audit Annual Report for 2016/17. This summarised clinical audit activity across the Trust, adhering to the national requirement reflected in the Trust Clinical Audit Procedure, which reflects national best practice. The report also set out the Trust's priorities for 2017/18.

16. Health & Safety

16.1 In 2016 the Trust was one of only a few Trusts to receive a Royal Society for the Prevention of Accident (ROSPA) Safety Gold Award for its H&S management arrangement; this is a significant achievement for an organisation. During 2017 the Trust once again participated in the RoSPA Scheme and was again awarded Gold. During 2016 and 2017 the Trust received no visits / inspections, formal enforcement action or advisory letters from the HSE.

16.2 As Chief Executive I have signed the Annual Fire Safety Certificate of Compliance, in accordance with the Trust statutory responsibilities under the Regulatory Reform (Fire Safety) Order, as assurance was reported to the February 2018 Risk Management Committee. During the year the Committee received a number of assurance reports in light of the tragic events of the Grenfell Tower fire tragedy and the subsequent assessments that were carried out across the Trusts estate.

17. Promoting Safety

17.1 As Chief Executive I am working with the 'Freedom to Speak-Up Guardians' to embed and promote a culture of openness for staff to express concerns about patient care and safety. The Board received an update at the July 2017 meeting and the Audit Committee reviewed assurance at its March 2018 meeting.

17.2 The Chief Medical Officer is working with the 'Guardians of Safe Working' for the support and development of Junior Doctors. The Board of Directors are sighted on these roles, with quarterly reports to the Research, Education and Training (RET) Committee and the annual report received at the Board in May 2017, and information, included as a statutory requirement, within the Quality Account.

I can report that all trainees have now transitioned to the 2016 Junior Doctor Contract Terms and Conditions of Service and 12% have used the exception reporting process. However, through the Guardians of Safe Working, experience on the wards means this system is being under-used. There are four areas of major concern that have been reported and reviewed by the RET Committee.

18. Significant In-Year Matters

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

i. There were 88 reported events during the year that met the criteria for a Serious Incident (SI). Each case has been thoroughly investigated and reported to local commissioners. Detailed action plans

have been developed and implemented in response to specific cases.

ii. There were six incidents which qualified for reporting as a Never Event, relating to incorrect implant, wrong site surgery (2), retained object following procedure (2) and administration of medical air (a new Never Event added to the list in February 2018). These incidents have been subject to a Serious Incident investigation; the findings and actions have been discussed with commissioners and shared with staff across the organisation.

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

iv. There were 70 events that met the criteria for reporting to the Health & Safety Executive under the provisions of the Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) Regulations. The Trust has continued to raise the profile of safety management during the year, and has received reports on progress at the Risk Management Committee.

v. The Trust has supported and co-operated with an independent review commissioned by NHS England regarding an incident on a medical ward at St James's hospital in February 2015 (STEIS Ref 2015 8112). The Trust commissioned an independent investigation; this was completed in March 2016 and received by local commissioners and NHS England.

vi. At an aggregate level the Trust did not meet the national requirement to treat a minimum of 92% of patients within 18-weeks of referral for those patients on the incomplete standard pathway. We are likely to close the year with an aggregate performance at 87.66% with seven reporting specialties not meeting the incomplete standard (Trauma & Orthopedics, Plastic Surgery, Urology, General Surgery, ENT, Neurosurgery and 'Others').

vii. The main underperformance relates to the impact of the non- elective pressure on elective IP activity, which although offset with significantly increased over 18 week Outpatient activity, has grown due to the severe restrictions on elective operating during winter 2017/18.

During 2017/18 LTHT reported 52 week breaching patients for the first time in over two years. This accelerated during winter 2017/18 leading to a total of 153 patients reported as breaches, with the main underpinning issue being the lack of elective operating capacity for patients not classified as clinically urgent.

Pressures at LTHT remain due to longer term insufficient capacity and flow into Leeds from closed or struggling surrounding facilities:

- Spines (long standing regional capacity insufficiency
- Neurology (Mid York's)
- Paediatric surgery across West Yorkshire (particularly Paediatric ENT and Paediatric Urology)
- Manchester Paediatric Cardiology patients volume being higher than first anticipated.

Further requests have been made to support with Dermatology, Ophthalmology and Respiratory Medicine from Mid Yorkshire and Calderdale, alongside support from Mid Yorkshire for their Bariatric service.

viii The Emergency Care Standard (ECS) national target of 95% of patients being seen within 4 hours of presenting in A&E was not achieved in 2017/18 with pressures at both sides of the city continuing throughout this year. Whilst

A&E attendances and admissions via A&E did not grow, pressures due to the congestion in the A&E departments as hospital wide bed pressures/ challenges to discharge patients into out of hospital care continued at unprecedented levels.

LTHT actions were continued - GPs in A&E, the Bilberry and Heather units (at the Wharfedale site, supplemented by three wards at SJUH during 2017/18), co-location of medical assessment in A&E, as well as the instigation of a new Frailty Unit and Winter Room, and two supporting system wide events - Perfect Week and Multi-Agency Discharge Event (MADE) - however performance has continued to be challenging.

ix The continued bed pressures resulted in the Trust not meeting the national requirement for all last minute cancelled operations to be rebooked within 28 days. Previous progress made in 2015/16 (84 breaches) has not been able to be sustained during 2016/17 (276 breaches) and 2017/18 (309 breaches YTD).

x The Trust met the national requirement to undertake 99% diagnostic tests within six weeks of referral throughout 2017/18 apart from January 2018 when issues with Cardiac Echo staffing arose, but were rapidly addressed. The major issue in 2018/19 will remain MRI capacity, due to equipment replacement outages and overall capacity constraints until the new equipment and replacement programme is in place.

xi The Trust has not achieved the national requirement to treat a minimum of 85% of patients referred for suspected cancer within 62 days of referral from a GP or Dentist since March 2016, however the standard has been met for 6 out of 12 months during 2017/18 for internal patients (those first referred and treated at LTHT).

Late referrals to LTHT from other providers continues to be the major factor in the achievement of the overall 62 day standard. The Trust continues to work closely with neighbouring providers, GPs, Commissioners and other stakeholders although to date this has yet to result in an improvement to the timeliness of referrals to the Trust, which includes local breach reallocation processes. Work to improve internal systems and processes and build capacity continues to improve performance in key challenged pathways. The process for the monitoring of long waiting patients, i.e. those waiting more than 104 days without treatment has continued with the position stabilised at the level of 40 patients per month despite the bed pressure position during the majority of 2017/18.

xii The Trust has met the national requirements to see a minimum of 93% of patients within 14 days for i) urgent GP referral for suspected cancer and ii) the breast symptomatic target, for all months in 2017/18 bar January and March for the urgent GP referral for suspected cancer standard. The main issue in January was the annually repeated issue related to patient choice to defer their appointments over the Christmas period. In March, performance was not achieved due to the impact of 2 episodes of snow on our biggest cancer 2ww clinic days.

xiii The Trust has continued to meet the 31 day first treatment and all 31 day subsequent treatment standards throughout 2017/18.

xiv The reduction of HCAI remains a high priority for the Trust Board and the organisation as a whole. In 2017/18, 124 patients developed Clostridium difficile Infection (CDI) in our care against our trajectory of 119. This total is a small rise on the number that we had last year. All cases have been subjected to root cause analysis and we have continued to

identify a greater proportion of the cases, in conjunction with our commissioners, as having no "lapse in care" whilst in our Trust.

The number of patients with MRSA bloodstream infections (BSI) is low with no significant variation year on year, with eight cases attributed to LTHT which is a reduction on last year's position, when 11 cases were assigned to LTHT. 2017/18 has seen the development of an HCAI collaborative which utilises the Model for Improvement as a framework for testing new interventions to reduce HCAI Blood Stream Infections. The days between such positive samples varies, nonetheless currently there is an early indication that we are extending the intervals between cases.

There is now a "national ambition" to reduce healthcare associated bloodstream infections with certain Gram-negative bacteria, namely Escherichia coli (E. coli), Klebsiella species and Pseudomonas aeruginosa, by 50% by March 2021. In 2017/18, 185 patients developed an E.coli BSI in our hospitals, this is a reduction compared to last year when 195 patients were diagnosed with E.coli BSI whilst in our care.

xv The Trust is mitigating on-going challenges associated with the historic legacy of lack of basic capital and infrastructure investment. Hence the high level risks within the Corporate Risk Register described as; unserviceable critical IT infrastructure and resilience issues along with issues with corroded heating pipes and power failures due to electricity infrastructure/ resilience with risks to clinical services. Estate issues relating to Seacroft impact both dental services and breast screening. The Finance & Performance Committee recommended to the Board, who in turn approved the Capital Programme for 2018/19 with the largest investment in recent years of £69 million, however there still mains a large backlog to capital investment across the whole Trust.

Work continues to develop the Strategic Outline Business Case for Building the Leeds Way, the re-development of the LGI site, gaining support in year support from NHS Improvement. This is cited within the STP for West Yorkshire. Many issues associated with delivering healthcare from a Victorian estate, poor capital investment and service re-design and relocation will be addressed within this development.

xvi Compliance to other regulatory bodies - The Medicines and Healthcare Products Regulatory Agency (MHRA) carried out a Good Clinical Practice (GCP) system inspection of the Trust and University of Leeds laboratories which undertake primary and secondary end point analysis of clinical trials on 17 & 18 October 2017. The formal report is awaited.

It is a legal requirement of all organisations sponsoring and hosting Clinical Trials of an Investigational Medicinal Products (CTIMPs) to comply with UK medicines for human use (clinical trials) regulations (2004). The move in the NHS from paper to electronic health records systems has led to significant compliance issues in relation to GCP in NHS organisations. The Joint Research Governance Committee (JRGC) recognised that this is a complex issue but it is essential for the Trust to address and resolve non-compliance.

xvii Education and Training - Unless the General Medical Council (GMC) National Trainee Survey (NTS) results of the Trust improve over the coming months (in the areas of Medical Micro Biology, Trauma and Orthopaedics and General Surgery) there is a risk of a triggered GMC and or Health Education England (HEE) quality review, and/or the removal of trainees either from the speciality or the Trust.

Relocation of the Undergraduate Hub to a smaller space resulted in the loss of a number of facilities valued by students and which contributed to the 'student experience' score.

There is a risk that reductions to pre-and post-registration professional education funding will impact on the Trusts ability to increase the academic capacity and capability of the non-medical professional workforce with a resultant impact on service provision.

xviii I have been made aware of current discussions relating to risks that are not currently described on the Corporate Risk Register. These will be explored in more detail by the Chief Medical Officer and reported to the Risk Management Committee should further action be required; i) paediatric cardiac services; clinical risks related to PICU capacity and ii) risk of failure of IT back up of the E-Medicines system.

19. Concluding Remarks

As Accounting Officer with responsibility for maintaining a sound system of internal control at Leeds Teaching Hospitals NHS Trust, I have reviewed the system of internal control. I am delighted to report that for 2017/18 the Trust has delivered a significant financial surplus thus working towards achieving the Board's aim to return the organisation to financial sustainability, as originally defined within the recovery plan. This is a huge indication of the effective systems and management, along with the governance of the Board and its Committee structures, underpinned by the accountability framework.

There are significant financial pressures on the wider NHS and Leeds Teaching Hospitals NHS Trust, as with other trusts, have a challenging Waste Reduction Programme to address for 2018/19. We will move to an Aligned Incentive Contract with local Commissioners and NHS England for 2018/19 which will reduce our historic risk of income volatility. We continue to actively drive transformation for better patient outcomes and financial savings through the work of WYAAT, and we are currently exploring the establishment of a Wholly Owned Subsidiary for many benefits including a commercial and structured approach to income generation to support the delivery of financial plan for 2018/19.

20. Conclusion

My review confirms that Leeds Teaching Hospitals NHS Trust has a system of internal control in operation, and progress has been made, but further improvement is underway across a range of priorities to better support the achievement of the Trust's policies, aims and objectives going forward. Those control issues highlighted in this statement have been or are currently being addressed. I confirm that there are no other significant breaches of internal control that have been brought to my attention in respect of the financial year ended 31st March 2018 and up to the date of approval of the annual report and accounts.

Signed

Julian Hartley, Chief Executive

Date: 24 May 2018

2.4 Remuneration report

Pay Multiples (subject to audit)

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

The banded remuneration of the highest paid director of the Trust in the financial year 2017/18 was £235-240k (2016/17, £230-235k). This was 8.73 times (2016/17, 8.66) the median remuneration of the workforce, which was £27,196 (2016/17, £26,854). The highest paid director in both 2017/18 and 201617 was the Chief Medical Officer. Remuneration ranged from £15-20k to £235-240k (2016/17 £15-20k to £230-235k).

Total remuneration includes salary, enhancements and non-consolidated performance-related pay. It does not include any severance payments, employer pension contributions and the cash equivalent transfer value of pensions. Remuneration is calculated on the annualised full-time equivalent staff of the Trust at the reporting date (31 March 2018).

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

Salary and Pension entitlements of Senior Managers

A) Salaries and allowances

	2017-18					2016-17				
Name and title	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000
Dr L. Pollard CBE DL - Chair	40-45	15	0	0	**45-50**	40-45	17	0	0	**45-50**
C.A. Johnstone - Non Executive Director (Vice Chair) (to 31 Jan 2018)	5-10	9	0	0	**5-10**	5-10	6	0	0	**5-10**
M Chamberlain - Non Executive Director	5-10	3	0	0	**5-10**	5-10	5	0	0	**5-10**
C Chambers - Non Executive Director	5-10	0	0	0	**5-10**	5-10	0	0	0	**5-10**
M Ellerby - Non Executive Director	5-10	10	0	0	**5-10**	5-10	17	0	0	**5-10**
Prof M Livingston - Non Executive Director (from 01 Feb 2018)	0-5	0	0	0	**0-5**	n/a	n/a	n/a	n/a	**n/a**
J Narang - Associate Non Executive Director (from 01 Feb 2018)	0-5	0	0	0	**0-5**	n/a	n/a	n/a	n/a	**n/a**
A.J. Page - Non Executive Director (to 31 Jan 2018)	5-10	0	0	0	**5-10**	5-10	0	0	0	**5-10**
R Simpson - Non Executive Director (from 01 Feb 2018)	0-5	0	0	0	**0-5**	n/a	n/a	n/a	n/a	**n/a**
Prof P.M. Stewart - Non Executive Director	5-10	0	0	0	**5-10**	5-10	0	0	0	**5-10**
J.M. Hartley - Chief Executive	230-235	0	0	65-67.5	**295-300**	225-230	0	0	57.5-60	**285-290**
Prof S Hinchliffe CBE - Deputy Chief Executive and Chief Nurse	180-185	0	0	25-27.5	**205-210**	175-180	0	0	25-27.5	**205-210**
R Corbridge - Chief Digital and Information Officer (from 20 Nov 2017)	50-55	3	0	10-12.5	**60-65**	n/a	n/a	n/a	n/a	**n/a**
S H Neville - Director of Strategy & Planning	150-155	50	0	20-22.5	**175-180**	145-150	39	0	17.5-20	**170-175**
Dr Y.A. Oade - Chief Medical Officer	205-210	0	30-35	10-12.5	**245-250**	205-210	0	25-30	30-32.5	**265-270**
D.A.Royles - Director of Human Resources and Organisational Development	165-170	0	0	7.5-10	**175-180**	165-170	0	0	27.5-30	**195-200**
S Worthington - Director of Finance (from 03 Jul 2017)	130-135	6	0	87.5-90	**220-225**	n/a	n/a	n/a	n/a	**n/a**
J Ehrhardt - Acting Director of Finance (to 02 July 2017)	30-35	0	0	25-30	**60-65**	n/a	n/a	n/a	n/a	**n/a**

Taxable expense payments are rounded to the nearest £100 in the above table. Pension related benefits are shown in bands of £2,500. All other remuneration is shown in bands of £5,000

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

Taxable expenses for the Director of Strategy and Planning relate to a lease car. Taxable expenses for the Director of Finance and Chief Digital and Information Officer are car parking paid via salary sacrifice. All other taxable expenses are in respect of taxable business mileage. There are no long term performance pay or bonuses for senior managers in the current or preceding financial years.

All pension-related benefits are calculated using the HMRC method as set out in Section 229 of the Finance Act 2004. The Department of Health and Social Care have clarified that for NHS bodies this is the "Real increase in pension multiplied by 20 plus the real increase in lump sum less contributions made by the individual equals Accrued Pension Benefits". The NHS Pension Scheme is a "defined benefits" scheme based on final salary and/or career average earnings. Thus where a senior manager's salary increases this results in a larger movement in the overall value of their pension entitlement. Similarly, where there is a limited increase in the value of the pension payable relative to inflation and the employees contributions, then the HMRC calculation can show a "negative pensions benefits" figure for the year which is then shown as a "nil" figure in the table. These factors mean that year on year there can be significant volatility in the reported pensions benefits for an individual.

Salary and Pension entitlements of Senior Managers

B) Pension benefits

Name and title	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age as at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 01 April 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
J.M. Hartley - Chief Executive	2.5-5	0-2.5	65-70	165-170	1,078	80	1,202
Prof S Hinchliffe CBE - Deputy Chief Executive and Chief Nurse	0-2.5	5-7.5	75-80	235-240	1,598	105	1,745
R Corbridge - Chief Digital and Information Officer (from 20 Nov 2017)	0-2.5	0-2.5	10-15	30-35	198	2	207
S H Neville - Director of Strategy & Planning	0-2.5	5-7.5	60-65	180-185	1,185	82	1,299
Dr Y.A. Oade - Chief Medical Officer	0-2.5	5-7.5	85-90	265-270	1,850	100	2,009
D.A.Royles - Director of Human Resources and Organisational Development	0-2.5	0-2.5	65-70	205-210	1,308	41	1,370
S Worthington - Director of Finance (from 03 Jul 2017)	2.5-5	5-7.5	65-70	170-175	1,014	103	1,181
J Ehrhardt - Acting Director of Finance (to 02 July 2017)	0-2.5	2.5-5	25-30	60-65	246	15	322

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

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

The Trust has made no contributions to stakeholder pensions for its senior managers during the current and preceding financial years

Staff numbers and costs

Average staff numbers	2017-18			2016-17
	Total Number	Permanently employed Number	Other number	Total number
Medical and dental	**2,133**	2,070	63	2,019
Administration and estates	**2,689**	2,663	26	2,621
Healthcare assistants and other support staff	**3,588**	3,166	422	3,357
Nursing, midwifery and health visiting staff	**4,200**	4,055	145	4,222
Nursing, midwifery and health visiting learners	**6**	6	0	1
Scientific, therapeutic and technical staff	**1,927**	1,905	22	1,878
Social care staff	**8**	8	0	10
Healthcare science staff	**1,045**	1,028	17	1,056
Other	**471**	468	3	471
Total	**16,067**	**15,369**	**698**	**15,635**

	2017/18	2016/17
Number of permanently employed staff	15,369	14,702
Other staff	698	933
Total average staff number	**16,067**	**15,635**
Staff engaged on capital projects	28	20

Employee benefits

Employee Benefits - Gross Expenditure (£000s)	2017/18			2016/17		
	Total £000	Permanently employed £000	Other* £000	Total £000	Permanently employed £000	Other* £000
Salaries and wages	552,118	537,917	14,201	529,729	516,714	13,015
Social security costs	50,702	50,702	0	48,390	48,390	0
Apprenticeship Levy	2,689	2,689	0	0	0	0
Employer Contributions to NHS Pensions	65,960	65,960	0	63,072	63,072	0
Other pension costs	0	0	0	135	135	0
Termination benefits	100	100	0	0	0	0
Temporary staff	32,684	0	32,684	39,135	0	39,135
Total employee benefits including capitalised costs	704,253	657,368	46,885	680,461	628,311	52,150
(Costs capitalised as part of asset)	(1,295)	(1,295)	0	(909)	(909)	0
TOTAL - excluding capitalised costs	**702,958**	**656,073**	**46,885**	**679,552**	**627,402**	**52,150**

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

Sickness absence data

Staff sickness absence and ill health retirements	2017/18	2016/17
Total days lost	139,844	132,409
Total staff years	15,133	14,614
Average working days lost	**9.24**	**9.06**
Number of persons retired early on ill health grounds	12	25
Total additional pensions liabilities accrued in the year (£000s)	616	1,227

Expenditure on consultancy

	2017/18 £'000	2016/17 £'000
Consultancy costs	596	1,001

During 2016-17 the Trust negotiated a revised PFI financing agreement in respect of Bexley Wing. This accounts for the higher cost of consultancy compared to 2017-18.

Exit packages

	2017/18	2016/17
Exit package cost band		
£25,001 - 50,000	1	0
£50,001 - £100,000	1	0
Total number of exit packages	2	0
Total resource cost (£)	**100,000**	**0**
Voluntary redundancies including early retirement contractual costs	2	0
Total value of agreements (£)	**100,000**	**0**

Off-payroll engagements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	0
Of which, the number that have existed:	
for less than 1 year at the time of reporting	0
for between 1 and 2 years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which,	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	15

2.5 Regulatory ratings

The Trust is registered with the Care Quality Commission, has no compliance actions in force and is fully compliant with the Fundamental Standards. There was a follow-up inspection undertaken by the Care Quality Commission in May 2016; relating to the inspection that took place in March 2014. The Trust received an overall Good rating when the final report from the follow-up inspection was published in September 2016.

The Board of Directors welcomed the report and the significant improvement in the ratings. Progress continues to be made in accordance with the plan, which is monitored through the Quality Assurance Committee. The Trust is fully complaint with the registration requirements of the Care Quality Commission.

The CQC undertook an unannounced inspection visit at St James's Hospital on 20 December 2017 focusing specifically on the care of patients in non-designated areas on medical and older people's wards, which is a consequence of the sustained operational and patient flow pressures across our health care system. We continue to work with our partners to address this; the care of patients in non-designated areas continues to be monitored daily through our operational processes to ensure our patients continue to receive safe care.

The final report was received by the Trust on 29 June 2018, which included 7 areas for improvement linked to 5 Regulations (Requirement Notices). The trust will produce an action plan in response to the recommendations. The report will be publicly available on the CQC website. The action plan will be monitored through the Quality Assurance Committee, joint quality meeting with commissioners and engagement meetings with the CQC

2.6 Information Governance

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

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

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2017/18.

The Trust is fully committed to ensuring that personal information is protected and used appropriately. We also constantly review our existing processes to significantly minimise the likelihood of breaches. This has included preparing for the General Data Protection Regulation (GDPR) regulation coming into force.

2.7 Modern Slavery Act

The Trust complies with the Modern Slavery Act, specifically section 54 'Transparency in supply chains' which is the section directly relevant to the corporate sector. The Trust uses the Crown Commercial Services Supplier Questionnaire to ask questions of suppliers to ensure their compliance with the Modern Slavery Act. In addition, products purchased through third party distributors such as NHS Supply Chain, have the assurance of national frameworks to ensure compliance with the Act.

2.8 Our People

One of our goals is to make Leeds Teaching Hospitals the best place to work and we have been doing lots of work to move towards this. Our greatest asset is our people and we value our staff highly. Their skill and dedication means we have some of the country's leading clinical expertise and can offer patients the highest quality, most compassionate treatment and care.

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

Our people also play a significant role in the development of the Trust. With strong encouragement and leadership from our Chief Executive and senior team, engagement with people working in our hospitals has improved over the past 12 months, going from 3.83 in 2016 to 3.85 in 2017 (on a scale of up to 5). The Trust has the most improved engagement score from 2012 to 2017 in the country.

This is the foundation on which The Leeds Way has been developed and is at the core of the way we do things around here.

Workforce statistics

Trust Board - at 31 March 2018

Gender	Job Role	Position Title	Number
Female	Medical Director	Medical Director	1
	Non Executive Director	Chairman	1
	Non Executive Director	Non Executive Director	1
	Nurse Manager	Chief Nurse / Deputy Chief Executive	1
Female total			**4**
Male	Chief Executive	Chief Executive	1
	Non Executive Director	Non Executive Director	6
	Senior Manager	Director of HR	1
	Senior Manager	Director of Finance	1
	Senior Manager	Director of Strategy & Planning Chief Digital and Information Officer	1
	Senior Manager	Director of Strategy & Planning	1
Male total			**11**
Grand total			**15**

The gender division of all other employees, as at 28 February 2018, is included below.

Gender	Head Count
Female	13,324
Male	4,436
Grand Total	**17, 760**

This is an increase of 583 members of staff from last year. The Trust recruited over 3,100 people in the past 12 months; this includes 1,000 medical and dental staff and a total of 570 new nurses, midwives and operating department practitioners started in band 5 positions in the Trust.

On 8th March 2018, International Women's Day, the Trust published its Gender Pay Gap information on the Government's website. More information is included in the supporting our diverse workforce section below.

Organisational Learning

Organisational Learning provides education, learning and development opportunities to all our staff, including a range of management and leadership development programmes, coaching, and learning bursts.

Inductions

Corporate Induction performance has remained positive with 99% of new recruits attending.

To recognise the importance of patient feedback, a review of Corporate Induction has been completed from a patient's perspective. The overall feedback was positive and areas for improvement have been addressed.

To continue the welcome to the Trust and to ensure staff are aware of relevant local policies and procedures, staff are given a Local Induction within 28 days of commencing employment. 87% of new starters have received a Local Induction in the last 12 months.

Agenda for Change (AfC) Appraisal

Our 2017 Staff Survey shows that LTHT performed above the national average both for number of appraisals completed, and the quality of the appraisal experience. In the 2017/18 Agenda for Change (AfC) appraisal season, 13,961 individuals received an AfC appraisal. The overall performance was 97% which is a 1% increase year on year.

Mandatory Training

The mandatory training framework is made up of 13 topics which ensure that all staff members receive the training and updates they need in order to adequately perform their role and ensure the safety of our patients. This includes completion of in excess of 70,000 training interventions on an annual basis.

Overall mandatory training performance within the Trust has been maintained at 92% and to ensure continuous improvement a review of all mandatory training topics has been completed using the Leeds Improvement Method (LIM) tools and techniques.

IT training and Clinical Systems Training

In 2017/18, 21,289 IT and clinical systems training interventions were delivered. These were delivered either as a face to face classroom session or by eLearning. Access to clinical systems training has expanded following an increase in the amount of induction programmes where training is now offered.

Leeds Female Leaders Network

The Leeds Female Leaders Network now has over 700 members and in 2017/18 two more network events were held. The events feature inspirational role models speaking of their experiences, and this provides a forum for members to informally network.

Talent and leadership update

Over the past 12 months 385 staff members took part in our leadership development programmes, as shown in the table below:

Programmes

Apr 2017-Mar 2018	Target audience	Number of participants
CMI - Level 2 Team Leading	Team leaders and supervisors	12
Leadership & Management Apprenticeship Level 3	Aspiring/ First line managers	36
Leadership & Management Apprenticeship Level 5	Middle managers	18
Leadership & Management Apprenticeship Level 6	Middle managers	12
Medical Leadership - Foundation	Doctors and above	23
Medical Leadership - Advanced	Doctors and above	20
Introduction to Management	Bands 3 - 7	113
Leading for Patients - B5	Nurses, Midwives Healthcare Scientists and Allied Health Professionals	27
Leading for Patients - B6		88
Leading for Patients - B7		36

Medical Leadership and Engagement

The Medical Leadership and Engagement Steering Group has overseen a proactive and collaborative programme of networks and development opportunities as outlined below:

- the Faculty of Medical Leadership and Management 360 Feedback Tool, which was made accessible to LTHT medical colleagues and Medical Leadership Programme delegates
- a variety of topical subjects were discussed at the various Trust Medical Networks including: New Consultants' Network, Lead Clinician Group and the Junior Doctors' Body
- 'Mentoring for Doctors' training is designed to ensure that there is the resilience and capacity within the Trust for all newly appointed medical staff to access a mentor. A total of 122 consultants have now been trained as mentors
- the newly launched 'Walk in My Shoes' programme commenced in September 2017 and provides junior doctors with the opportunity to expand their empathy and understanding of management challenges through shadowing a general manager. To date eight junior doctors have completed the programme

Sage and Thyme programme

The SAGE & THYME® foundation level workshops teach staff at all levels the communication skills needed to provide person-centred support to someone with emotional concerns or distress. In the past 12 months 263 members of staff were trained in the Sage and Thyme approach.

Human Factors Training

In 2017 we introduced Human Factors training for staff at LTHT. This consisted of a half day awareness session and a two day intensive training programme for theatre teams and simulation trainers. To date 127 staff have accessed this.

Breaking the Silence

In October, 25 staff members attended a newly commissioned half-day interactive workshop. The focus was to reduce the stigma around mental health and wellbeing in the workplace. The attendees explored the causes of mental health, and practical tools which can be applied in the workplace to create a culture of openness and trust where staff feel confident to discuss their wellbeing. This programme was very well received and is now incorporated in the Training Prospectus for 18/19.

Making Reasonable Adjustments in the Learning Environment

This half-day interactive workshop was delivered in March. It was designed for trainers, educators, clinical educators and facilitators. It was an opportunity to reflect upon current teaching practices and how to ensure a fully inclusive learning environment that benefits all learners.

Health and Social Care Education Conference

In July Organisational Learning delivered the Trust's first education conference. This event was created to act as a platform for staff in educational roles to share and promote their good work, whilst also offering a valuable networking space for the 171 attendees.

Continuous Professional Development for Coaches

The Trust is committed to developing and supporting all trained coaches through CPD events to maintain their competence and increase awareness of the service. Three CPD events were run in 2017-18, covering topics including Resilience, Career Coaching and Contracting. Each of the CPD events were followed by Coaching Supervision.

Matron and AHP Operational Leads Forum

In April the Matron and AHP Operational Leads Forum launched. This was designed to create greater networking opportunities and to share best practice across the professions. Topics covered at the forums have included the challenge and opportunities involved in leadership roles, resilience and authentic leadership. The attendance and engagement in the forum continues to increase.

Health Coaching

Health coaching helps people gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.

16 Health Coaches were trained last year to support our Oncology patients and our staff through the Health & Wellbeing Champion role.

Where Cultures Meet

To support and expand on the learning and development opportunities for medical and senior management, the Organisational Learning team provided the programme 'Where Cultures Meet- building bridges not walls' delivered by trained facilitators. 14 individuals attended the one day programme. The programme enabled participants to explore how cultures form, the power dynamics that typically occur when two or more cultures meet and ultimately providing insight into how to productively manage the meeting of cultures.

Leading a Resilient Team

A new half day programme commenced in March called 'Leading a Resilient Team'. It provided managers, team leaders and supervisors with the tools and skills to confidently build and maintain resilience within their own teams. A series of nine half day programmes are scheduled across the year and advertised in the new prospectus.

Work experience, schools engagement and employability

The Trust is working with a variety of organisations to achieve the key strategic objectives set out encouraging widening participation through the national Talent for Care agenda.

Establishing good links with local schools, colleges and communities in a number of ways has been essential and we have developed these by:

- the recruitment of a further 61 Trust staff as volunteer Healthcare Career Ambassadors who promote NHS careers and jobs
- embedding our four-week internship placements to local schools, and mentoring students through the Career Ready programme
- continued working with our agreed partnership schools, including the development of resources

and engagement activities highlighting career options in the NHS

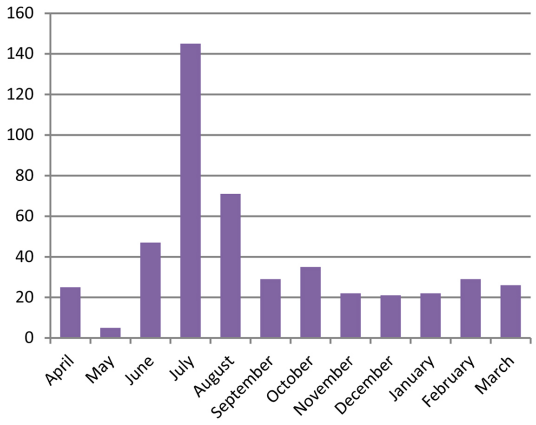
- the promotion of the various Apprenticeships on offer at LTHT, including hosting three Apprenticeship Open Days reaching almost 600 prospective employees and attendance at the Leeds Apprenticeship Fair with colleagues from other NHS Trusts in Leeds
- providing 477 individuals with a 'work experience welcome' who then went on to undertake placements across a variety of CSU's.
- applying for and subsequently being awarded the 'Fair Train Bronze Award' for work experience in September 2017. This was in recognition of our continued commitment to monitor and improve our work experience offerings at LTHT. The Trust hopes to improve further achieving 'Silver' or 'Gold' by the end of March 2019
- continued growth of Trust employability programmes following the development of relationships with organisations including The Princes Trust, Department for Work & Pensions, Leeds City College, Leeds City Council, Johnson & Johnson and the Ministry of Defence. We will work with these partners to provide NHS work placements for individuals who may be interested in potential employment in the Trust.

West Yorkshire & Harrogate Excellence Centre

The West Yorkshire & Harrogate Excellence Centre (WYHEC) is a regional training hub hosted jointly by Leeds Teaching Hospitals NHS Trust in partnership with Bradford District Care NHS Foundation Trust.

In 2017/18, the WYHEC secured funding from the Local Workforce Action Board (LWAB) which has been used to recruit a dedicated project team to deliver on the five LWAB priorities (Primary Care, Employability, Shared Resources, Stakeholder Engagement & Apprenticeships). The WYHEC project team have used this funding to develop 64 training programmes to be delivered across the West Yorkshire & Harrogate footprint.

LTHT Work Experience Activity 2017/18



Apprentices

The Trust laid out ambitious plans for utilising the apprenticeship levy following its introduction in May 2017. The focus was to use apprenticeships to address workforce gaps, both introducing new staff and developing the skills of our existing employees.

At the year-end for 2017/18, Leeds Teaching Hospitals had 596 apprentice starts, a 50% increase from 2016/17. We were also named as the top NHS employer of Apprentices nationally.

We had expected to reach nearly 700 apprentice starts, however delays in some of the standards being made available, along with difficulties identifying providers to deliver at scale, have meant that we have not achieved that aspiration this year. We are confident that 2018/19 will see a further growth in our Apprenticeship starts, particularly with the Nursing workforce plans in place to commence the Apprentice Nurse programme in June closely followed by the introduction of our Nursing Associate Apprenticeship Programme.

The introduction of the Apprentice Levy has been a catalyst for exploring options to use apprenticeships across further disciplines and this has allowed the Trust to engage with neighbouring Leeds NHS organisations to commission programmes. The Trust has had 22 Apprenticeship programmes active this year, delivered by 15 Training Providers.

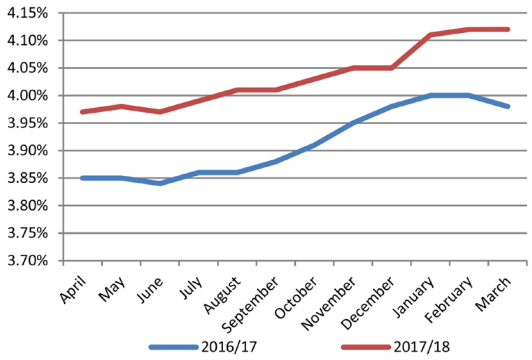
Additionally, through the West Yorkshire & Harrogate Excellence Centre, the Trust has successfully engaged across the WYH STP to identify opportunities to engage collaboratively on apprenticeships. 2018/19 will see 26 Apprenticeship Programmes offered across the Trust, of which 10 have been commissioned for delivery collectively, eight via the WYHEC and two pan Leeds.

Sickness absence

12 month sickness trend 2016/2017 and 2017/2018

Our sickness rate across the Trust has increased in 2017/18 for both short and long term sickness; which is consistent with our peer Trusts. The rate for the Trust 2016/17 compared to 2017/18 is outlined below.

LTHT total sickness rate for past two 12 month periods



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

Supporting our diverse workforce

The annual NHS staff survey tells us that our staff who have a protected characteristic including disability, gender and race are for the most part more positive about their working experiences than they were in 2014. As part of the "Our People (Staff and Volunteers) are supported and engaged" workstream, the Trust has set three targeted ambitions to improve the experiences of these staff in relation to the key findings of:

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

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

In 2017, we advanced from Level 1: Disability Confident Committed to Level 2: Disability Confident Employer. Throughout 2018, the Trust will be working towards being awarded Level 3: Disability Confident Leader.

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

Also in 2017, our Black Asian and Minority Ethnic (BAME) Staff and Volunteer Network went from strength-to-strength and a peer support group for staff living with a long term health condition was established to make sure the work experiences of BAME and disabled staff are positive.

In addition to our work on disability, race and gender, in 2017 the Trust worked in partnership with Stonewall on the Stonewall Workplace Equality Index, made further progress against all five objectives of the Trans Equality Pledge and LGBT staff established a LGBT+ Staff Network to make sure the work experiences of lesbian, gay, bisexual and trans staff are positive.

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

	2014			2017		
	White	BAME	% Gap	White	BAME	% Gap
% staff experiencing discrimination at work in last 12 months	10%	25%	15%	7%	23%	16%
% staff believing the organisation provides equal opportunities for career progression / promotion	89%	70%	19%	90%	75%	15%
	Disabled	Not disabled	% Gap	Disabled	Not disabled	% Gap
Overall staff engagement	3.45	3.71	0.26%	3.63%	3.87%	0.24%

Trade Union Facility Time Publication Requirements:

We are in the process of collating the April 2017-March 2018 data to report externally under the requirements of the Trade Union (Facility Time Publication Requirements) Regulations 2017. This will provide information on the paid time off provided to trade union representatives for trade union duties and activities during the year. The first report will be published by 31 July 2018 on our website and will be accessible via www.leedsth.nhs.uk.

Health and Wellbeing

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

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

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

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

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

In 2018 we launched the Long Term Conditions group. This is a support group for employees with long term conditions; the group also incorporates other services such as health trainers and health initiatives.

All new starters in the Trust are emailed information on health and wellbeing and offered one month's free fitness membership. Staff are also empowered to complete personal wellbeing assessments and set goals and targets to improve their health and wellbeing. This includes a website which also lists active challenges, advice sheets and the staff health and wellbeing benefits available.

The Trust's intranet has been updated and information to support staff and managers about domestic abuse and violence has been included. The Trust supported the nationwide '16 days of action' and White Ribbon campaign to raise awareness.

We also gained the bike friendly business accreditation and received a grant for £5,000 to improve storage at the LGI and SJUH. This improvement in facilities is just one of many ways that we are improving health and wellbeing for staff across the Trust.

The Trust ran three seasonal campaigns;

1. Be Santa to a senior
2. Reverse advent calendar
3. Pass on a present

These campaigns include partnering with community groups, and enabled staff to donate unwanted presents to local charities.

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

Occupational Health Service

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

Accreditation is awarded following formal inspection of evidence and working practice together with annual review against the following standards:

- business probity
- information governance
- people
- facilities and equipment
- relationships with purchasers
- relationships with workers

OH leads and manages the Trust staff flu campaign which this year began on 2 October. By 31 October we had met the national target of 70% of frontline healthcare workers vaccinated – two months ahead of the CQUIN funding target date.

Final figures reported for staff flu vaccination were 80.9% of frontline healthcare workers and 77.6% of all staff vaccinated. This is a significant result and our highest figures since reporting began.

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

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

Due to qualified staffing capacity, waiting times in 2016 for in-service referrals did escalate up to six weeks. By working with HR colleagues and the private sector, OH has reduced and maintained waiting times back to within the national Key Performance Indicator (KPI). During 2017/2018 the average waiting time to see a qualified OH clinician was 6.0 days.

The national requirement is for 98% of staff to be assessed for fitness to work within two days of receipt of form. The KPI for on-employment clearances of new staff has consistently been exceeded during 2017/18.

Health and Safety

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

We have a Trust Board approved Health and Safety Policy, which explicitly details roles, responsibilities, arrangement and integration with the Trust corporate governance processes. It also includes our detailed procedures relating to specific risks such as Fire Safety, Violence and Aggression, Ionising & Non-Ionising Radiation, Musculoskeletal Disorders, COSHH and Slip/Trip prevention.

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

In 2017, we conducted an audit of the previous year's performance in which 543 (97%) wards and departments of the total number across the Trust participated.

Reactive monitoring of health and safety data, in particular RIDDOR reports following serious incidents, shows an overall declining number of serious health and safety incidents over time however the numbers reported to the Health & Safety Executive (HSE) increased between 2016 and 2017.

In 2017 the Health and Safety Executive (HSE) did not issue Leeds Teaching Hospitals with any statutory enforcement notices that require employers to take immediate action to improve health and safety risks.

Public / Employers liability claims following alleged harm due to negligent acts by the employer decreased in 2017.

Injuries from used disposable medical devices, especially hollow bore needles that may be contaminated with blood and body fluids, is a major infection risk to healthcare employees and continues to be an area which is closely monitored & managed when incidents arise. Reporting of such incidents has improved over time which may account for the increasing numbers of this type of injury alongside increasing staff and patient numbers.

We are very proud to have once again been awarded the ROSPA Gold Award for our Health and Safety management systems and arrangements. This is a significant achievement and one that we are very proud of.

RIDDOR (staff) - significant work related injuries and diseases

Year	2010	2011	2012	2013	2014	2015	2016	2017
RIDDOR's	117	109	97	69	76	65	48	73
All reported incidents	20679	21426	24214	25219	26285	28467	30785	32425

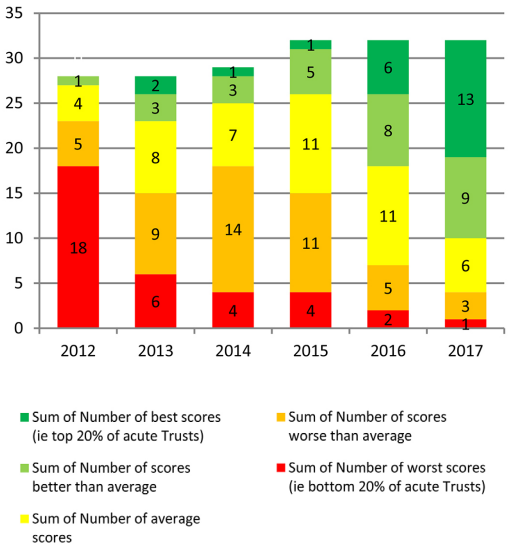
What did our staff tell us in the staff survey?

The annual NHS staff survey was published on the 7th March and was completed by 30% of eligible members of staff. This paper outlines the key findings from the staff survey, highlighting achievements and details actions over the next year.

LTHT's positive results have not been reflected nationally, with 21 key findings declining and only 11 improving. LTHT has now moved from a position where the Trust was behind the national average to one where the Trust is now performing above average for the majority of key findings. In 2017 a full census was undertaken for the third time, 30% (5168) of eligible employees took part.

Annual Progress

LTHT has shown great progress since 2016, improving in nine of the 32 key findings, with 13 now in the top 20% of acute trusts. The table below shows how the Trust has improved its position year on year.



LTHT Staff Engagement Score

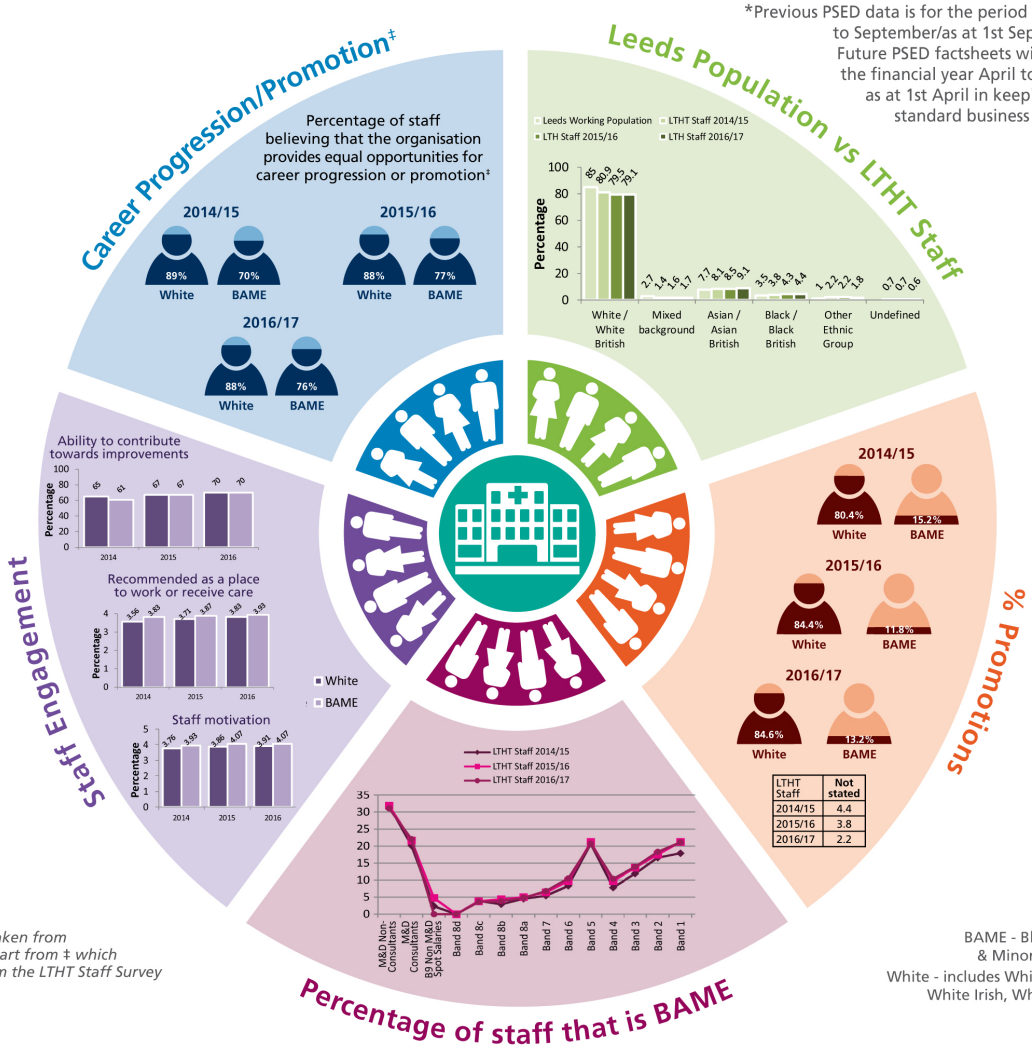
Staff engagement looks at three key findings covering staff motivation, staff perception of their ability to make improvements and staff willingness to advocate for LTHT as a place to receive treatment or work. In the period 2012 - 2017 we are the most improved trust nationally, moving from a score of 3.44 in 2012 to 3.85 in 2017 and are above average for this measure. The staff engagement score is particularly important as studies show that higher staff engagement is linked to improved patient experience.

Understanding our people

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

Ethnicity@LTHT

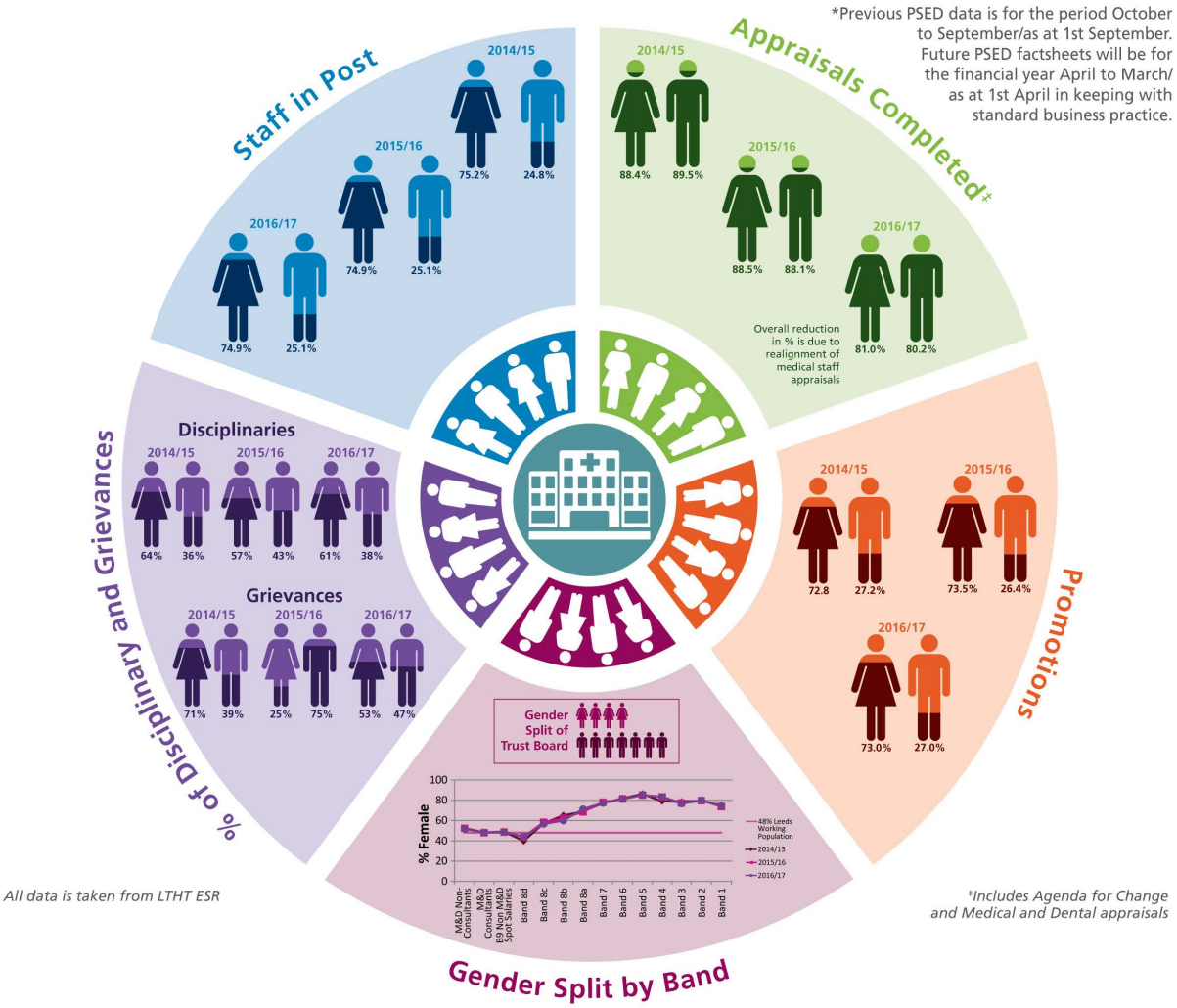
*Previous PSED data is for the period October to September/as at 1st September. Future PSED factsheets will be for the financial year April to March/ as at 1st April in keeping with standard business practice



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

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

Gender@LTHT



All data is taken from LTHT ESR

‡*Includes Agenda for Change and Medical and Dental appraisals*

2.9 Medical Education and training

High quality education is one of the strategic goals of the Trust. We deliver some of the largest clinical education programmes in the country, and we have a rapidly expanding programme for apprentices. We have excellent partnerships with a range of universities and further education institutions both in Leeds, and also in the wider region. In medical education, there are more than 1,300 undergraduate medical students and in excess of 950 postgraduate trainees. There are also more than 1,200 undergraduate nurses, midwives, allied health professional and scientific students undertaking clinical placements in LTHT.

Undergraduate medical education

We provide a range of clinical placements for medical students from the University of Leeds Medical School, across all five years of the MBChB degree and delivers a range of high quality additional teaching. In the past year, we continued the positive trend of improving overall scores in student feedback, and these are now some of the best in the region. The team at Leeds Teaching Hospitals has improved the quality and timeliness of feedback data to CSUs over a period of years, which has significantly enhanced engagement with clinical leaders.

The Multi-Professional Student Forum continues to go from strength to strength, and during the year was shortlisted for a national HSJ Award. In addition to the quarterly Trust-wide forum meetings, we also run meetings in CSU's. The forum ensures that students' voices are heard by senior managers and members of the forum also present their experiences to the Trust Board.

The Undergraduate Hub moved to a new location in Ashley Wing at the start of 2018, and at the same time we have continued to increase the amount of teaching on offer, with a range of breakfast sessions, journal club, and an expansion of the hugely popular Self Directed Practice Room.

Postgraduate Medical Education

There continues to be positive engagement between CSU leaders, educationalists and the Medical Education Team. Representatives from each CSU come together with the medical education team in the Medical Education Sub Committee, which is well attended. We continue to roll out improved educational metrics to CSU colleagues, and there have been considerable improvements in the quality of placements.

In parallel, a new Junior Doctor Body (JDB) has been established with the goal of improving engagement and communication with trainee doctors, as well as building their involvement in quality improvement initiatives. We have also appointed a Chief Registrar in medical specialties.

Through the year, we continued to provide better pastoral support to trainees experiencing difficulties, with the aim of identifying problems as early as possible.

Clinical Skills, Simulation and Technology Enhanced Learning

The Leeds Institute for Minimally Invasive Therapy (LIMIT) moved into a new location in Beckett Wing during the year, thereby significantly increasing its capacity to deliver more courses. LIMIT enjoys a fantastic reputation not just in the Leeds area, but also internationally. The staff in LIMIT, combined with a highly motivated clinical faculty, have considerable expertise in delivering high quality sessions, ranging from bench-top clinical skills simulation, human factors and team interaction activities, through to highly technical virtual reality surgical simulators.

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

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

NHS Staff Libraries and Evidence Service

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

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

The team is also working with clinicians to bring library services, including evidence search facilities closer to the work place.

Pre-registration education

We offer high quality clinical placements in a wide range of settings for around 900 Nursing, Midwifery and Allied Health Practitioner (AHP) students from most of the universities in the Yorkshire and Humber region. Their learning is supported by more than 1,500 mentors and practice supervisors, including new mentors who were supported through the Support for Learning in Practice programme in 2017/18.

In 2017/18 we supported 13 Trainee Assistant Practitioners to complete their training and commissioned a further four places on a new Assistant Practitioner Apprenticeship, which now incorporates a therapy module to further enhance the skills and flexibility of this workforce.

We continued to work as part of the West Yorkshire Nursing Associate Pilot Test Site to enable the successful implementation of the new Nursing Associate work based learning foundation degree. We have supported 22 trainees who are due to complete in December 2018 and we will be recruiting to a further 30 places for the Nursing Associate Apprenticeship in 2018 and continue to do this as part of the West Yorkshire Employer Partnership.

We have worked in collaboration with the University of Leeds to develop one of the UK's first Nursing Degree Apprenticeships, due to commence in June 2018.

Post-registration Education & Development

We encourage staff in our hospitals to be lifelong learners. Registered professionals are supported to further develop their learning through appraisal with the aim of enhancing, improving and innovating patient care. We have enhanced our leadership and management development offering in 2017/18.

Connecting Leaders in Care was launched in 2018 with the purpose of connecting and engaging with our clinical care leaders, enabling two way communication, the sharing of best practice and development of the workforce.

The Matron and Allied Health Professional (AHP) networking forum was launched to enable informal development and networking in this group of staff. We have revised the criteria for access to the Leeds Hospital Charitable Foundation Chief Nurse Fund in order to maximise the use of this resource for as many staff as possible. We work very closely with Health Education England and our

partners in Higher Education to ensure as many of our staff are able to access post registration education to meet their development needs and the development of our services as possible. Further work continued in 2017/18 to explore alternative funding options and innovations to enable more of our staff to access CPD.

In 2017/18 we were supported by Health Education England (HEE) to continue the delivery of Advanced Clinical Practitioner roles, developing the clinical workforce for the future. A further 25 trainees have commenced their training posts, undertaking clinical practice alongside a Masters programme at university.

Preparing our workforce - IPP and Preceptorship

All new nursing and midwifery starters to the Trust take part in our unique Introduction to Professional Practice programme during their first week, which prepares them for working in our clinical areas. In 2017/18 we implemented a refreshed programme, that now incorporates a patient journey and the new technological advances associated with nursing care such as eMeds and eObs.

In 2017/18 we introduced a Trust wide Preceptorship Programme to support those new into nursing posts. This collaboration of Clinical Educators and Corporate Nursing gives six structured days throughout the first six months, teaching Communication Skills, Resilience and End of Life care. The facilitated support forums each month enable new starters to share their challenges and achievements in a safe space. Learning from these staff members is starting to shape future preceptorship and ensure we offer our staff the very best start in their employment with us. Feedback has been very positive with new staff valuing the support and time dedicated to their development.

Workforce transformation

In view of a national shortage of registered nurses we have been working with the CSUs to review their current workforce models and skill mix to optimise patient care. A number of CSUs have developed new models and roles in conjunction with physiotherapy and occupational therapy colleagues. The approaches include employment of therapists into the ward leadership team, and rotation to the ward team to work alongside the nursing team in providing care and embed therapeutic care.

Section 3
Patient Care and Experience

Patient Care and Experience

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

3.1 Involving patients and the public

How feedback has supported Trust developments

Work that started in 2016/17 to ensure tools are available in the Trust to capture the patient and public voice, were further developed in 2017/18. Successes include the continuation of the Patient Reference Group as a key source of support to the Trust. We also have a database connecting us with members of the public which helped us capture public opinion on a number of key issues throughout the year.

These great achievements can be seen by the range of involvement activities that it is known occurred throughout the year. This demonstrates that the organisation is considering more often that the contribution of patients is important to take into account when key service changes are proposed. Here are some examples:

- Elderly medicine services held an engagement event with approximately 30 older people from BME communities. Useful feedback was obtained, particularly in relation to food choices and transport.
- The Patient Reference Group were consulted on a number of key issues for the Trust which in all cases influenced Trust decision makers. Topics explored included the public perception of Scan4Safety and the content of the Trust Patient Experience Strategy.
- Approximately 60 responses were received from members of the Leeds LGBT community who completed a survey to provide feedback about their hospital experience. The equality and diversity team are now using this to inform their workplan.
- The Quality Improvement team supported a workshop which was aimed at better understanding how patients with Parkinson's disease would like to be supported to manage their medicines. The team explored a number of options with the patients and carers present which has influenced how this work will now be taken forward in the Trust.
- In 2017, the members database was used to make 6266 contacts with patients and the public who have signed up to support the Trust. They were asked for their views on a number of different topics, including a proposal to remove payphones from outpatient environments. The database was also used to gather feedback on the content of an End of Life Care booklet and the content of the Trust Complaints policy.

Always events

'Always Events' projects are a way of staff and patients working together to identify and introduce a change into a clinical area which will have a positive impact on patient experience. A specific model for change is followed which is promoted by NHS England and supported by a National team.

2017/18 was the first year in which we began to work with Trust teams to consider their patient feedback and to identify where we could focus on taking forward an 'Always Event ' project. During the year, two key areas were identified for this support and both are progressing well on moving forward with their project.

- The first project is concentrating on improving the patient night time experience on four of our hospital wards. To identify the best way to do this, feedback was sought from 480 patients. A member of the patient experience team also spent time on the wards overnight, to directly experience the environment and contribute to our learning.

A number of developments are in the pipeline so far to support this work. These include an information leaflet for patients, a night time banner to remind staff to be quiet and comfort packs which provide patients with simple measures to help them sleep, such as eye masks and ear plugs.

- Our second project is focussing on the experience of patients who attend theatre and undergo anaesthetic. This work began with the relevant clinical service undertaking a survey with patients called 'Before and After You Sleep' which generated much interesting information. On 15 December 2017, the service then held a very successful patient engagement event which was supported by a graphic illustrator and which expanded on the survey feedback. More than 130 suggestions and ideas were generated from this event which are being used to identify quick service improvements as well as to inform the content of potential 'Always Events'.

We aim to continue to implement our chosen 'Always Events' and test the impact they have on our patients' experience. We will then use our learning to develop more 'Always Events' to improve the care we provide.

Public Health - The Power of Patients

We discovered, by looking at our data, that the Trust performs a high number of tests, such as scans and x-rays when compared to other teaching hospital Trusts.

Our public health team wondered if it was possible to understand why this might be in some situations. They were particularly interested to see what patients would think about a change in scanning rates, if that was to happen.

The team concentrated on care provided for patients with one particular condition. They asked patients for their opinions in two ways. Firstly, past and present patients were surveyed to understand their experience of having the condition and of having scans at LTHT. Secondly, they held an innovative focus group of people who had never had the condition but who had similar scans in the past. The focus group was shown a video of a doctor talking to camera as though he was giving them a diagnosis of the condition. During the video he explained the challenges of managing the condition and the potential health concerns associated with scanning too often. Patient feedback from both sources was collected and shared with clinicians who manage patients with the condition at LTHT.

Doctors responded positively to receiving this feedback and have committed to review practice as a result. They have said that the approach that was taken to gather feedback and hearing from patients helped influence their decisions. They are now working on the following in response to the feedback:

- Reducing the time it takes to scan patients
- Finding ways to reduce anxiety
- Finding ways to increase available information and support

What patients in the forum said:

- Listening to the consultation on video made them feel anxious and uncertain
- There is too much information to take in when you see the doctor for the first time
- They would appreciate having Clinical Nurse Specialist support around the time of initial diagnosis, so they can ask more questions when things have sunk in
- It is important to have certainty about dates of clinical tests and results
- Scans should take place only if they are absolutely necessary
- Patients did not want to decide whether a scan was necessary - they felt doctors should decide that.

What doctors receiving the feedback said:

"Valuable work and very helpful to hear patient comments and views"

"This approach provided insight into the wider context of decision making"

"It was nice to meet and work with people I wouldn't in normal practice and has encouraged thought in other areas of practice"

"I hope this continues in the Trust"

3.2 Improving patient experience

Friends and Family Test

The Friends and Family Test (FFT) at Leeds Teaching Hospitals is now available in a number of formats, which allows our patients to have more choice in how they provide feedback to us about their experiences at the Trust. During 2017, these options, which include, paper, online surveys, text messaging and instant voice messages, have been made available across the Trust. This has resulted in not only a higher number of patients providing feedback, but also in Trust staff being able to use this feedback in a much more useful way.

The FFT team has been working with colleagues and patients across the Trust to improve the process for FFT and to make this more user friendly. Some of the achievements in 2017/18 are outlined below:

- The Trust achieved some of its highest ever response rates in 2017 which demonstrates our staff commitment to ensure every patient has the opportunity to give feedback.
- The FFT team has worked alongside IT colleagues to successfully roll out an electronic survey using hand held tablets. This is now available in every adult inpatient ward across the Trust.
- In collaboration with the Trust's Youth Forum, the FFT team has designed new children and young people's FFT cards – the design was inspired by our young patients who gave some excellent feedback specifically relating to the need to recognise that we have diverse families across our communities and that our feedback cards should reflect this.
- In summer 2017, the FFT team supported a FFT workshop with a team from maternity services. This was a great success and generated lots of innovative ideas about how more women could be encouraged to get involved in FFT. This also helped to develop Maternity staff FFT champion and the CSU now has numerous FFT champions across their departments.
- Business cards, which include a QR code have now been made available. This allows patients to feedback from the comfort of their own home rather than feeling pressured to complete a survey on discharge.

National Patient surveys

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

In the 2014 Children and Young Person's Survey we scored less well than we would have liked for a number of questions relating to the way we communicate with the parents of our patients. As a result of this feedback we developed an action plan which would help us make the care we give children more family centred. The 2016 survey demonstrated that we had significantly improved on our 2014 survey results for these questions.

Children and Young Peoples Survey 2016

We take part in the Children and Young People's Inpatient and Day Case Survey every other year. The results of the 2016 survey were published in July 2017. The survey asks parents (for children aged 0-8) and parents and children (for children aged 8-15) specific questions about their treatment and care at our hospital. The table below summarises the questions in which we scored statistically significantly better than in 2014. LTHT also scored significantly better than 70 comparator Trusts for 24 questions resulting in us being the fourth most improved Trust in 2016.

Children and Young Peoples' Survey: significant changes since the last survey in 2014 (lower scores are better)

	2014	2016	National Trust Average
Areas in which we have got significantly better since last year (survey question)			
Hospital room or ward was not clean	3%	0%	3%
Staff did not always provide clear information to parents about their child's care and treatment	23%	10%	16%
Staff did not agree a plan with parent for their child's care	12%	5%	8%
Parents did not always have confidence and trust in staff members treating child	22%	11%	20%
Staff did not keep parent fully informed about what was happening whilst child was in hospital	32%	21%	28%
Staff did not fully know how to care for child's individual or special needs	30%	19%	24%
Staff caring for child did not always work well together	26%	17%	23%
Parent felt that child was not always looked after well by staff	24%	12%	17%
Parent did not always feel treated with respect and dignity by staff	21%	9%	15%
Overall: Parent rated experience as less than 7/10	16%	6%	11%
Areas in which we have got significantly worse since last year (survey question)			
None			

Leeds Children's Hospital will continue to build on our achievements in the 2016 survey and to aim to deliver family-centred individualised care to all our children and young people and their families.

National Cancer Patient Experience Survey 2016

The 2016 National Cancer Patient Experience Survey was published in July 2017 and sampled adult patients undergoing cancer treatment as inpatients or daycases between April and June 2016. LTHT scored better than the expected range for 11 questions, worse for only one. We also improved our performance significantly against our 2015 survey for two questions. There were no questions in the survey for which we performed significantly worse. The Trust was ranked 17 out of 147 Trusts in the country and as the 10th most improved Trust of 147 Trusts.

National Cancer Patient Experience Survey 2016. Benchmarking questions which fell outside the expected range for a Trust of the same size. (In this survey higher scores are better).

	LTHT	National Trust Average
Questions for which LTHT fell outside the expected range for a Trust of the same size (positive score)		
Deciding the best treatment for you: Patient felt that treatment options were completely explained	86%	83%
Clinical Nurse Specialist (CNS) : Patient given the name of the CNS who would support them through their treatment	94%	90%
Support for people with cancer: Hospital staff gave information about support groups	90%	84%
Support for people with cancer: Hospital staff gave information about impact cancer could have on day to day activities	87%	81%
Hospital care as an inpatient: Patient's family or someone close definitely had an opportunity to talk to a doctor	77%	73%
Hospital care as an inpatient: Given clear written information about what should / should not do post discharge	90%	86%
Hospital care as an inpatient: Staff told patient who to contact if worried post-discharge	96%	94%
Hospital care as an out-patient / day patient: Doctor had the right notes and documentation with them	97%	96%
Homecare and support: Patient definitely given enough support from health or social care services after treatment	56%	45%
Your overall NHS care: Patient given a care plan	44%	33%
Your overall NHS care: Taking part in cancer research discussed with patient	47%	29%
Questions for which LTHT fell outside the expected range than would be expected for a Trust of our size (negative score)		
Finding out what was wrong with you: Patient told they could bring a family member or friend when first told they had cancer	71%	76%

Comparison with the 2015 National Cancer Patient Experience Survey

	2015	2016
The Trust has improved significantly on the following questions		
Hospital staff gave information about the impact cancer could have on day to day activities	81%	87%
Patient definitely given enough support from health or social services after treatment	43%	56%
The Trust has worsened significantly on the following questions		
None		

The Leeds Cancer Centre will continue to work hard to deliver improvements to the Cancer pathway. Their action plan and progress will continue to be monitored by the Leeds Cancer Board.

How we responded to feedback

During 2017/18, we improved the work we did to capture the changes that have happened as a result of what our patients were telling us.

As part of the Trust nursing, midwifery and allied health professional commitment, we agreed that each clinical service unit would share how their practice had changed as a result of patient feedback. The feedback that was taken into account was any information that had been provided through the Friends and Family test, via national patient surveys or through local engagement initiatives that services had taken forward.

We collected all the information and produced a report which showed that all our clinical service areas had taken positive action to improve the experience of patients in their care. The report was shared across the Trust and at our Patient Experience Sub-Committee.

Some examples of improvement from patient feedback:

Patients said: A leaflet should be available for patients going home in the early stages of labour.

What we did: We developed an information leaflet to support women in the early phase of labour to provide information and reassurance for women who choose to go home.

Patients said: It would be nice to have better facilities for relatives who are on wards for long periods.

What we did: On ward J08 a store cupboard was converted into a facility for relatives to make hot drinks and a dedicated visitor shower/toilet has been put in place.

Patients said: When they have been involved in major trauma incidents they often need on-going support.

What we did: We worked closely with Day One, our Major Trauma charity which supports major trauma patients here at Leeds, to provide patients with access to further support.

3.3 Improving information for patients and carers

The Trust holds a Patient Information Forum every three months, which involves a group of key stakeholders coming together to improve internal processes for developing and managing patient information at the Trust. The group is made up of Trust staff and patient representatives; the group has made great progress since April 2017, with many new projects being developed.

Over the last year the patient experience team has supported numerous 'Patient Information' projects, some of which are outlined below.

- A new piece of software has been investigated which will allow the Trust to offer published patient information leaflets in up to 90 languages. This new system will allow for immediate translation of these documents and can be accessed in paper form, electronic form or can be read to the patient as there is a voice option.
- The Trust now has 250+ leaflets available on the Trust internet page which are accessible to the public. This work is on-going and is anticipated to increase significantly over the next year.
- The Trust is scoping a new document management system for internal use that will allow for more robust management of all patient information. This system has the potential to increase the number of leaflets added or updated meaning patients will have more access to information that is current and up to date

The aim for 2018/19 is to:

- roll out new translation software Trust wide and measure the impact this has on patients access to information.
- roll out the new document management system to ensure between governance of patient information at the Trust and better access for patients to current and up to date information.

3.4 Resolving complaints

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

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

In 2017/18, we saw an increase in complaints of 5.5%. The complaints team has continued to work with clinical areas with an aim to both reduce the number of complaints received and reduce the length of time we take to formally respond to complainants either in writing or by meeting. We have also been collecting examples of good practice within the Trust in how we learn from complaints and better share that learning.

We have delivered a number of bespoke training sessions to clinical teams across the Trust to increase their knowledge in complaints handling and letter writing skills.

Following feedback from complainants that they were not always kept up to date with the progress of their complaint, the complaints team introduced Keeping in Touch Tuesdays (KitKat). This new initiative has resulted in a greater satisfaction for our complainants and better relationships being built between themselves and the complaints team.

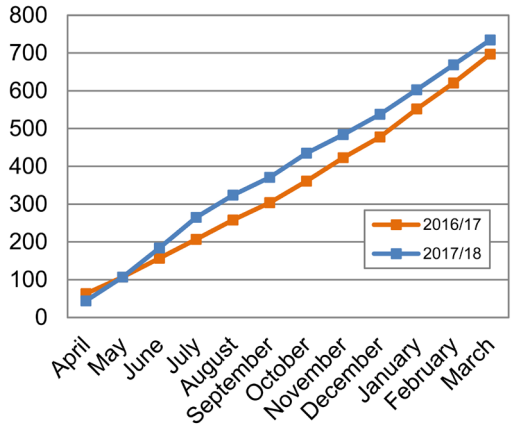
We have been collecting examples of learning from complaints and are collating a database of actions taken at the Trust in response to feedback. This feedback will be shared Trust wide.

Service changes in response to complaints

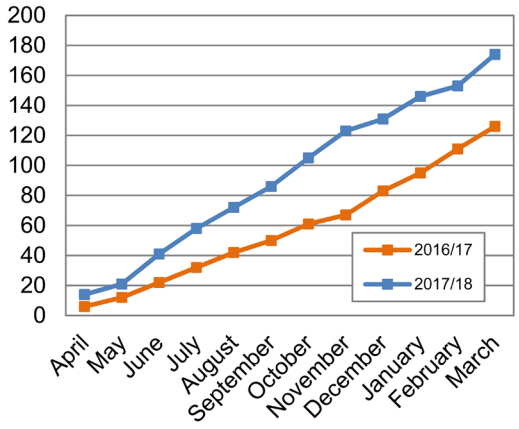
As part of the Trust nursing, midwifery and allied health professional commitment, we agreed that each clinical service unit would share how their practice had changed as a result of patient feedback. The feedback that was taken into account was any information that had been provided through the Friends and Family test, via national patient surveys or through local engagement initiatives that services had taken forward.

We collected all the information and produced a report which showed that all our clinical service areas had taken positive action to improve the experience of patients in their care. The report was shared across the Trust and at our Patient Experience Sub-Committee.

Number of complaints received (cumulative)



Number of complaints reopened (cumulative)



3.5 Working with partners

To ensure our patients continue to be at the heart of everything we do, one of our goals is to improve care and services by working closely with our partners across health and social care. We work with local and national commissioners, health and social care providers and Leeds City Council which helps us to provide an enhanced quality of care to our patients.

West Yorkshire and Harrogate Health and Care Partnership

We are part of the West Yorkshire and Harrogate Health and Care Partnership, which brings together all health and care organisations in our six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. This collaboration aims to develop and transform health and care by creating sustainable organisations, systems and partnerships.

In February 2018, the Partnership published 'Our Next Steps to Better Health and Care for Everyone' which describes the progress made across the partnership and sets out ambitions for the next 12 months and beyond. You can read the document at www.wyhpartnership.co.uk/next-steps.

West Yorkshire Association of Acute Trusts (WYAAT)

We are a key partner in the West Yorkshire Association of Acute Trusts (WYAAT). This group of hospital provider Trusts is effectively the delivery mechanism for acute provider aspects of the health and care partnership.

WYAAT enables hospitals in West Yorkshire and Harrogate to work more closely together to give patients better access to services, facilities and expert care. There are a number of different work areas that help to ensure more streamlined decision-making across the region and improve how we deliver services for our patients.

By bringing together the wide range of skills and expertise across West Yorkshire and Harrogate, we have an immense opportunity to work differently, be innovative and make changes that will improve the care we provide.

Leeds Academic Health Partnership

We are a founding member of the Leeds Academic Health Partnership (LAHP).

One of the biggest partnerships of its kind in the UK, the LAHP aims to improve the health and wellbeing of the people of Leeds by driving innovation in healthcare through collaboration between health, academic and other organisations. Other LAHP partners include three universities and all the NHS Trusts and clinical commissioning groups in Leeds and the City Council.

Since it was established in late 2015, the LAHP's membership has grown to include associate member, Yorkshire and Humber Academic Health Science Network, and affiliate members, St Gemma's Hospice, Yorkshire Cancer Research and Leeds City College.

The LAHP works to:

- improve the quality and of healthcare services while also improving their efficiency
- reduce health inequalities – narrowing the gap in health outcomes between poorer and more affluent communities.
- drive inclusive economic growth to create wealth and jobs.

The LAHP strategy to 2021 prioritises preventing ill health and helping people to care for themselves better. The strategy focuses specifically on:

1. Childhood obesity
2. Mental ill health in children and young people
3. Heart and circulatory health
4. The links between physical and mental ill health
5. Frailty
6. End-of-life care.

Healthwatch

During 2017 / 18, we continued to work with Healthwatch Leeds to understand what patients were saying about our services. We have also worked in partnership with them to plan good ways to seek the views of patients and the public from across Leeds about our plans and our services.

Outpatient services are delivered at Leeds Teaching Hospitals Trust across five hospital sites. Approximately 1.3 million patients were seen in the Trust outpatient departments in 2016.

It is important we have access to up to date feedback from our outpatients. During 2017/18 we continued to work with Healthwatch Leeds who completed a planned series of visits to 18 of our outpatient departments. Healthwatch provided a written report for each department visited which contained helpful information on patient views. In total, they spoke to 904 patients.

The information provided has helped the outpatient management team to understand the issues that matter most to patients. It has also helped the team plan the improvements that need to be taken forward to address these issues. One example of a positive improvement that has already been achieved related to self-check in machines. Many patients reported that these did not work properly and that they were frustrated by them. The management team have now upgraded the self-check machines and made some changes to them, which has resulted in them working much better. Healthwatch Leeds took part in a film which was shown at the Trust Annual General Meeting in September 2017 and which describes their contribution to this work.

In February 2018, the Trust also took part in a Leeds-wide workshop which was facilitated by Healthwatch. The workshop aimed to bring different organisations together from across the city to seek the views of patients and the public on a number of different topics, as holding one meeting to do this is more efficient than lots of organisations holding separate meetings.

We talked to the people who attended about our plans for a new healthcare building in Leeds and asked them how we and make sure we keep the public informed about progress.

The outpatient management team continues to work on the Healthwatch feedback provided to address the issues that patients have raised and aim to ensure they complete this. Some of the findings have resulted in the need for the Trust to undertake longer term projects to improve experiences and these are underway.

Our aim is also to continue to support the development of new ways to engage with people across Leeds and to participate where we can in new and useful initiatives.

Carers

During 2017/18, we were delighted to receive the 'Commitment to Carers' kitemark. This recognised the commitment we had made, as a member of the Leeds Carers Partnership Group, to support Leeds becoming the best city for carers.

During Carers' week in June 2017, our Chief Nurse and colleagues took the opportunity to publicise this achievement and to remind staff of the actions we were progressing to improve the experience of carers. In addition, we partnered with Carers Leeds to hold stalls promoting the week on both of our main hospital sites.

In addition, we updated our nursing assessment document to ensure that when it is identified that a patient is supported by a carer, the carer is automatically given information about what LTHT can offer to support them to stay with their relative or friend (if that is what they wish to do).

We also developed a Carers page on our Trust website, which provides information about 'John's Campaign', Carers Leeds and other local and national sources of support.

We continued to work closely with Carers Leeds and are fortunate to host two Carers Leeds support workers, who offer practical support to carers of patients with Dementia and carers who require advice on funding additional care.

In 2018/19, we will continue our Commitment to Carers and in addition we will be contributing to regional work undertaken by the West Yorkshire and Harrogate (WY&H) Health and Care Partnership. The aim of this piece of work is to heighten the profile of carers in a more holistic way and to ensure a more consistent approach to the way carers are supported across the region.

Volunteers

Voluntary Services have been working on increasing the number of Volunteering roles available across the Trust. We have also been focusing on improving our engagement with the current volunteers to ensure those who volunteer at Leeds Teaching Hospitals have a positive experience and want to stay with us.

In 2017/18 158 new volunteers have been recruited across the Trust. We are committed to designing new and innovative roles that meet the needs of our patients, in addition to our more traditional roles such as Mealtime and Activity volunteers. These remain important also as we recognise the significant impact these volunteers have on patients' experiences.

This year we have celebrated success in a number of areas.

- Hospital Guides - Our Estates and Facilities department has worked with Voluntary Services to recruit more Meet and Greet Volunteers, who provide front of house support and signposting for patients around our hospital sites.
- Children's Hospital - Voluntary Services has supported the Children's hospital to launch a Scouts and Guides play scheme. This has now been operational for 12 months and is very popular with our younger patients. In March 2017, our new 'Supersibs' volunteer led crèche for siblings of premature babies was also launched in the children's hospital, which as far as we know is the first of its kind.
- Model Ward - Voluntary Services have been working with the acute surgical wards to develop a 'Model Ward'. This work has resulted in developing volunteering roles designed around the patient. This aims to understand how volunteers can be successfully used in a ward area by ensuring the ward has as many volunteers as they need. This is an on-going project and will continue into 2018/19.
- Emotional Support and Spiritual Care – Voluntary Services have worked with Chaplaincy colleagues to increase the number of volunteers now in our Emergency Departments. These volunteers provide friendship, emotional support and signposting to support services where required.
- Peer Support and activities- The Trust's stroke support volunteer programme has gone from strength to strength over the last year and we now have a Stroke Ambassador programme based on our Acute Stroke Unit. These volunteer ambassadors, who have experienced a stroke themselves, provide much needed emotional support to patients, carry out activities on the unit, provide companionship and offer a helping hand with rehabilitation. We are committed to sharing best practice and learning from others to ensure Leeds Teaching Hospitals is the 'best place to volunteer'. As such, we have has signed up to be part of a national learning network led by 'Helpforce', a national initiative aimed at harnessing the potential of volunteers to assist the NHS. This national networking opportunity allows the Trust to work in collaboration with other Trusts and continue to build on our successes.

Volunteer Engagement

During the last twelve months, Voluntary Services have continued to engage with our current volunteers, to ensure that anyone who volunteers at Leeds Teaching Hospitals has a good experience and wants to stay with us. We

have achieved this by holding volunteer focus groups every three months, providing more specialised training than ever before and giving every volunteer at the Trust an opportunity to feedback by carrying out a volunteer's satisfaction survey. We have also held two celebration events this year in June 2017 and a special Christmas event that took place in December 2017. Both events were attended by our Trust Executive Team and were very well received by our volunteers.

Involving our members

In 2017/18, our membership remained at 25,930. The mix of gender, ethnicity and age is monitored to ensure our membership continues to be representative of the wider Leeds population, as well as Yorkshire and Humber and the rest of England. Our data is checked on a monthly basis against national death records and the NHS Spine to ensure that we only hold current information on our members. Our members are active in supporting the work of our patient experience teams - more information about this can found on p156.

Our membership magazine, Connect, was circulated twice in 2017/18 and is packed with informative articles on the fantastic work taking place in our hospitals. The magazine was redesigned during the year which transformed it into a digital format which is much more interactive. We have written to all our members to explain the cost savings associated with printing and posting our membership magazine, and invited all to update their details to receive this in the new electronic version. The editions provided members with a unique insight into the great work happening across the Trust including Building The Leeds Way and The Leeds Improvement Method.

Chaplaincy

The Trust's chaplaincy service is provided by a small team of paid chaplains, supported by a dedicated group of chaplaincy volunteers drawn from the local community. This past year has seen many changes to our team: Chris Swift left his post as Head of Chaplaincy Services in the summer and we were delighted to welcome Ben Rhodes who is now leading the team.

Our volunteers have been the constant through these staff changes: following special training these volunteers more than double the contact chaplaincy can have with patients and staff. It is an invaluable part of our service, which brings comfort and encouragement to countless patients every year. It also allows wider participation from those of different beliefs, ranging from Hindu to Humanist volunteers.

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

Alongside the everyday support for our patients and staff within the hospitals of the Trust, the Chaplaincy team also hosted the Centenary Commemoration for Nellie Spindler, a Leeds nurse who lost her life serving on the front line during the battle of Passchendaele. Nellie is commemorated in the Chapel at St James' Hospital. Attending the service, which was covered by local and national news media, were representatives of Nellie's family, members of the Royal British Legion, Queen Alexandra's Royal Army Nursing Corps, together with members of staff currently serving with the armed forces reserves.

The Baby Memorial Services were held in support of bereaved parents for both the St James in October and the LGI in early December. Supported by Chaplains and volunteer members of the Spiritual Care Team, around 400 parents and other family members gathered at these services to remember their baby.

In November, Chaplaincy also hosted the Transgender Day of Remembrance at Leeds General Infirmary. This commemoration was

developed and co-produced in partnership with members of the community with a large attendance by individuals and supporting organisations.

The Chaplaincy team was also delighted to welcome members of the Sikh community to the Faith Centre in the Autumn, and joined with them in the Sikh National Day of Prayer for those who have used our hospital services as well as those working in our hospitals.

3.6 Leeds Hospital Charitable Foundation

Leeds Hospital Charitable Foundation (LHCF) is the charity partner of Leeds Teaching Hospitals. The charity is dedicated to supporting and enhancing the highest standards of healthcare and patient and family wellbeing. With the valued help of staff, patients, volunteers, donors and supporters, the charity raises and manages funds which have significant additional benefit for patients, families and staff within the Trust.

The charity supports us by enhancing health and wellbeing, developing new services, providing specialist equipment, supporting specialist staff, promoting education and training and enabling research and innovation.

LHCF is governed by a Board of Trustees, with Dr Edward Ziff OBE as the Chairman.

In September 2017, David Welch was appointed as the charity's inaugural Chief Executive. He is responsible for leading and driving forward an ambitious transformation plan for 2018 and beyond including a full relaunch of the charity to coincide with the Leeds General Infirmary's historic 150th anniversary in May 2018. This is an incredibly exciting time for the charity, as it develops an infrastructure and identity which will allow it to reach its potential as a world class charity partner to Leeds Teaching Hospitals, placing patients and families at the heart of all it does.

Strengthening Our Partnership

2017/18 was an important year in terms of strengthening the collaboration between the Trust and LHCF. The Chief Executive of LHCF conducted a significant engagement exercise across the Trust to convey the charity's new strategic direction, and commitment to work in partnership with us to support exceptional healthcare.

Our Activity in 2017/2018

As a clear sign of this strengthening partnership the charity has provided a record £13m of funding to Leeds Teaching Hospitals during 2017/18. £2m was allocated as capital funding to purchase equipment and £11m as funding for revenue schemes which support a range of services dedicated to improving patient care. This would not be possible without the on-going generosity of the charity's valued supporters, for which we are extremely grateful.

This funding is governed by the LHCF Board and supported by various Special Advisory Groups, comprising a charity Trustee and Leeds Teaching Hospitals representatives to ensure full strategic alignment. These groups focus on funding projects in relation to:

- enhancing the hospital environment for patients;
- providing equipment to enhance patient care;
- supporting education and training for staff; and
- supporting research and innovation.

Examples of Funded Projects

Below are some examples of projects the charity has funded over the last year, to illustrate both the scope and benefit of the funding provided.

- Supply of Esaote portable ultrasound scanners: These scanners are used for a screening programme aimed to detect Abdominal Aortic Aneurysms in men.

The scanners are significantly more technologically advanced than those used previously, allowing for much more accurate measurement, thereby reducing the chance of poor quality images and increasing diagnostic accuracy. As the device is portable, this allows for the provision of an efficient local service and increases access for hard to reach groups.

- Family room - Paediatric Intensive Care Unit: Initiated in response to parents' feedback, the family room provides a comfortable, practical, and relaxing space close to the unit for parents and family members. The family room in includes a small kitchen unit, comfortable furniture and a small play area for siblings. This project has improved the quality of service and family experience, and is in direct response to identified needs of patients and families.
- The charity supported various conferences, awards and training programmes for staff including the Time to Shine Awards. Aligned with The Leeds Way, the Time to Shine Awards support the sharing of best practice and recognise the achievements of staff within the Trust, acknowledging their hard work and positive impact on patients.
- LHCF continued to support the annual Nursing and Midwifery Conference which recognises the important work undertaken by this group of NHS staff. The event is an opportunity for shared learning, generating insights and celebrating the successes of the previous year. The conference also focused on developments in care and patient experience including research, compassion in practice and collaboration.
- The charity made significant investment in research and innovation, including the establishment of the first Leeds Children's Clinical Research Facility (CRF). Leeds Children's Hospital has a long and proud history of delivering cutting edge research in paediatric oncology and malignant haematology. Funding enabled the conversion of an existing clinical area into a modern Children's CRF. Leeds Children's CRF now provides a dedicated age-appropriate research environment, improving the quality and quantity of research involving children and young people with cancer. The Leeds Children's CRF enhanced the experience of children and young people with cancer participating in clinical research studies, further elevating the profile of research and ultimately improving patient outcomes.
- The charity provided funding for dedicated research time for two Consultant Radiologists as part of the Adult Clinical Research Facility.
- The charity has exciting development plans to ensure they maximise the impact and benefit of their charitable funds and will seek new and innovative opportunities to support staff within the Trust, further enabling them to deliver exceptional care and support to patients and families.

3.7 Emergency preparedness

The Trust has responsibilities for Emergency Preparedness under the Civil Contingencies Act 2004, as a category one responder and the Health and Social Care Act 2012, as an NHS funded provider. These are further defined through the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2015 and the associated Core Standards. In summary the Trust is required to have risk assessments for emergencies and business continuity disruptions, response plans, staff training and regular exercises to test our arrangements.

The Trust undertakes an annual self-assessment against the EPRR core standards which are confirmed by the Board to the Department of Health through agreement with the West Yorkshire Local Health Resilience Partnership (LHRP) assurance process and submission through NHS England. In 2017/2018 the Trust was confirmed as meeting a SUBSTANTIAL level of compliance against the core standards.

For the first time in 2017, the Trust also welcomed a site visit from NHS England and the Leeds Clinical Commissioning Groups. As a Major Trauma Centre for adults and children, the Trust provided evidence of our assurance to the visiting team and an inspection of the Emergency Department at Leeds General Infirmary was undertaken. Following the visit, the Trust was rated GOOD against this enhanced assurance.

As in previous years, Yorkshire Ambulance Service NHS Trust visited both Emergency Departments in 2017 to undertake an annual assessment of the Trust's capability to respond to a Chemical, Biological, Radiological, Nuclear (CBRN) or Hazardous Materials' incident. It was confirmed that the Trust was appropriately prepared for these types of incident which would require patient decontamination arrangements to be mobilised.

The Trust has responded to a number of events in the past year. This has included both internal disruption to services through estates or digital incidents as well as external and wider incidents. Of particular note was the Wannacry cyber attack in May which impacted NHS organisations across the country; and the need to support local patients following the Manchester Arena terrorist attack shortly after. Nationally the terrorist threat level has escalated to critical on two occasions requiring the trust to provide confirmation that our major incident and security response arrangements are in place and robust.

Business continuity

The trust has benefitted from the expertise of the business continuity manager from Yorkshire Ambulance Service during the last year and the learning and support from this secondment continues to be embedded within CSU and Trustwide arrangements. Our plans and training have been tested regularly through both live incidents and exercises with further training and exercises planned in the coming year.

Chapel Allerton Hospital evacuation - June 2017

In May 2017, the Trust responded to a suspicious package at Chapel Allerton Hospital. Whilst the object of concern was later confirmed as neither a deliberate attempt to threaten the trust or an explosive device, the incident required siginificant coordination as over 100 patients were safely evacuated and cared for. The incident provided important learning for the Trust for these types of incident and progress against the actions arising from this event continue to be monitored through the Emergency Planning Coordination Group.

Exercise Mohawk - December 2017

Public Health England (PHE) led a Yorkshire and the Humber wide mass casualty exercise to test the NHS response to a multi-sighted terrorist attack occurring in the region. This 'virtual emergo' exercise, named Mohawk, was part of four exercises undertaken across the country and brought together teams from across the Trust to test our plans for receiving and treating a large number of casualties. The exercise provided valuable learning and confidence that significant additional capacity could be achieved to provide initial lifesaving treatment to patients that arrived at our hospitals.

Severe weather - February and March 2018

Heavy snow disrupted the travel of staff and patients on a number of days at the start of the year. The Trust maintained all services throughout this period with individual colleagues making heroic efforts to get to work. A minimal number of appointments and procedures were postponed due to either staff or patients unable to travel. Support was provided by West Yorkshire 4X4 volunteers and staff offered their own vehicles to help transport colleagues stranded due to the snow. Facilities were provided to enable staff to stay overnight where

required at both St. James's and Leeds General Infirmary. These periods provided useful learning to improve our cold weather plan for next winter and the contingency arrangements for travel disruption generally.

Emergency Preparedness Team

Both members of the Emergency Preparedness team have had the opportunity to work across the organisation and our partners for their development in the past year on secondments within CSUs and supporting the North wide response to winter. During this time a number of additional staff have supported the team with the appointment of external secondees. A permanent Resilience Manager joined the trust in November and there are plans for a Resilience apprentice in the coming year to further strengthen the team and the Trust's preparedness.

Training

Staff at all levels within the organisation have maintained their competencies with command and control training provided internally and familiarisation of the Trust's incident coordination centre. Additionally we have trained an increased number of loggists to support the response to an emergency.

3.8 Equality and Diversity

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

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

We created the Equality and Diversity Strategic Group in November 2013, led by the Chief Nurse / Deputy Chief Executive, to deliver on the equality and diversity agenda. For day to day delivery of the equality and diversity agenda, the Trust has an Equality and Diversity Team based in Human Resources which works closely with the Patient Experience Department.

Our Equality and Diversity Strategy 2015 to 2020

The Equality and Diversity Strategy was developed in 2015 to bring together the various parts of the equality and diversity agenda in a way that clearly articulates the commitment of the Trust with targeted ambitions otherwise known as equality objectives. These same ambitions help deliver on the key goals of the NHS Equality and Diversity Delivery System, which are set against each protected characteristic:

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

Throughout 2017/18 the following actions were achieved:

Equality and Diversity Strategy Targeted Ambitions		Action Achieved 2017 to 2018
1	We will increase representation of Black, Asian and Minority Ethnic (BAME) staff at Band 8b and above	Collaborative work between Organisational Learning Department and the Trust's 'BME Staff Network' ensuring existing talent management / coaching opportunities are accessible to all and BAME positive action initiatives successful in other organisations are effectively explored.
2	We will ensure we have a broadly representative workforce	Further analysis of outcomes from the 'publishing of equality information' with a focus on staff in post and recruitment and selection and monitoring of access to employability schemes by protected group.
3	We will improve staff survey results for our BAME staff regarding bullying and harassment and equal opportunities	Robust survey developed by the 'BME Staff Network' for completion by BAME staff with the findings addressed through their Terms of Reference. Lead organisation on regional event focusing on effectively addressing bullying and harassment within the workplace with national expert input. Delivered a comprehensive package of staff training to underpin day-to-day due regard to equality and diversity across all protected groups and increased the number of available Dignity At Work sessions.
4	We will improve staff survey results for our disabled staff regarding engagement	Established peer support group for staff living with limiting, long-term conditions and set up dialogue with disabled staff on setting up a disabled staff network.
5	We will reduce over-representation of BAME staff and men in conduct hearings	Fit-for-purpose, simplified Disciplinary Policy, inclusive of 'Incident Decision Tree' to safeguard against bias, and mediation/facilitated conversation provision. Availability of Difficult Conversations Training and decision to review to ensure all issues are addressed at the earliest opportunity.
6	We will achieve 50:50 gender balance on Trust Board	Held a number of events centred on women being effective leaders as part of The Leeds Female Leaders Network. Measured and considerate use of Search Firms. Implementation of NHS Insight Improvement Programme and Shadow Board Programme.
7	We will improve the experience of Trans staff, patients and carers	Awarded assurance of compliance against the Trans Equality Pledge for a second year due to continued roll-out of Trans Awareness Training, hosting Transgender Day of Remembrance, building stronger alliances with the local Trans community and continuous review of Trans Staff Guidance.
8	We will improve the experience of staff, patients and carers with mental health problems	Continued use of 'Know who I am' hospital passport for people with dementia, sign up to 'John's Campaign' ensuring carers of people with dementia are supported and PALS outreach reaching mental health support charities including Touchstone. Achieved Level 2 Disability Confident, continued roll out of 'Creating a Mentally Healthy Workplace' learning bursts, introduction of 'Living with a Long-Term Medical Condition' learning burst and roll out of Employee Assistance Programme.
9	We will improve the experience of patients who do not have a religion or belief	Leeds Religion and Belief Hub link established for collaborative work and enhancing of existing work within the Trust, roll out of Religion and Belief Awareness Training and production of monthly staff newsletter on religious events to raise awareness and encourage engagement.
10	We will improve the experience of Lesbian, Gay and Bisexual (LGB) staff, patients and carers	Continued roll out of LGB Awareness Training, launch of LGBT+ Staff Network, lead organisation on Leeds LGBT+ Staff and Allies Pre-Pride Engagement and Networking Event, highly visible presence at Leeds Pride 2017, participation in Stonewall Workplace Equality Index and key partner on LGBT+ Health and Wellbeing Subgroup.

11	We will ensure ready access to hospital services and information	Interpreting and translation services provided through Language Line Solutions and Leeds Deaf and Blind Society, review of Interpretation and Translation Policy and Guidance providing clear and fit-for-purpose direction to staff, continued roll out of Sensory Awareness Training and establishment of Sensory Awareness Subgroup to Patient Reference Group.
12	We will improve patient survey results of older inpatients, young patients using maternity services, LGB patients accessing A&E and BAME outpatients	Patient survey analysis planned for 2018/19 to provide current position against all patient-related targeted ambitions.

Publishing of equality information

Leeds Teaching Hospitals NHS Trust publishes information in July each year to determine the extent at which equality is placed at the heart of everything we do. The key headline actions that emerge from the analysis of the equality information are subsequently incorporated into the annual review of the Equality and Diversity Strategy to ensure seamless delivery on the equality agenda. The key findings and actions identified in 2017 are set out below.

	Key Findings for 2016 to 2017	Key Findings for 2017 to 2018
All people can access the Trust's services and experience the best possible clinical outcomes every time.	BAME patients remain more likely than White (White British, White Irish, White Other) to not attend an outpatient appointment, but the % gap has closed by approximately 25% over the last 12 months. White patients remain more likely than BAME to not be treated within 4 hours by the Emergency Department (ED), but the % gap has closed by approximately 30% over the last 12 months. Older patients remain more likely to be treated within an 18-week period from the point of referral. The % gap has grown by approximately 50% in the last 12 months. The older the patient the less likely they are to be treated within 4 hours by the ED. The % gap has grown by approximately 80% in the last 12 months. Muslims, No Religion or Belief and Sikh remain more likely than other religions not to be treated within 18 weeks from the point of referral. The % gap has increased by 25% in the last 12 months. Christians remain more likely than other religions to not be treated within 4 hours by the ED. The % gap has increased by approximately 50% in the last 12 months.	Further implementation of NHS Accessible Information Standard and improvement projects within Outpatients CSU, including fit-for-purpose patient leaflets, appointment letters and text reminders, to ensure information and communication support needs of all patients are met and people are in a position to attend outpatient appointments. Provide assurance that the process behind treatment of patients in the ED is not biased and the patient experience is positive. Carry out further analysis of ED intelligence to identify the different patient journeys by protected group. Ensure robust and safe discharge and admission of older patients by working closely with the Trust's multi-disciplinary team and Adult Social Services and implement plans to meet the needs of patients with complex needs within the ED. Further roll out of the Patient Advice and Liaison Service within the different communities, including the different age, ethnic and religion/belief groups, to ensure all concerns are raised and addressed as far as reasonably possible. Consider Friends and Family Test (FFT) feedback with the support of the new FFT system, including ensuring it is representative of all protected groups and equality-related themes are identified and addressed. Reduce 'Not Known' and improve data quality through staff training on the purpose of capturing the data.

	Key Findings for 2016 to 2017	Key Findings for 2017 to 2018
All employees are supported, representative of the local community and led to deliver on equality.	BAME staff employed at LTHT broadly reflect the local population with a higher proportion in the medical and dental workforce. However, there is not the level of consistency in the spread of BAME staff across Agenda for Change grades. Our BAME staff report that they are less likely to believe that there are equal opportunities for promotion at LTHT. There has been a slight increase in the percentage of BAME staff receiving a promotion from 2015/16. The number of staff declaring their Religion or Belief has increased from 8% in 2011/12 to 59% in 2016/17. Women make up 75% of the Trust's workforce with a roughly even gender split in the most senior roles. The proportion of women varies across the paybands. Men were more likely to have been involved in a disciplinary or grievance than women and the percentage of men involved in a disciplinary has increased from 36% of the total in 2014/15, 43% in 2015/16 to 47% in 2016/17. We employ a larger proportion of staff over the age of 50 than are in the working population. However, our workforce is under represented compared to the Leeds working population for staff under the age of 20.	Work with the BAME staff network to develop and promote learning opportunities to support BAME staff to progress in the organisation. Roll out the programme of HR and Unconscious Bias Training to support managers in making fair and equitable decisions. Continue to improve the information we hold about our staff through the roll out of the electronic staff record self-service module and employee on- boarding system for new starters. Continue the Trust's talent management programme, Talent@Leeds, and use the Female Leaders Network to encourage women to step into leadership roles. Pay due regard to gender in the providing of relevant leadership opportunities, including the recently launched NHS Insight Improvement Programme and Shadow Board Programme. Roll out the Trust's HR training for managers to ensure that HR processes are applied equitably. Implementation of programme of schools engagement, work experience and internships to highlight and provide opportunities in healthcare to young people. Significantly increase the number of apprenticeships on offer.

Section 4
Quality Account

Quality Account

4.1 Chief Executive's Statement from the Board

4.1.1 Introducing the Trust

The Leeds Teaching Hospitals NHS Trust (LTHT) is one of the largest and busiest NHS acute health providers in Europe, a regional and national centre for specialist treatment, a world renowned biomedical research facility, a leading clinical trials research unit, and also the local hospital for the Leeds community. This means we have access to some of the country's leading clinical expertise and the most advanced medical technology in the world. Each year we treat around 1.5 million patients across 7 hospital locations:

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

We have a £1 billion budget, providing local and specialist services for our immediate population of 770,000 and regional specialist care for up to 5.4 million people.

Our patients are at the heart of everything we do. We employ almost 17,000 people who are committed to delivering high quality care to all our patients all of the time. We also have an international reputation for excellence in specialist care, research and medical training. We contribute to life in the Leeds region, not only by being one of the largest employers, but by supporting the health and well-being of the community and playing a leading role in research, education and innovation.

4.1.2 Development of the Quality Account

Our Quality Account for 2017/18 has been developed with our staff, stakeholders and partner organisations, including clinicians and senior managers, commissioners at NHS Leeds Clinical Commissioning Group (CCG), and Healthwatch Leeds. It has been approved by the Trust Board

4.1.3 Chief Executive's Statement on Quality

On behalf of the Trust Board and staff working at Leeds Teaching Hospitals NHS Trust, I am pleased to introduce you to our Quality Account for the year 2017/18.

Once again we had much to be proud of in our achievements during the last 12 months. We have continued to make improvements in quality and safety whilst facing significant financial and operational challenges, these achievements are highlighted in the Quality Account.

We have also continued to experience pressures relating to emergency admissions and capacity within our hospitals throughout the year, which has affected all NHS trusts, particularly during the winter months. We have worked with our partners in health and social care to improve the flow of patients and facilitate timely discharge, including working with them on improvement programmes, Perfect Week in October 2017 and a Multi-Agency Discharge Event (MADE) in March 2018. The aim of these programmes was to identify delays in the system, unblock them and simplify patient flow, working in collaboration with our partners. We have expanded the service we established with Villa Care at Wharfedale hospital last year to additional wards at St James's hospital. This will continue to be a priority in 2018/19, focusing on patients in our hospital beds who have been assessed as being medically fit for discharge.

Last year we reported that Leeds Teaching Hospitals NHS Trust was chosen to be one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known locally as the Leeds Improvement Method, providing a framework for improving quality and efficiency across the organisation. We have continued to develop this approach in 2017/18 and we are making excellent progress. We are training more staff in staff in lean methodology and this is making a big impact on the services we provide for patients as it continues to be embedded in our safety culture. This is underpinned by our Quality Improvement Strategy 2017-20. You will see the progress we have made against this in the Quality Account together with the goals for continued improvement in 2018/19.

"Caring the Leeds Way - Our Professional Commitment" was launched throughout the organisation in April 2016 as part of our nursing, midwifery and AHP strategy and we have continued to deliver the goals in our strategy in 2017/18.

Once again we were delighted with the results of the NHS Staff Survey and we were one of the highest performing Trusts nationally compared to the previous year's results. This shows the impact the Leeds Way continues to have in the Trust and the values that underpin this, creating a positive culture where staff feel engaged.

We have worked with our clinicians, managers and local partners at Leeds Clinical Commissioning Group and Healthwatch Leeds to identify the priorities set out in our Quality Account for 2018/19. I hope you enjoy reading this summary of our achievements in 2017/18 and the work we have to done improve quality and safety in our hospitals.

Signed

Julian Hartley, Chief Executive

18 June 2018

Signed for, and on behalf of the Trust Board

4.2 Improving our Quality of Service

4.2.1 Progress against our Quality Goals 2017/18

Clinical Effectiveness

We know continued pressures on our capacity, impact the ability to manage effectively and optimally all our patients within both emergency and elective pathways, which is why our Leeds Improvement Method Value Streams (see section 3.1) were selected and supported by the Guiding Board to improve flow across different areas of the Trust.

- Chapel Allerton Orthopaedic Centre - elective pathways in total hip and knee replacement patients
- Timely discharge - Abdominal Medicine & Surgery, specifically focusing on prostate surgery patients
- Step down from Critical Care to Neurosciences
- Capacity and Flow within Ophthalmology Outpatient Services
- 7 day service and 14hr consultant review within Acute Medicine

Patient Safety

Nationally set priorities, our continued commitment to provide harm free care, alongside feedback from patients and carers helped us to shape our areas of focus for Quality Improvement. These include:

- Improving the care of patients with acute kidney injury (see section 3.2.1)
- Improving the care of patients with sepsis (see section 3.2.2)
- Improving the recognition and response of the patient clinically deteriorating (see section 3.2.3)
- Reducing the incidence of falls and harm sustained by patients following a fall (see section 3.2.4)
- Reducing harm and Improving Patient Safety Culture by Integrating Daily Patient Safety Huddles on Wards (see section 3.2.5)
- Reducing the number of hospital acquired pressure ulcers (see section 3.2.6)
- Improving care for patients with Parkinson's (see section 3.2.7)
- Reducing healthcare associated infections and promoting the best use of antibiotics- (see section 3.2.10)

Patient Experience

Our staff, local partners, HealthWatch Leeds, and our patients and their carers helped us determine our patient experience priorities (see section 3.3.2):

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

4.2.2 Our Priority Improvement Areas for 2018/19

We know from our Quality improvement work in recent years that early improvements in patient experience and processes occur, but delivering true impact on patient outcomes across the Trust (for example reducing cardiac arrests and falls) takes several years of commitment to both identifying the interventions that make a difference and adapting these at scale across the Trust. This is matched by the findings from the Virginia Mason Institute that work streams can take 3 years or more to improve outcomes for patients.

Therefore our priorities for the Trust for 2018/19 were identified as:

- Those existing improvement programmes that need ongoing commitment to ensure improvements already made are sustained, spread and embedded across the Trust
- Alongside supporting new areas of work to continually improve the services we provide.

The overarching principle for all these work streams is their importance to provide a positive patient experience, high quality care, with optimal outcomes. They have been grouped under the section headings below for the requirements of this Quality Account document.

Patient Safety

We continue to support our Patient Safety and Harm Free Care Improvement Programmes to improve outcomes further and spread the improvements Trust wide. These include: Acute Kidney Injury, Sepsis, Pressure Ulcers, Antimicrobial Stewardship, Falls, Deteriorating Patient, Safety Huddles, Parkinson's, and Maternity Services. New areas of focus include: improving the quality of care for patients requiring joint replacements, and medication safety.

Clinical Effectiveness

We continue to support the sustainment and spread of improvements within all our Leeds Improvement Method Value Streams from 2017/18, for example:

- Learning from the TURP pathway to focus on more discharge pathways with Abdominal Medicine and Surgery
- Learning from improvements within Acute Medicine to improve patient flow in Emergency Department
- Embedding improvements in flow within Outpatient Services

Alongside supporting new areas of work in 2018/19 to improve flow in:

- Adult Cardiac Surgery
- And among patients medically optimised who remain in hospital for longer than 21 days.

Patient Experience

Our identified new areas of commitment here are:

- Supporting two 'Always Events', which aim to:
  - Improve the night time experience for patients
  - Improve the anaesthetic / theatre experience for patients
- Reporting how we have obtained public and patient feedback and taken this into account, in our planning of 'Building the Leeds Way'.
- Each bed holding CSU undertaking two new patient and public involvement activities and reporting how using the feedback obtained has influenced patient care.
- Caring the Leeds Way
- Research & Innovation Ambassadors

Progress against all our quality objectives will continue to be monitored, measured, and reported to the appropriate governance groups and committees within our Quality Committee Structure and summaries provided to the Quality Assurance Committee.

Quality Improvement Strategy

We published our first Quality Improvement Strategy in 2014 and are really proud of the improvements we have achieved in the last 4 years. Having created excellent foundations to take our ambitions significantly further, we updated our Strategy for 2017 - 2020, which was approved by our Trust Board in March 2017.

In our 2017-2020 Quality Improvement Strategy we reflect on the progress we have made and set our ambitions for the next 3 years, including areas we wish to improve even further, as well as setting new priority areas. It focuses on four main areas, with patient experience at the heart.

This strategy is shaped by:

- Working with our staff and patient representatives
- Our current work with the Virginia Mason Institute and partner organisations
- Our collaborative quality improvement work, supported by partners, including the Improvement Academy

Quality Improvement Framework 2018/19

Leeds Improvement Method

The Quality Improvement Strategy brings together our existing approaches to improvement; utilising both Lean Methodology and the IHI Model for Improvement, to form the Leeds Improvement Method (LIM). Our underpinning philosophy of LIM is that everyone working at LTHT is empowered to make improvements in their daily work bringing the benefits of a safe, high quality experience, for every patient and member of staff.

The Leeds Improvement Method aims to reduce variation and waste, alongside using small scale tests of change to continuously improve. Quality improvement works best when those involved directly in the work are empowered to make changes and use local measurement to make further improvements.

In LTHT we have already seen the value of using improvement science. Utilising these approaches throughout the organisation will enable LTHT to achieve the ambitions set out in the strategy and become a place where everyone is committed to continually improving the quality of care for our patients.

During 2017/18 we continued to grow, scale up and spread implementation of the Leeds Improvement Method, working with the prestigious Virginia Mason Institute.

Our education, training and development programme, which has been fully integrated into our Leadership programmes and the core induction programme for all staff, has engaged with over 4,500 staff in the use of the method to date. We have also invested in developing 250 leaders with more specialised skills in the use of the management method, known here as Lean for Leaders. This course runs over 12 months, builds on the Leeds Way values, and represents an intense immersion in the philosophy, method and behaviour required of an operational leader here at Leeds. This competence has been embedded in the job descriptions for all core operational (Clinical and Non Clinical) leadership roles, reflecting the importance of this work here at Leeds.

The patient experience and quality teams have been working together to deliver a series of workshops entitled 'Making Quality Count'. The aim of these is to engage patients and families in quality improvement activities in the trust. Leading the work has been a representative from patient experience; a quality/clinical perspective and also two lay patient representatives.

Together the group has designed a process by which clinical teams and patients develop the skills and knowledge to take part in/ lead QI projects facilitating staff and patients working together to achieve a truly patient centred improvement. We also invite patients, carers and their families to attend and be skilled up in QI via our LTHT QI training programme alongside staff.

We have trained over 250 staff members in QI methodology, approximately 50 patients have attended the 'Making Quality Counts' sessions and so far six patients have completed the full QI training sessions, with more on the waiting list to attend.

LIM Underpinning the Leeds Way

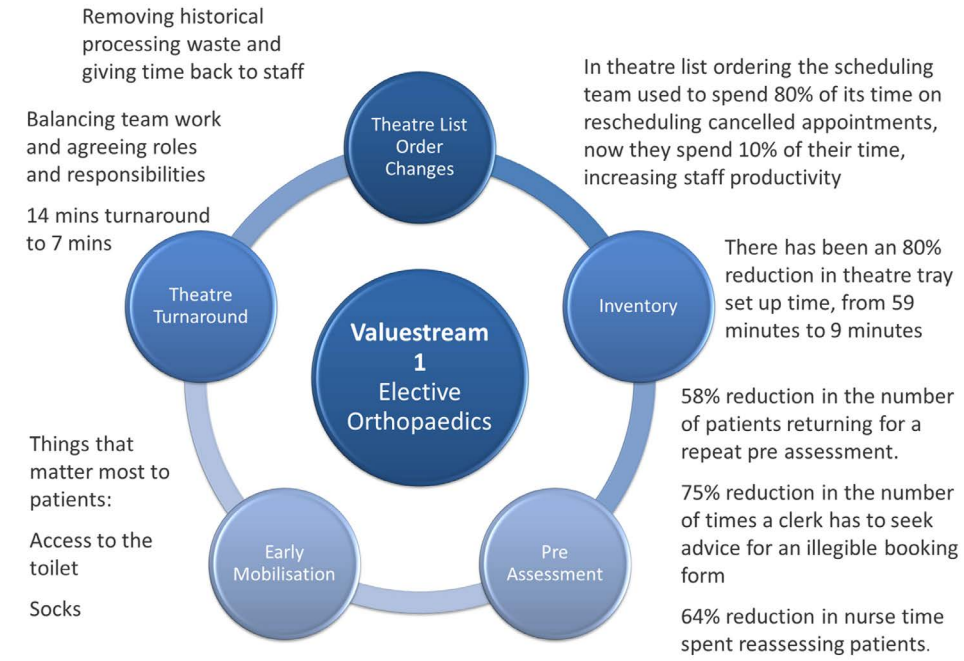
4.3 Review of Quality Programme

4.3.1 Leeds Improvement Method Value Streams

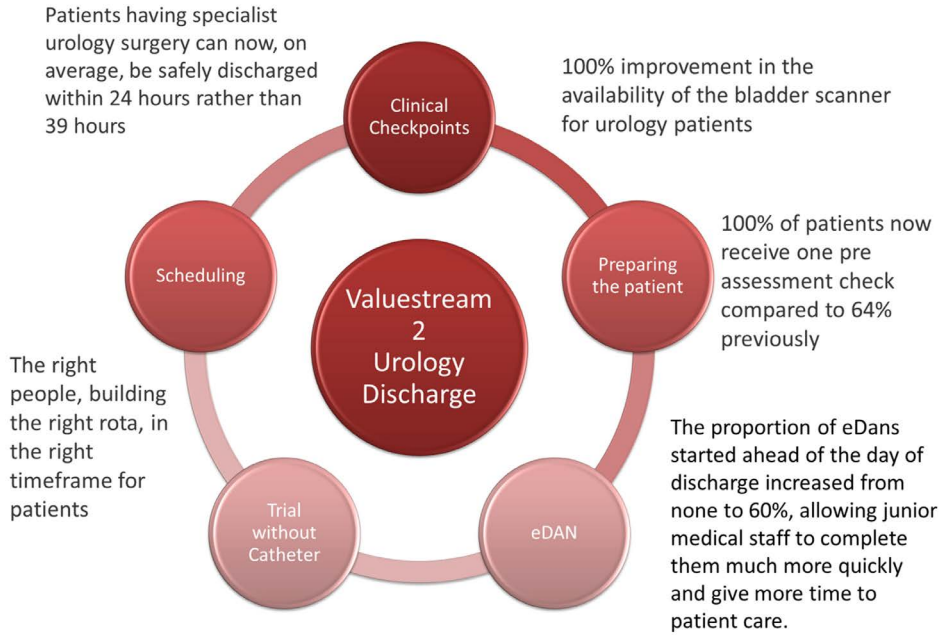
Five work areas launched in 2016/2017, known as Value Streams, continue to embed the use of the Leeds Improvement Method to create positive step changes in safety, quality and experience for their patients.

Key Achievements for 2017/18

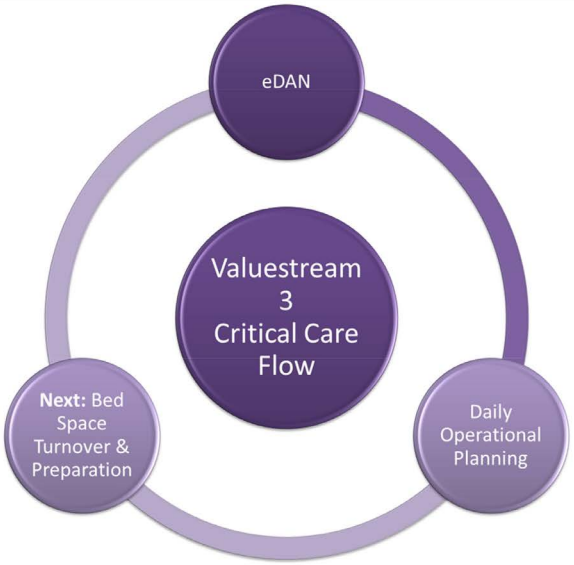
Elective Orthopaedic - Total Hip and Knee Replacement



Discharging Transurethral Resection of the Prostate (TURPs) Patients



Critical Care and Neurosciences working collaboratively to improve patient care as patients move from Critical Care wards to Neurosciences wards



A reduction in set up time for an eDan from 29 minutes to just 6 minutes where systems have been populated with information by clinicians at the time rather than retrospectively.

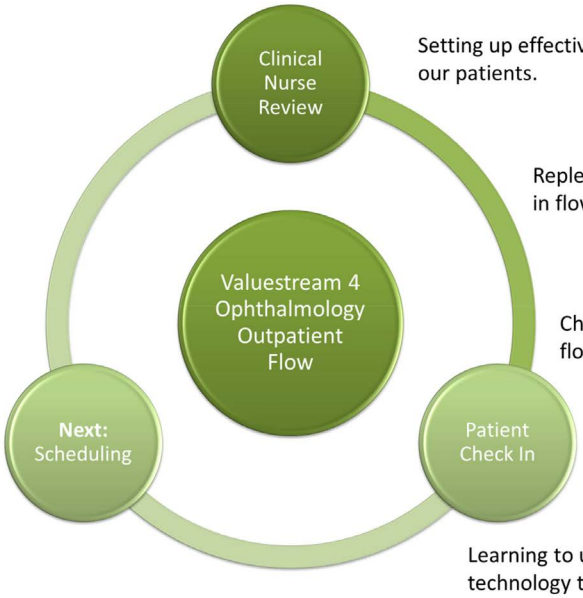
Creating visibility of information

Using systems to drive daily work

Reducing time to make decisions

Starting the first patient on time at 8am

Ophthalmology and Outpatients services working collaboratively to improve patient experience during an Ophthalmology Outpatient Appointment



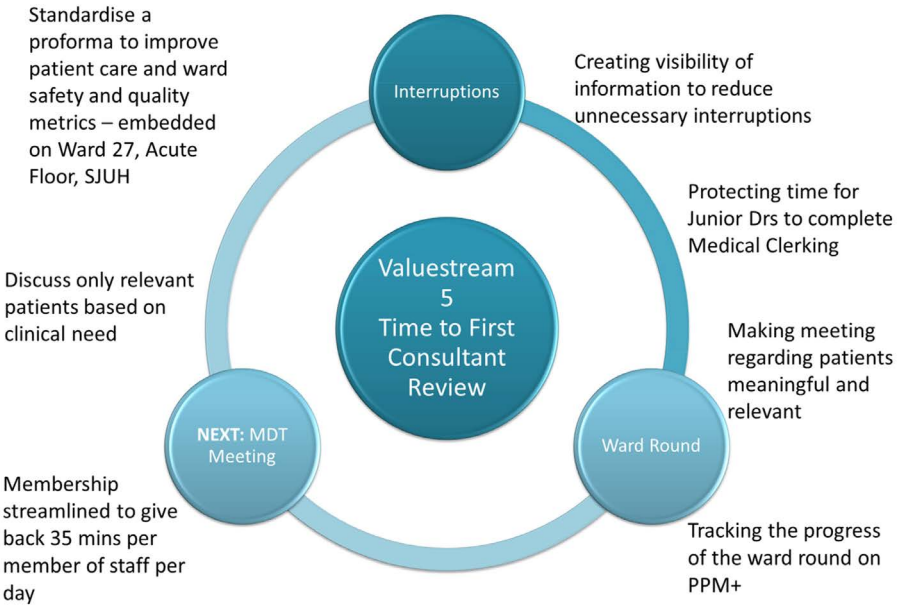
Setting up effectively for our patients.

Replenishing stock in flow

Check in patients in flow

Learning to use our technology to its optimum.

Emergency and Specialty Medicine – Time to First Consultant Review



Aims for 2018/19

We will be continuing to scale up and spread this work across the Trust through the further development of our Lean for Leaders programme. This will be underpinned by continuing the development of the education and training curriculum, particularly focussing on practical work with the tools and techniques and coaching staff to work effectively with them.

In April 2018 we are confident that we will gain formal accreditation from Virginia Mason Institute demonstrating our continued discipline in maintaining the integrity of the method.

We are increasing the size of our Kaizen Promotion Office (KPO), the team who deliver this work in the Trust in recognition of our progress so far and our need to scale up and spread.

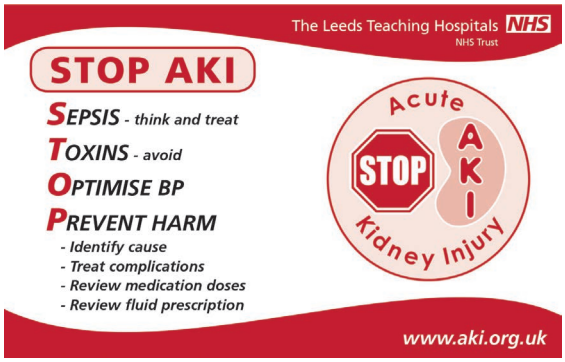
4.3.2 Patient Safety

Acute Kidney Injury (AKI)

Background

Acute Kidney Injury (AKI) is a major cause of harm, with half a million people sustaining AKI in England every year. It has a major impact on patients, including increased length of stay in hospital, the risk of progression into chronic kidney disease, and an increased risk of dying. It is estimated that AKI could be preventable in 20-30% of cases, so making improvements in the detection and treatment of AKI can make a big difference for our patients.

LTHT was part of a Health Foundation 'Scaling up Improvement Programme' in 2016. The STOP AKI care bundle was introduced to improve the care of patients with AKI by increasing awareness, education and management of this cohort of patients.



Key Achievements in 2017/18

- An AKI alert is now visible on all wards within the Trust, allowing staff from all areas to complete the care bundle when the patient is identified as having AKI.
- AKI status now links from the eWhiteboard to eObservations to alert staff of the requirement to complete an AKI assessment or follow policy related to the patient's current AKI status.
- The AKI staging and advice regarding on going care is now automatically populated in the Electronic Discharge Advice Notice (EDAN).
- Management of hydration and in particular patients with AKI is now a part of monthly Ward Healthcheck audits
- Patient information leaflets have been developed in different formats to increase patient awareness.

Aim for 2018/19

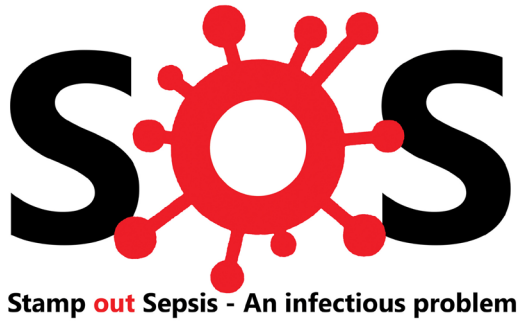
Our ambition is to continue to support the on-going use of the electronic alert. Education and training will be a key focus in 2018/19 to ensure that all staff are aware of AKI diagnoses and management, and the importance of including information on the EDAN; this will ensure continuity of care and treatment throughout the patient pathway.

Improvement in the Care of Patients with Sepsis

Background

Sepsis is a life-threatening condition that arises when the body's response to an infection causes it to attack its own tissues and organs. There are around 260,000 cases of Sepsis each year in the UK; recognising the signs early and treating without delay is crucial. LTHT is committed to ensuring Sepsis is identified and treated promptly. We are focusing on a number of measures and processes to reduce the burden and devastating impact Sepsis can have.

Trust staff continue to use the successful BUFALO sepsis intervention bundle and, particularly during 2017/18, focus has been on ensuring early identification of sepsis via screening and prompt administration of antibiotics. These are crucial aspects of sepsis management and form part of the national sepsis CQUIN which LTHT has been engaged with since 2016.



Key Achievements in 2017/18

During 2017/18 the LTHT Sepsis Team focused on ensuring safe, high quality, compassionate care, by providing staff with access to a variety of tools and resources to support our sepsis work. These include:-

- Continued use of LTHT's BUFALO treatment bundle including BUFALO bags equipped with all the necessary items to take a sample of blood for culture testing
- Implementation of our adult sepsis screening tool, both the paper-based and electronic version within the electronic observations (e-obs) system
- Implementation of our paper-based paediatric sepsis screening tool
- Educational events across the Trust including;
  - World Sepsis Day (WSD)
  - Providing regular feedback to staff who have been involved in the care of Septic patients
- Further roll-out in terms of support and resources to additional wards and departments
- Introducing elements of quality improvement (QI) methodology to support our aims including developing the existing sepsis steering group in to a wider sepsis collaborative
- Survey undertaken focused on the barriers effecting prompt prescribing of antibiotics for sepsis treatment
- The use of eObs, eMeds and PPM has revolutionised the way the CQUIN data is collected.

Aims for 2018/19

We will continue our focus on patient safety in relation to Sepsis and continue to align our work with the four national Commissioning for Quality and Innovation Framework (CQUIN) targets.

We will be holding a Stamp out Sepsis (SOS) in May 2018, providing opportunity for healthcare professionals to attend this unique educational event.

Having achieved the 2016/17 CQUIN for Sepsis we will be appointing a Sepsis Nurse is to bolster the capacity of the sepsis team to deliver the roll out across the whole Trust using the Leeds Improvement Method QI methodology and a collaborative approach to this. A key target for this year is to improve time to deliver of antimicrobials to patients with Red Flag Sepsis from the time they trigger a screen on eObs.

Deteriorating Patients

We want to continue to improve the treatment and care of our patients when they deteriorate on our wards, to ensure they receive safe, timely and effective treatment and care, and better end of life care.

In July 2014 we started a collaborative with 14 wards trialling small scale tests of change, to reduce avoidable deterioration. Following testing, an intervention bundle of the most successful changes (including escalation of care stickers, and a brief guide for staff recording observations) was created, and tested across all pilot wards, before beginning to scale up to other Trust areas.

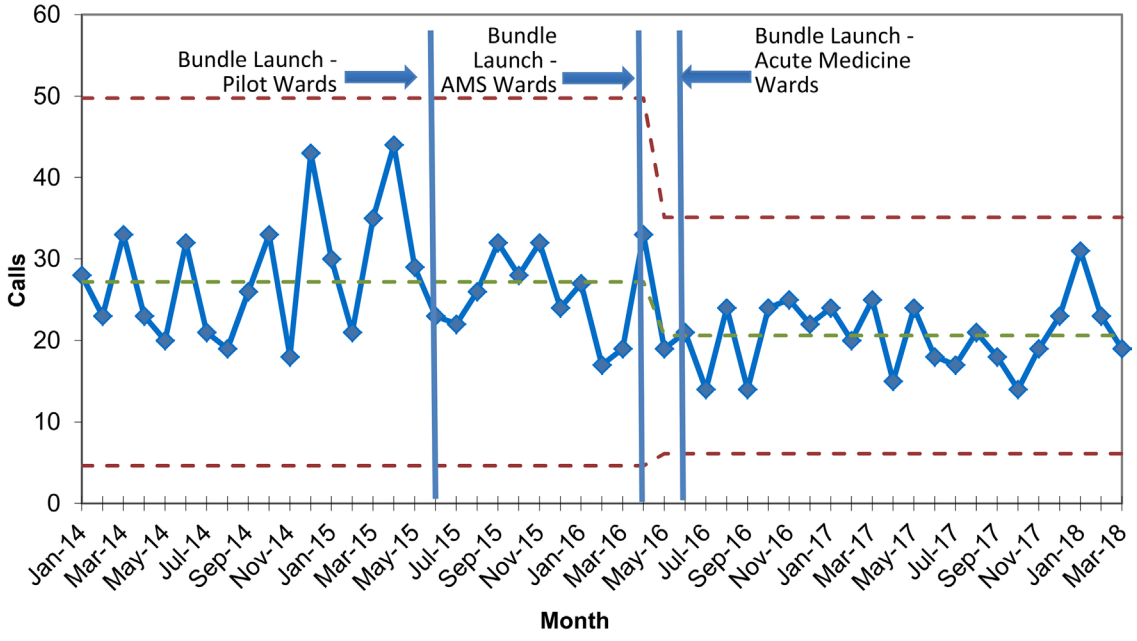
Achievements in 2017/18

- In 2017/18 we scaled up the intervention bundle further, to Trauma and Related Services, Neurosciences, Womens CSU, and Head and Neck CSU.
- We have seen a 25% reduction in cardiac arrest calls across LTHT and 32% at SJUH
- The rate of cardiac arrests per 1000 admissions at SJUH is now 25% lower than the national average
- Trust wide we have had 31% less cardiac arrests than 2015 (108 people), and 7% (19 people) less than 2016

Aims for 2018/19

In 2018/19 we aim to complete scale up across the Trust, support adaptation of interventions in non ward areas and develop new innovations to strive towards a goal of a 50% reduction in cardiac arrest calls across the Trust.

Trust-wide Cardiac Arrest Calls January 2014 - March 2018



Reducing Patient Falls

Background

Falls are the most common cause of injury in a hospital and result in both psychological and physical harm including: bleeding, fractures or even death in vulnerable patients. Falls have an annual cost to the National Health Service (NHS) of £2.3 billion, with an average cost of £2,600 per fall.

Key Achievements in 2017/18

There has been a sustained reduction in all falls and falls with harm as measured by the monthly prevalence audit as part of the Safety Thermometer.

Since April 2017 falls with harm have seen a statistically significant reduction of 62% with the mean recalculated from 0.39% to 0.15%.

Following the success of the quality improvement collaborative, which saw 14 pilot wards reduce falls per 1000 bed days by 53%, this work has been handed back to CSUs to continue and own.

Throughout the year, CSUs have worked to reduce falls. Oncology CSU held a falls awareness week for staff to attend looking at all aspects of falls prevention and seeking innovative ideas to pilot. Abdominal Medicine & Surgery CSU have focused on improving compliance with falls prevention training.

Despite continued operational pressures, monthly variations of falls incidences represent natural variation.

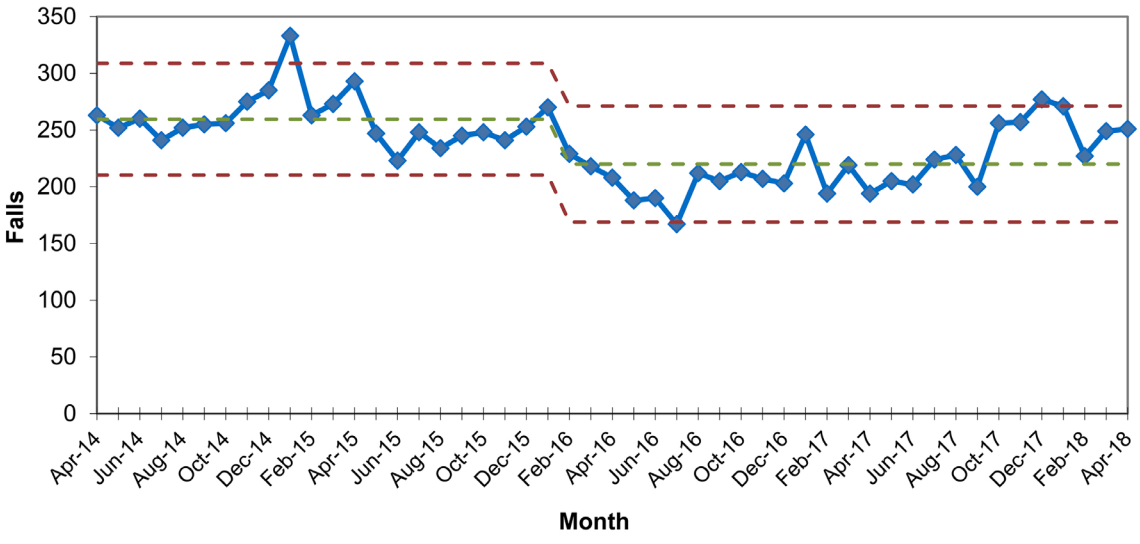
Leeds Teaching Hospitals participated in the Royal College of Physicians Inpatient Falls Audit in 2017. Areas of good practice highlighted included, being good at ensuring that call bells were within reach of patients and continence care plans were used widely.

Aim for 2018/19

Our ambition is to:

- Achieve a 10% reduction in the number of patient falls
- Achieve 90% compliance with staff training - aided by the falls prevention e-learning package.
- Embed use of delirium assessments and care plans.
- Pilot a visual assessment tool from the Royal College of Physicians.

SPC chart demonstrating the number of falls across LTHT



Safety Huddles

Background

In partnership with Yorkshire and Humber Improvement Academy and supported by a grant from The Health Foundation we have established 'Safety Huddles' across our wards. Leeds Teaching Hospitals and is one of four hospitals scaling up Safety Huddles between 2015 and 2017.

Safety Huddles are team meetings, which take place at a regular time each day for 5 to 15 minutes, and involve all members of the team. Team members can confidently speak up and jointly act on any safety concerns they have, allowing wards to continually learn and improve, as well as to celebrate success. Safety Huddles are focused on one or more agreed patient harms (identified by the team) such as falls, pressure ulcers, or avoidable deterioration, and ownership of ward data is a crucial part of the huddle, for example, monitoring days between falls etc.

Key Achievements in 2017/18

- So far, 91% wards in Leeds are huddling and 45% wards have achieved a statistically significant reduction in patient safety incidents e.g. falls
- We are now seeing the Trust-wide impact of safety huddles, with a significant reduction in cardiac arrests of 25% and a 30% reduction in falls
- Staff surveys have shown that Safety Huddles have led to a positive shift in teamwork and safety culture
- The Portering Team at SJUH have established their own Safety Huddles, which have improved inter-departmental working, patient experience and staff satisfaction. As a result, Porter Paul Tobin has won the prestigious award 'UK Operational Support worker of the Year' for his work establishing the portering huddles.
- We have showcased work at national conferences and were shortlisted for the Royal College of Physicians Excellence in Patient Safety Award 2017.

Huddles allow staff to feel empowered and more confident to speak up, and non-clinical staff have reported increased job satisfaction and feeling part of the wider multi-disciplinary team.

Example of a Safety Huddle

Aim for 2018/19

Our ambitions are;

- To provide continued support to all wards huddling; to both sustain huddles and achieve a step reduction in their chosen harm area.
- To continue to support any ward who wishes to start huddles with light touch coaching

Reducing Pressure Ulcers

Background

It is estimated that 80-95% of all pressure ulcers are avoidable. Pressure ulcers are painful, may lead to chronic wound development and can have a significant impact on a patient's recovery, their quality of life, as well as increase length of hospital stay.

Our aim is to reduce all avoidable pressure ulcers by 10% through the adoption of the SSKIN framework. This has been widely tested and implemented in a range of acute hospitals and community settings across England, Wales and Scotland.

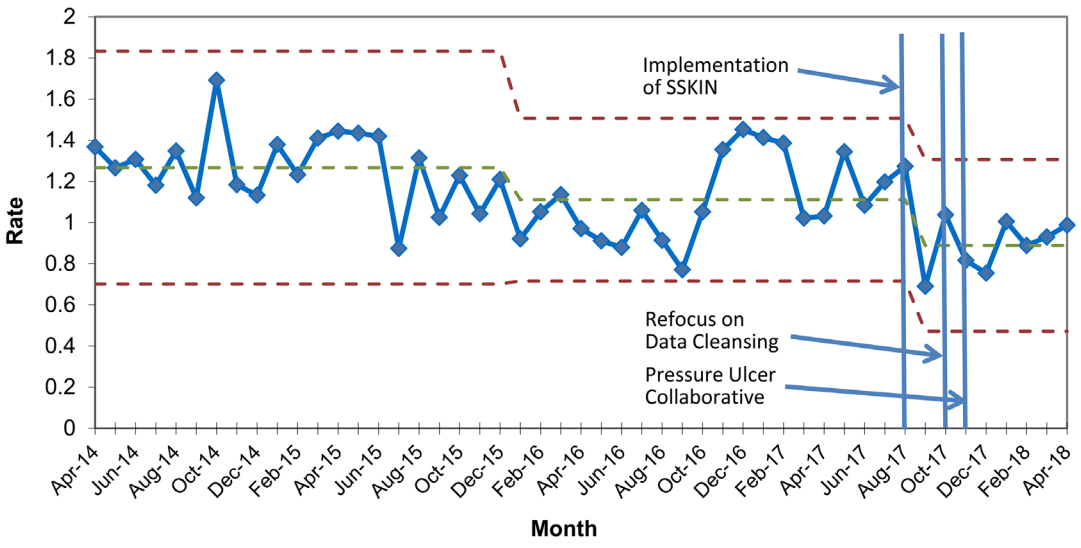
Surface - appropriate mattress/cushion
Skin Inspection
Keep Moving
Incontinence/Moisture
Nutrition/Hydration

Key Achievements in 2017/18

- Rollout of the SSKIN Bundle across LTHT for adult services following the successful pilot within a number of CSU's, in July 2017.
- Launch of the Pressure Ulcer Collaborative on International "Stop the Pressure Day" in November 2017.
- Achievement of a 43% reduction in avoidable pressure ulcers on pilot wards
- Streamlining of the Tissue Viability triage system which has reduced the amount of time spent on patient allocation and more time on patient visits.
- Development and launch of SSKIN weeks for individual CSUs and wards. These have been a proactive way of encouraging wards and CSUs to actively participate in improving pressure ulcer awareness and promote SSKIN in their clinical areas.

Monthly variation in pressure ulcer numbers continues, representing natural variation. The focus on data cleansing, launch of the PU collaborative and the implementation of SSKIN has had a positive impact on the number of incidences reported over recent months. Harm from category 3 pressure ulcers has reduced by 8%. Early re-categorisation of un-gradable pressure ulcers may have contributed to this reduction in severe harm through prompt investigation and learning from incidents.

Developed Pressure Ulcers per 1,000 Bed Days



Aim for 2018/19

Our ambition for 2018/19 is to:

- Reduce all avoidable hospital acquired Pressure Ulcers by 35% in pilot ward areas.
- Scale up the Pressure Ulcer Collaborative initiatives across other wards in the Trust in order to achieve and sustain further reductions in the number of hospital acquired PUs Trust wide.
- Implement an adapted SSKIN bundle across Maternity and Paediatric services.
- Promote Cross-City working with partners in Leeds Community with the re-launch of regular Cross-City meetings.
- Our ambition is to have no category 4 avoidable hospital acquired pressure ulcers and no more than two category 3 avoidable hospital acquired pressure per month as part of a longer term reduction programme.
- Implement a Pressure Ulcer Steering Group to oversee improvement work across the Trust in all CSUs and help in sharing not only lessons learnt from the RCA process and outcomes of Panel meetings but also to spread good practice.

Improving Care for Patients with Parkinson's

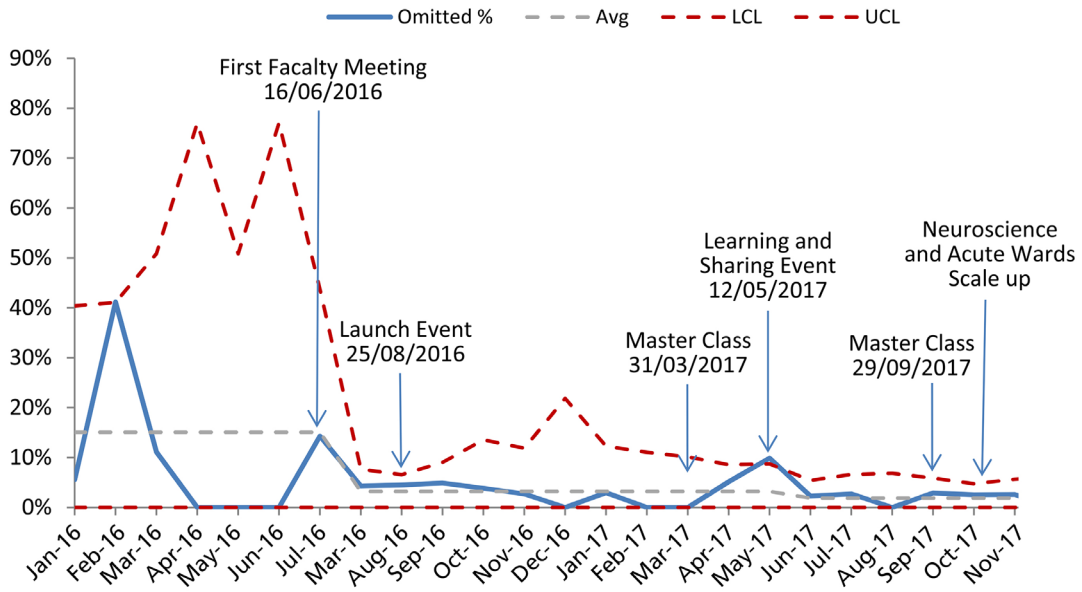
Background

There are approximately 1500 patients with Parkinson's in the Leeds area, and around 30-40 inpatients in the Trust with Parkinson's at any time. In 2016, following feedback from patients and carers, we formed our Parkinson's Quality Improvement Collaborative. Carers and people with Parkinson's are active members of this collaborative group as well as a multidisciplinary team of staff members.

Ideas for improvement were developed and tested by teams in pilot areas. Our aim is that all people with Parkinson's receive timely administration of medication and holistic care. The three primary drivers identified to achieve this are:

- Identifying and promptly administering Parkinson's medications
- Improving culture, teamwork, and accountability
- Identifying and promptly managing patients with swallowing difficulties

Parkinson's Medications Omitted in 24 Hours, January 2016 - November 2017



Key Achievements in 2017/18

By working with patients and carers, we have created a bundle of the successful interventions tested in pilot areas, and initiated scale-up to all adult wards within the Trust.

By raising awareness of the need for timely administration of medication and the role every team members can play, we have seen a reduction in omitted Parkinson's medications from 15% to less than 4%. There has also been a reduction in the delay in patients receiving their first dose of medication after admission from over 7 hours to 67 minutes.

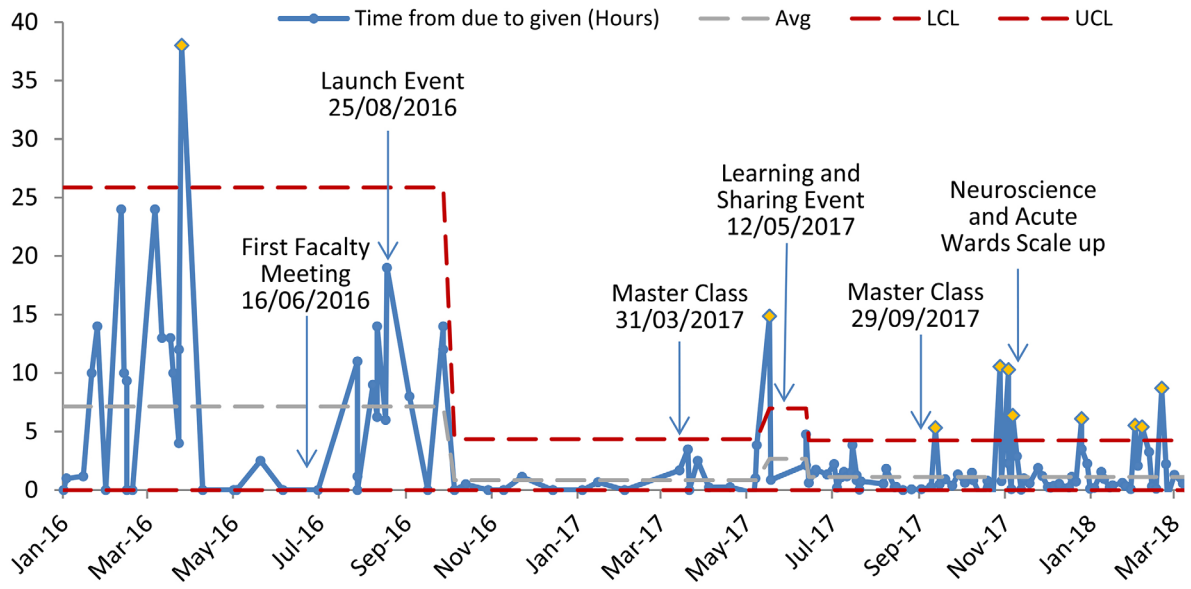
We have also;

- Established a bi-annual educational Masterclass and educational video for hospital and community-based staff
- Conducted a Patient Experience event with patients and carers to discuss patient-centred approached to medication administration
- Supported carers and staff members to present our work at regional, national and international conferences, and been shortlisted for the 2018 Parkinson's Excellence Network Award for Excellence in Parkinson's Care
- Initiated spread of our work to other Trusts within Yorkshire and the North East

Aim for 2018/19

We aim to have completed the scale-up of our interventions to all adult areas within the Trust by August 2018, so all of our patients receive high-quality and safe care as inpatients. We aim to further involve our patients and carers and to pilot novel interventions for self-medication administration in 2018/19.

Delay in first dose of Parkinson's Medication after admission, January 2016 - November 2017



Maternity Care - Reduction in Harm

Work continues to align the national maternity safety campaign with local implementation through the development of quality improvement schemes and the national maternity Better Births strategy locally.

National Maternal and Neonatal Health Safety Collaborative

In 2017 LTHT was successful in its application to be included within wave 1 of the 3 year programme, to improve safety and quality.

Selection of the four topics of focus: reduction in smoking in pregnancy; improving delays in the induction of labour pathway; learning from excellence, and improving the homebirth referral rate, have been developed using Quality Improvement theory and methodology.

A safety culture survey has been conducted on both delivery suites as part of the collaborative work.

Obstetric Anal Sphincter Injury

The use of clinical dashboards had informed the Women's CSU of being an outlier for 3rd and 4th degree perineal tears. Significant multi-disciplinary work using quality improvement methodology to define areas to focus on, have led to reducing the number of tears by 75%. This work will continue in 2018/19 to ensure it is embedded in all practice.

Stillbirth / Neonatal Deaths

LTHT has seen a reduction in the stillbirth rate by 24.6%. This aligns with the national ambition to reduce stillbirth by 20% by 2020 and 50% by 2030, with regional recommendations for stillbirth review. LTHT have been involved in the piloting of the new MBRRACE national Perinatal Mortality Review Tool (due to be launched late 2018).

LTHT have also been accepted into the second wave of The National Bereavement Care Pathway (NBCP) pilot sites.

In September 2017 LTHT introduced the offer for all women who book to have their baby in Leeds access to Baby Box, which is a platform of educational content for maternity care in Leeds. Women receive a baby box on completion of a short programme which reinforces safe sleep principles.

Development of Elective Caesarean Section Surgical Lists

Both maternity units have been involved in piloting the effectiveness of using identified operating days for elective Caesarean sections. This early work has achieved excellent feedback from clinical teams and most importantly from the women and their families.

Local Maternity Strategy Implementation

Work continues with identifying, developing, and implementing areas of the local maternity strategy which aligns with the national Better Births agenda. Personalisation of service provision remains high on the agenda and working alongside our service users to co-design and produce service models which are effective and sustainable.

Introduction of Birth-rate+ (Workforce Planning Acuity Tool)

We recognise the importance of having the right staff in the right place at the right time. Birth-rate + is the only recognised midwifery workforce planning tool, and has been commissioned for implementation on both delivery suites, followed by roll out to other areas to ensure our patient acuity is matched in need to workforce.

Local Maternity System's (LMS)

The West Yorkshire and Harrogate LMS is a programme of work which has been set up to make sure all women, their babies and their families receive the care they choose and need, before and after having a baby, as close to home as possible. LTHT are working with colleagues across West Yorkshire and Harrogate to develop a plan that will improve care over the next 5 years and beyond. Information is available at www.wyhpartnership.co.uk

Quality Improvement in Surgical Teams

In 2018 LTHT became one of 40 NHS organisations taking part in the Quality Improvement in Surgical Teams (QIST) Patient Safety Collaborative, which aims to improve the quality of care delivered to patients requiring joint replacement surgery, by 2020. The programme is funded by Northumbria Healthcare NHS Foundation Trust, the British Orthopaedic Association, and NHS Improvement.

The collaborative will focus on two main areas;

- Reducing anaemia related transfusion, critical care, length of stay and readmission rates
- Reducing surgical site MSSA related infections

The programme will use a breakthrough serious collaborative model, and the first of seven learning events will take place in May 2018.

Reducing Rates of Healthcare Associated Infections (HCAI)

The reduction of HCAI remains a key priority for the Trust, and this is reflected in the key objectives achieved in 2017/18:

- Development of an HCAI Trust-wide Collaborative, supported by a Faculty
- Launching an expanded approach to offering MRSA decolonisation for our "at- risk" patients
- Employing the Leeds Improvement Method to modify the CDI nurse role to attend safety huddles and provide greater education in ward areas
- Utilising social media such as Twitter to run a CDI campaign

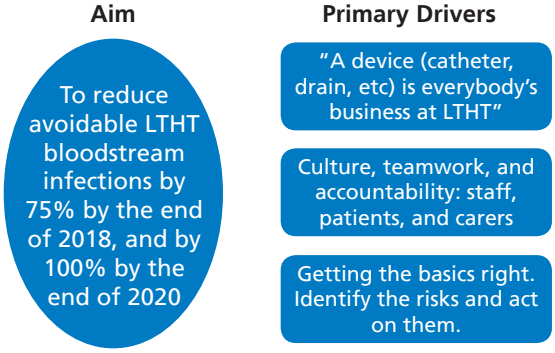
MRSA

The national 'Zero Tolerance' approach to MRSA bacteraemia remains in place and we are firmly committed to achieving this. There will continue to be an emphasis on the interventions that have been shown to work in preventing any / all HCAIs. The days between MRSA bacteraemia graph below shows early indication that we are extending the days between cases.

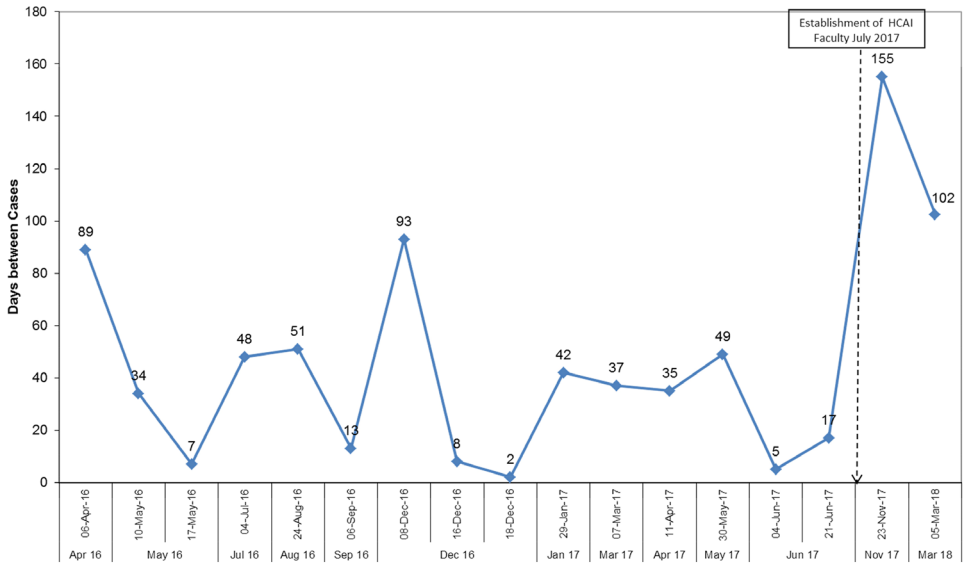
There is now a "national ambition" to reduce healthcare associated bloodstream infections with certain Gram-negative bacteria, namely *Escherichia coli, Klebsiella* species and *Pseudomonas aeruginosa*, by 50% by March 2021; with the initial focus on a 10% reduction of *E coli* bacteraemia, across the whole health economy, in 2017-8. These challenging goals are mirrored in the agreed aims of our local HCAI Collaborative. The primary drivers to achieve this are in Figure 12. Members of the Faculty have been meeting fortnightly to review progress and share the results of the "small tests of change" that have been trialled in specific ward areas. Our second "Big Learning Event" will be happening in Spring 2018 where we will be able to share the results more widely, and recruit new areas to try the strategies that have worked.

The IPC leadership team have participated in the Lean for Leaders programme. To further build on the safety culture we have trained all our IPCN and administrative team in lean methodology: one of our projects enabled us to reduce the time taken for staff to undertake mandatory and priority IPC training thus freeing up time for patient care.

HCAI Driver Diagram



Days Between MRSA Bacteraemia Cases



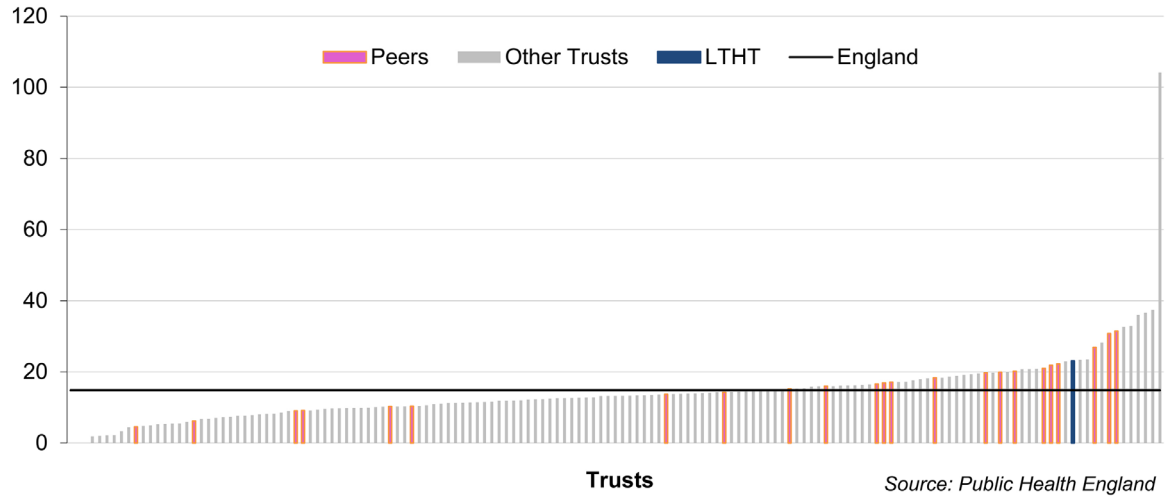
CDI

The Trust's nationally-set CDI objective for 2017-18 was the same as in 2016-17, as for all acute trusts in England, which for LTHT was 119. However, our ambition remains to prevent any potentially avoidable cases. We continue with a post-infection review process whereby local commissioners can agree that there were no significant lapses in care during a patient's pathway in LTHT, and we aim to further increase the proportion of these. A CDI Twitter Campaign was launched to share lessons learnt from root cause analysis investigations

CDI Cases per 100,000 bed days 2016/17 vs 2017/18

Rate of Trust apportioned C.Difficile cases pere 100,000 occupied bed days for patients aged >2		
	LTHT	National
2016/17	21.82	14.01
2017/18	23.04	14.84

CDI Rate 100,000 bed days



Source: Public Health England

The IPC nurses continue to support the clinical teams with the work they are doing to promote hand hygiene. The team visited staff in clinical areas, offering advice and using a Corneometer machine that measures skin moisture to promote healthy hands and contributes to improved hand decontamination.

As part of a continuous programme to include children in the fight against infection and encourage hand hygiene, a competition was held earlier in the year where patients from Leeds Children's Hospital were asked to design covers for the soap and hand sanitizer dispensers.

The two winners displaying their designs

Ensuring the equipment we use on our patients and the environments we work in, are safe and free of infection is also of paramount importance. This year, in conjunction with our Estates colleagues, we are introducing a new specific IT system to record, report and monitor the results we obtain from relevant water samples.

The rising prevalence of pathogenic bacteria with the ability to resist multiple different classes of antibiotics is a well-recognised global phenomenon. We need to continue to protect the therapies that we have now so that they will continue to be effective for our future patients. This means that we need to ensure patients receive the most appropriate antibiotic for their clinical condition at the time - i.e. not only starting smart but also that we then focus subsequently. The national CQUIN for Severe Infections in 2017-18, promotes a judicious approach to antibiotic use and we are confident that we will achieve the reductions required.

We also remain watchful for any unanticipated or novel infections emerging in our global village in 2017-18, such as Ebola and Zika viruses in recent years. In the autumn of 2017, measles was circulating in Leeds, as it was in some other English cities, in association with a rise in cases in some other European countries. LTHT IPC team worked closely with the Children's CSU and others, to prevent onward transmission of this highly contagious infection within LTHT; as well as being closely involved in the successful city-wide campaign to control it.

Antimicrobial Stewardship

Antimicrobial Stewardship is what we are doing to improve the use of antibiotics to treat patients with infections without causing them harm or contributing to the problem of developing resistance to current antibiotics.

In 2017/18, we have focused on reducing potential patient harm this year by:

- Changing from vancomycin (our most commonly used intravenous antibiotic for patients with penicillin allergy) to teicoplanin, which will reduce kidney injury.
- Working with CSUs to improve the review of the antibiotics given within the first three days, to reduce harm from healthcare acquired infections like Clostridium difficile, and to reduce the time patients stay in hospital from extended intravenous antibiotic use.
- Developing a reporting tool to identify which patients are on IV antibiotics within the hospital to help doctors and infection experts to ensure patients receive the safest treatment.

Throughout the year we have also been managing severe antibiotic shortages. Nearly all infection treatment guidance has been revised based on available antibiotics, and our electronic prescribing system that is being rolled out across the Trust has also been updated.

The targets we have been set for 2018/19 are:

- Zero "avoidable" MRSA bacteraemias
- No more than 118 cases of CDI.
- There is now a "national ambition" to reduce healthcare associated bloodstream infections with certain Gram-negative bacteria, namely *Escherichia coli (E. coli), Klebsiella* species and *Pseudomonas aeruginosa*, by 50% by March 2021.

Aims for 2018/19

- Participate in the NHS England and NHS Improvement urinary tract collaborative for systems wide improvement, focusing on interventions to reduce healthcare associated UTI's.
- We will identify the successful HCAI interventions from the tests of change completed by the HCAI collaborative, and those ideas will be used to formulate a HCAI care bundle.

The challenge is to deliver this continuous improvement, whist ensuring that the actions already implemented to achieve the tremendous overall reductions witnessed to date are sustained.

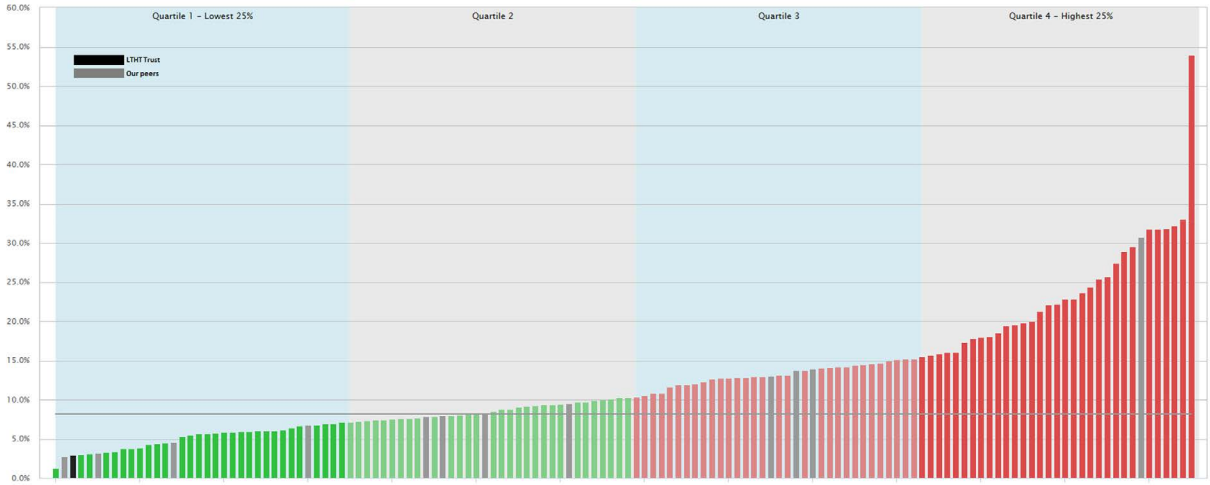
Medications without Harm

Comparing safe medication practice in our Trust to other hospitals

The most recent nationally available figures show our Trust in a favourable position with regard to our peers. The distribution of Medication Related Incidents causing harm among all Trusts nationally to March 2017 is shown below. LTHT is in black and our peers are in grey.

We encourage our staff to report all incidents involving medicines so we can continue to investigate and share learning to minimise harm.

Medication Related Incidents Nationally to March 2017



Reducing Harm from Preventable Venous Thromboembolism (VTE)

Venous thromboembolism (VTE) or blood clots can be caused by being in hospital, so reducing the risk of these occurring is an important part of patient care. Assessing adult patients on admission to hospital for their risk of developing blood clots, or their risk of bleeding, helps us decide how best to care for each patient.

Key Achievements in 2017/18

The VTE Prevention Team has worked with the clinical teams to improve VTE assessment rates. They also worked with the electronic prescribing team to develop an alert which reminds doctors to complete a risk assessment and appears whenever a clinician tries to prescribe a medicine. This improved completion rates in December 2017 by over 2% to 93.81%, and work is on-going to improve completion rates further. The table below shows the percentage of patients who have had a VTE risk assessment in 2017/18.

In order to learn how we can prevent VTEs we complete investigations into all patients' care if they developed a VTE during or within 90 days of their hospital admission. We are now collating the details of the investigations and sharing learning with clinical teams.

A hospital associated thrombosis (HAT) is a thrombosis that occurs within 90 days of a hospital admission. The number of (HATs) has risen in 2017/18, however the number of preventable events has not increased; we are therefore confident that the reduction in risk assessment rates is not resulting in patient harm.

We have been incorporating what we have learnt from our investigations into HAT into the training we regularly provide to staff. On World Thrombosis Day in October 2017 we organised a Trust-wide study session for LTHT healthcare professionals who wanted to increase their knowledge and awareness of VTE, and what they could do to help our patients reduce their risk. We shared case studies of HATs to highlight learning points and illustrate how we can improve patient management and experience.

Aims for 2018/19

Our plans for the coming year are to improve risk assessment rates and achieve the 95% target while ensuring we continue to investigate HATs and feedback learning to clinical staff.

Percentage of admitted patients risk-assessed for VTE

Indicator	Reporting period	Trust performance	National acute average	National acute range
Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)[1]	Q4 2017/18	91.51%	95.18%	67.04% - 100%
	Q3 2017/18	92.23%	95.36%	76.06% - 100%
	Q2 2017/18	94.96%	95.25%	71.88% - 100%
	Q1 2017/18	93.52%	95.20%	51.38% - 100%

1 Excludes independent sector providers

Preventing Harm from Misplaced Nasogastric Tubes

Feeding through a misplaced nasogastric (NG) feeding tube is defined by NHS England as a Never Event. In 2017/18 we have continued to improve standards and safety for those who require nasogastric tubes for feeding (NGTs).

Radiographers are empowered to highlight any problems they observe and take action, enabling focused training/feedback to be given to individuals or clinical areas.

All incidents related to NG tubes are reviewed every 2 months at the Enteral and Parenteral Guidelines group meeting, with actions taken.

In the most recent NG tube audit, NG care plans were shown to be used for 94% of patients, with pH used first line in the majority of cases (the gold standard method to check safe placement). X-ray was used as the first line check of safe placement in only two cases and both of these with good reason, reflecting the excellent progress that has been made.

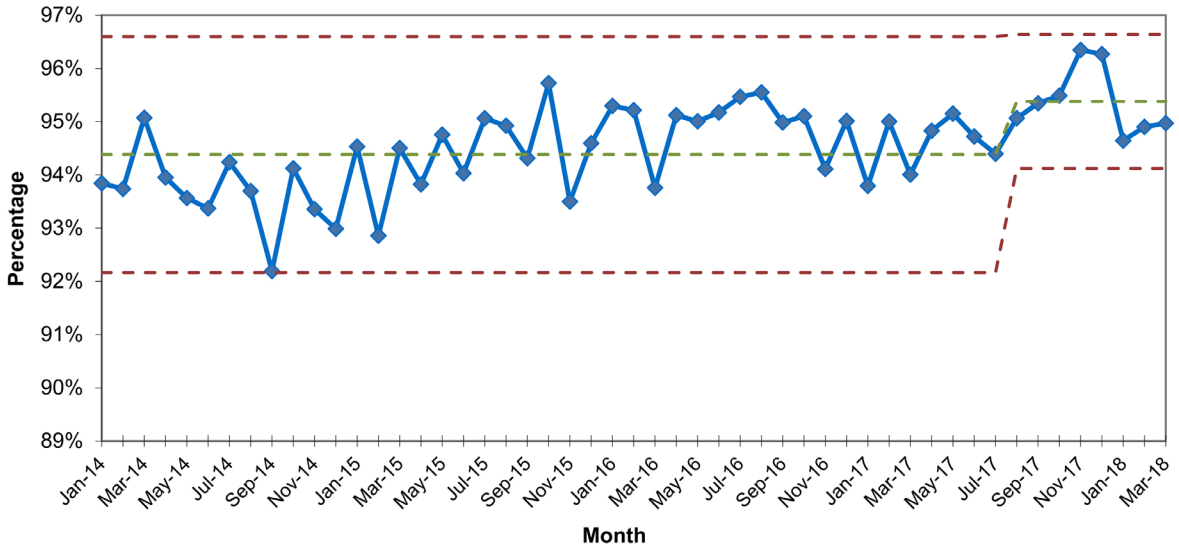
NHS Safety Thermometer

The NHS Safety Thermometer Classic provides a 'temperature check' on harms associated with falls, pressure ulcers, catheter associated urine infections (CAUTIs) and venous thromboembolism (VTE). Data is collected nationally on one Wednesday every month. Results are published on the NHS safety thermometer website. This gives a snap shot view of patients in the bed base at the time of the audit.

Harm free care performance for LTHT can be seen in the graph below.

Since December 2016, harm free care performance has been reported at greater than 95% for 8 months. Harm free care was reported to be 96% in November and December 2017. The improvements in our performance over time are due to a reduction in all falls, falls with harm and new pressure ulcers categories 2 to 4.

Harm Free Care Performance (January 2014 - March 2018)



(NB. The upper and lower control limit is calculated at 3 standard deviation points from the mean)

Safeguarding Vulnerable People

The Trust is committed to safeguarding all children, young people and adults at risk of abuse; we believe that everyone has an equal right to protection from abuse, regardless of their age, race, religion, gender, ability, background or sexual identity.

Leeds Teaching Hospitals NHS Trust continues to work to enhance safeguarding practice and standards across the whole organization to safeguard our most vulnerable patients and to continue to develop and embed a culture that puts safeguarding at the centre of care delivery.

Key Achievements in 2017/18

- We have produced our unique safeguarding Trust logo which helps improve practice and supports the wider awareness of safeguarding across the organisation.

- A full review of mandatory safeguarding training was carried out and new training developed: This training commenced in July 2017. Evaluation from the training is positive and equips all staff with the appropriate competences, skills and knowledge required to meet their individual roles.
- In October 2017 as part of West Yorkshire Safeguarding week, Leeds Teaching Hospitals Trust held our own Safeguarding Week. The week had a programme of various awareness raising events, and learning opportunities, across the Trust. Our campaign focused on 'What Safeguarding Meant to us?' which involved staff, patients and members of the public.

- Representatives from the Trust attended and contributed on a National Health Panel as part of intelligence gathering for the Independent Inquiry into Child Sexual Abuse (IICSA). LTHT ensures the important messages from the inquiry are cascaded throughout the organisation and to the citizens of Leeds.
- The specialist midwifery teams at LTHT are now reporting information on to the National web platform for Female Genital Mutilation: this ensures that any vulnerable women or girl is not only identified but ensures they are safeguarded.
- 2017/18 has seen the start of the Trust introduction of the National Child Protection Information System (CP-IS) into unscheduled care pathways. This NHS England sponsored nationwide initiative helps clinicians in unscheduled care settings identify vulnerable children. Data relating to children (including unborn children) with a Child Protection Plan (CPP), or with Looked After Status (LAS) is securely transmitted to and stored in CP-IS on the NHS Spine and is presented as a flag indicating the patient is a vulnerable child. By sharing data across regional boundaries, CP-IS helps health and care professionals build a complete picture of a child's visits to unscheduled care settings, supporting early detection and intervention in cases of potential or actual abuse.

Serious Incidents

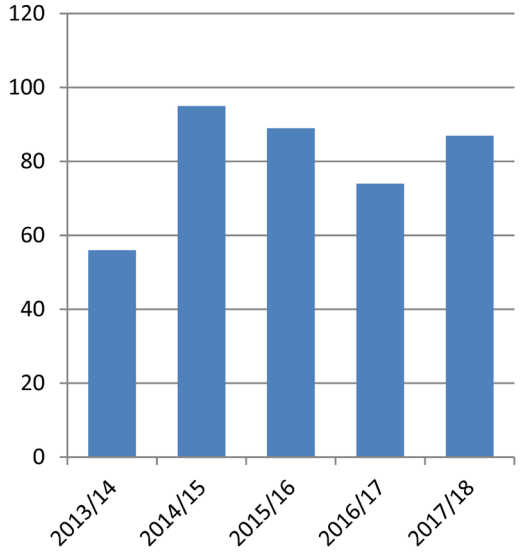
We are committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence: weekly meetings are held within the Trust to ensure these conversations take place.

The Trust Board receives a report in public on new serious incidents and the actions taken to reduce the risk. A more detailed discussion on serious incidents, including the lessons learned takes place at the Quality Assurance Committee, led by the Chief Medical Officer: this Committee provides assurance on the follow up of incidents and the implementation of learning, including undertaking more detailed reviews of any areas of concern identified.

We have made some significant changes to the Trust's incident management system to improve the experience for users in order to encourage more reporting and improve accuracy of the data captured. This allows us to extract useful theme and trend data to support clinical governance initiatives at local and Trust-wide level.

This year has seen an increase in the total number of serious incidents reported over the previous year but remains less than in the two years prior to that. The overall increase is due to more patient fall incidents leading to serious harm.

Number of serious incidents reported



Patient safety Incidents (NRLS) April 2017 - September 2017

Indicator	Trust Performance	Average all Acute Hospitals Performance	All Acute Hospitals Range
Rate of patient safety incidents (per 1000 bed days)	41.7	42.8	23.47 - 111.69
Number of patient safety incidents that resulted in severe harm	10	13.4	0 - 92
Number of patient safety incidents that resulted in death	2	5	0 - 29
Percentage of patient safety incidents that resulted in severe harm	0.1%	0.3%	0.1%-1.5%
Percentage of patient safety incidents that results in death	0%	0.1%	0%-0.5%

Learning from incidents

The Lessons Learned Group, established in 2014/15, continues to increase the effectiveness of learning lessons from serious incidents. Four learning points' bulletins have been produced Trust-wide during 2017/18 covering various topics including Never Events, VTE prevention and discharge planning. Videos continue to be made by the Clinical Service Units and uploaded onto the Lessons Learned YouTube Channel, with a local production relating to a serious medication error being viewed nearly 3000 times.

The LTHT intranet site has been updated with a Lessons Learned page where all staff can access all the learning points' bulletins, videos and resources to assist with learning.

The Trust has continued to publish regular safety briefings for staff, called Quality and Safety Matters. These have focused on a series of topics arising from serious incidents and complaints, to highlight the reasons why it is important that these things are managed appropriately and the actions that need to be taken to help reduce the risk. These have been sent to all wards and departments within the Trust to ensure that all staff are aware of these risks and what they need to do about them. The topics below were included in 2017/18:

Quality and Safety Matters Briefing Topics

Positive Identification of patients	Duty of Candour
Restricted us of open systems for injectable medication	Sepsis
Hospital Associated Venous Thromboembolism (VTE)	Safeguarding Adults and Children
Safe Removal of Dressings	Safe removal of surgical drains and catheter tubing
Safe use of sharps	Safe storage of cleaning products
Care after death	

Beyond Incident Reporting

In June 2017 the Risk Management team hosted a patient safety conference at Leeds General Infirmary; 'Beyond Incident Reporting'. Delegates from a variety of clinical areas and professions at Leeds Teaching Hospitals, and other NHS organisations in Yorkshire, spent the day learning about what happens to information from the incidents that are reported and how we use the information to improve services and care for patients.

Colleagues from various clinical service units shared with the delegates how they use incident data in their clinical area and shared some key lessons they have learned and disseminated.

As part of the conference Risk Management ran a session highlighting the impact serious incidents can have on individual staff members and teams and the support available in the Trust. A follow-up event is being planned for 2018-19.

LIST (Leeds Incident Support Team)

In 2017/18 we consolidated the introduction of the LIST with further support sessions for buddies to meet and discuss their experiences of helping colleagues involved in serious incidents.

The Leeds Incident Support Team (LIST) is a voluntary group of LTHT staff who have previously been involved in serious incidents. They have made a commitment to be available to talk to other staff who may become involved in a similar type of incident. They will talk through the process of an investigation and answer questions a staff member may have.

Never Events

NHS England revised the list of Never Events in 2017/2018, increasing the number from 14 to 16 (although one of the new category types is currently on hold as a defined Never Event).

The Never Events list provides an opportunity for commissioners, working in conjunction with trusts, to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur. Nationally the most commonly reported Never Events relate to retained surgical items, wrong site surgery, and wrong implants.

We have reported six Never Events during 2017/18 under the following categories:

- Retained foreign object x 2
- Wrong site surgery x 2
- Incorrect implant used x 1
- Administration of medical air instead of oxygen x1-*New category*

All of these Never Events were reviewed with the Trust's Chief Medical Officer and Chief Nurse and also with our commissioners at Leeds West CCG. They have also been reviewed with the clinical teams to ensure immediate action has been taken to reduce the risk of recurrence, that Duty of Candour regulations have been followed, and that they have been investigated in line with our serious incident procedure.

Duty of Candour

The statutory Duty of Candour regulation came into force on 27 November 2014. The Duty of Candour applies to all incidents that result in moderate harm, severe harm and death, using the National Reporting and Learning System (NRLS) categories for incident reporting.

Every week the Risk Management Department monitors the Datix web incident reporting system to ensure that where incidents have led to moderate harm, severe harm or death the Duty of Candour process has been followed, including offering an apology and an explanation that an investigation will be done to help us understand the cause of the incident so that we can learn from this.

We have supported clinical teams and staff to ensure the Duty of Candour regulation is complied with. We have published an electronic learning tool for staff and Quality & Safety matters bulletins, which have been shared with clinical teams across the Trust. We undertook an Internal Audit of our Duty of Candour approach this year which provided significant assurance that our process is becoming embedded across the organisation.

Scan 4 Safety

LTHT is one of six demonstrator sites for a programme that utilises standards to associate: patient, product, place and process.

This brings with it significant safety and efficiency benefits including:

- Tracking product use, eg tracking those used for a surgical procedure in an operating theatre.
- Tracking patients in each location they go to in our hospitals, including which bed they are in on which ward.
- Rapid identification of the location of products that have been recalled.
- Recording which staff are involved in procedures.
- Managing stock more efficiently, reducing stock stored and ensuring all stock is in date.
- December 2017 saw the completion of the 2 year programme phase, however, the work will continue to ensure the maximum benefits are realised.

Key achievements this year include:

- Scanning has been introduced into most theatres for high risk or high cost implantable products, to associate product to patient and lead clinician responsible for the procedure
- Scanning at the bedside has been successfully tested in a contained clinical area covering an inpatient ward, radiology suite and theatre. This associates a patient to a location and provides a detailed timeline of their movement within their electronic health record (EHR).
- We met all the milestones associated with the programme and achieved 98.7% compliance in an audit undertaken by the Department of Health & Social Care.
- There have been significant savings in theatre environments due to more robust stock control and management.
- The development of a mobile app that will facilitate point of care data capture direct into the EHR.

Key areas of work this year include:

- Roll out of scanning to all wards, with the mobile app available on mobile devices within the workplace.
- Maximising the potential of scanning at the bedside, opening the EHR, and completing an e-form direct into the electronic record at the bedside with the patient.
- Maximising the potential of scanning to provide robust information relating to patient flow and location.
- Further product capture across all theatres and moving towards capturing lower risk items
- Initiation of the programme across WYAAT

Scan4Safety Standards

4.3.3 Patient Experience

Priorities

Last year we continued to introduce a consistent approach to the way we listen to patients and the public. We also recognised the importance of asking people to help us with developments that would make a real difference to the experience of our patients and that some of these would take more than a year to achieve. Finally, we aimed to be able to describe the difference listening to the patient and public voice had made to our services. We have outlined later in this section the great work that has taken place this year towards the achievement of these goals.

Our Aims for 2018/19

This year, we will build on last year's progress and also demonstrate that patients and the public are included in service changes that are planned across the Trust. Consequently, our key areas of focus for 2018/19 are:

1. Measuring and reporting the impact of two 'Always Events', which aim to :
   - Improve the night time experience for patients
   - Improve the anaesthetic/theatre experience for patients
2. Reporting how we have obtained public and patient feedback and taken this into account, in our planning of 'Building the Leeds Way'.
3. Each bed holding CSU undertaking two new patient and public involvement activities and reporting how using the feedback obtained has influenced patient care.

Using Feedback to Support Trust Development

Background

One of our quality goals last year was to demonstrate patient and public feedback is used to support service and Trust developments, by capturing the resulting changes.

Key Achievements in 2017/18

Work that begun in 2016/17 to ensure tools are available in the Trust to capture the patient and public voice, were further developed in 2017/18. Successes include the continuation of the Patient Reference Group as a key source of support to the Trust. We also have a database connecting us with members of the public which helped us capture public opinion on a number of key issues throughout the year. We recognise the important contribution of patients when key service changes are proposed.

As part of the Trust nursing, midwifery and allied health professional commitment, we agreed that each clinical service unit would share how their practice had changed as a result of patient feedback. The feedback taken into account included information provided through the Friends and Family test, via national patient surveys or through local engagement initiatives that services had taken forward.

We collected all the information and produced a report which showed that all our clinical service areas had taken positive action to improve the experience of patients in their care. The report was shared across the Trust and at our Patient Experience Sub-Committee.

Patients said: A leaflet should be available for patients going home in the early stages of labour.

What we did: We developed an information leaflet to support women in the early phase of labour to provide information and reassurance for women who choose to go home.

Patients said: When they have been involved in major trauma incidents they often need on-going support.

What we did: We worked closely with Day One, a third sector organisation which supports major trauma patients, to provide patients with access to further support.

Patients said: It would be nice to have better facilities for relatives who are on wards for long periods.

What we did: On ward J08 a store cupboard was converted into a facility for relatives to make hot drinks and a dedicated visitor shower/ toilet has been put in place.

Aims for 2018/19

We will continue encouraging our clinical service units to report and celebrate the great work they are doing with the feedback they receive from patients.

Always Events

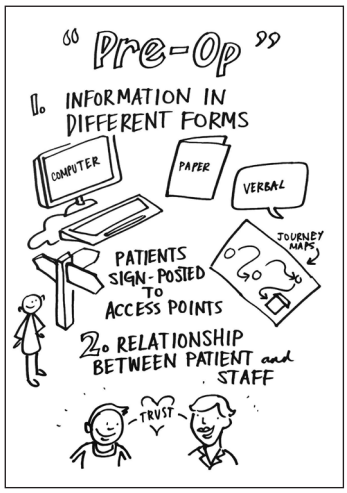
'Always Events' projects involve staff and patients working together to identify and introduce a change into a clinical area which will have a positive impact on patient experience. A specific model for change is followed which is promoted by NHS England and supported by a National team.

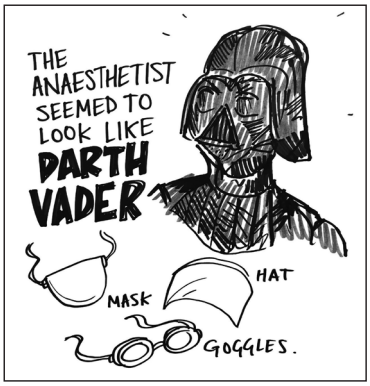
Key Achievements in 2017/18

In 2017/18 we began to work with Trust teams to consider their patient feedback and to identify where to focus an 'Always Event' project. During the year, two key areas were identified for this support and both projects are progressing.

The first project is concentrating on improving the patient night time experience on four of our hospital wards. To identify the best way to do this, feedback was sought from 480 patients. A member of the patient experience team also spent time on the wards overnight, to directly experience the environment and contribute to our learning. A number of developments are in the pipeline including an information leaflet for patients, a night time banner to remind staff to be quiet, and comfort packs which provide patients with simple measures to help them sleep, such as eye masks and ear plugs.

Our second project is focussing on the experience of patients who attend theatre and have anaesthetics. This work began with undertaking a survey with patients called 'Before and After You Sleep' which generated much interesting information. On 15 December 2017, the service then held a very successful patient engagement event which was supported by a graphic illustrator and which expanded on the survey feedback. More than 130 suggestions and ideas were generated from this event which are being used to identify quick service improvements as well as to inform the content of potential 'Always Events'. Some of the findings of the day are illustrated below.





Aims for 2018/19

We aim to continue to implement our chosen 'Always Events' and test the impact they have on our patients' experience. We will then use our learning to develop more 'Always Events' to improve the care we provide.

What have we done to improve the Experience of Patients

Interpreting Services

In 2017/18 we started working with a new interpreting provider, to provide all face to face and telephone interpreting at the Trust. We worked with them to build a hub of local interpreters which has now been fully operational since August 2017. We have also engaged with the Deaf and Blind Community to ensure they are satisfied the supplier is meeting their needs. Since August 2017, 93.7% of requests for interpreters have been fulfilled. We aim to ensure patients receive the most appropriate access support they need at the right time, and in the right place. We will continue to monitor service provision and check user feedback to ensure our service meets the needs of our patients.

Carers

During 2017/18, we were delighted to receive the 'Commitment to Carers' kitemark. This recognised the commitment we had made, as a member of the Leeds Carers Partnership Group, to support Leeds becoming the best city for carers.

Some of our achievements in 2017/18 include; updating our nursing assessment document to ensure carers are better supported when a relative or friend is in hospital, and updating out website to include a Carers page, which provides information about 'John's Campaign', Carers Leeds, and sources of support. We also work closely with Carers Leeds and host two Carers Leeds support workers, who offer practical support to carers of patients with Dementia and carers who require advice on funding additional care. In 2018/19 we will contribute to regional work undertaken by the West Yorkshire and Harrogate (WY&H) Health and Care Partnership, as part of the Sustained Transformation Programme. The aim is to heighten the profile of carers in a more holistic way and to ensure a more consist approach to the way carers are supported across the region.

Think Drink

We know that fasting for longer than is necessary causes unnecessary discomfort and that good hydration can aid recovery and earlier discharge from hospital, so we have been working to improve the experience of patients who are fasting before theatre. Guidelines say that patients can drink some water for up to two hours before they have a procedure which involves general or regional anaesthetic. We launched a campaign in March 2018 to raise awareness amongst staff and to encourage all areas to adopt this new practice. We will also be working on helping our patients understand better what they are allowed to do before surgery, so that they know they are able to drink for longer than they might expect to, when they are admitted to our hospital for planned surgery.

Maternity Services - 15 Step Challenge

The "15 Steps Challenge" is a suite of toolkits that explore healthcare settings through the eyes of patients and relatives, in order to improve their experience. In January 2018, the Trust Maternity Services held a big improvement event using the "15 Steps Challenge, and suggestions from the event included improved signage, updated notice boards, and a more comfortable environment. The service aims to use this feedback to make positive changes, and they will use the comments to influence meetings that are taking place to agree strategic service changes and redesign. Because the exercise was so useful, we plan to repeat it on a regular basis at both maternity sites across the city, and to feed the findings into senior meetings to bring about change.

Sit Up, Get Dressed, Keep Moving

We know that wearing nightwear in hospital reinforces a 'sick role' and that prolonged stays in bed, particularly for older and frail adults can result in serious deteriorations in their health in a short space of time. This can make it difficult for people to get back on their feet and makes

it harder for them to get home as quickly as they would like to after they have been ill. This year, we joined a national campaign which aims to raise awareness of the importance of wearing clothes during the day and keeping as active as possible whilst in hospital, as this enhances their well-being and self-esteem, and promotes dignity, independence, normality, and can aid recovery and a quicker discharge home. Patients have reported that this makes them feel better and more like themselves. Winifred, who was 102 years of age, told us that you are never too old to get dressed.

Matron, General Medicine with our Patient Representative for the Sit Up, Get Dressed, Keep Moving Campaign

We would like our hospital to become a place where it is normal to see patients on our wards in their own clothes, and are actively raising awareness with patients and families so they help in supporting the campaign. We know that some patients will not have anyone who is able to support them to do this, and we are exploring ways in which we can offer items of clothing to patients who would like to get dressed and don't have this help available.

The Power of Patients

We discovered, by looking at our data, that the Trust performs a high number of tests, like scans and x-rays, when compared to other teaching hospital Trusts, so we decided to explore why this was, and what patients would think about a change in scanning rates, if that was to happen. Patient feedback was collected and shared with clinicians who manage patients with certain conditions. Doctors responded positively to receiving this feedback and are now working on the following;

- Reducing the time it takes to scan patients
- Finding ways to reduce anxiety
- Finding ways to increase available information and support

The doctors involved in this work also aim to share this approach with others so that it can be used to support changes in other parts of the Trust.

Other Examples

- Elderly medicine services held an engagement event with approximately 30 older people from BME communities. Useful feedback was obtained, particularly in relation to food choices and transport.
- The Patient Reference Group was consulted on a number of key issues for the Trust which in all cases influenced Trust decision makers. Topics explored included the public perception of Scan4Safety and the content of the Trust Patient Experience Strategy.
- Approximately 60 responses were received from members of the Leeds LGBT community who completed a survey to provide feedback about their hospital experience. The equality and diversity team are now using this to inform their work plan.
- The Quality Improvement team supported a workshop which was aimed at better understanding how patients with Parkinson's would like to be supported to manage their medicines. The team explored a number of options with the patients and carers present, which has influenced how this work will now be taken forward in the Trust.
- In 2017, the members database was used to make 6266 contacts with patients and the public who have signed up to support the Trust. They were asked for their views on a number of different topics, including a proposal to remove payphones from outpatient environments. The database was

also used to gather feedback on the content of an End of Life Care booklet and the content of the Trust Complaints Policy.

Positive Engagement with our Service Users

Patient Information

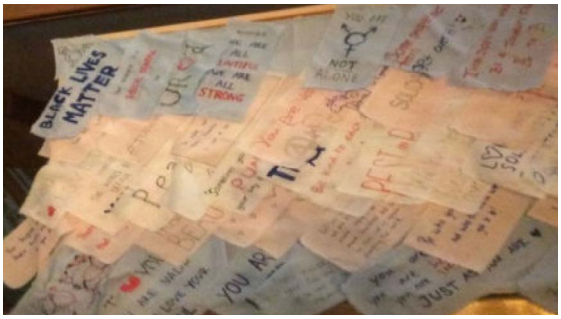
The Trust holds a Patient Information Forum every three months, made up of Trust staff and patient representatives, to improve internal processes for developing and managing patient information at the Trust. Over the last year we have tested a new piece of software which will allow the Trust to offer published patient information leaflets in up to 90 languages, and we aim to roll this out in the coming year. We have also published over 250 leaflets on our Trust website, and begun rolling out an improvement document management system to allow for better management and availability of patient information.

New Multi-Cultural Menu

Some of our patients who have specific religious or cultural requirements had told us that the multi-cultural menu we provided could be better, so in August 2017 we asked members of local faith communities to sample available products to decide what should be on the menu. We have updated our menus based on this, and a large number of positive comments have been received. In future, we aim to ensure that all of our patients are aware of the full range of menus available, as some patients have also told us that they didn't know about all the different menus we provide

Trans Day of Remembrance

In November 2016 we hosted our first Trans-Day of Remembrance event and invited local partner organisations to this. Following this, we worked with local trans-groups to improve and make the event more accessible. This year's event, in November 2017, was a success and was attended by more than 80 people: it included artwork produced in conjunction with Leeds College of Art.



TDOR Words of support making up the Trans Flag

Teaching Future Nurses about Patient Experience

Nursing students have traditionally undertaken placements in clinical areas as part of their training. The Trust Patient Experience Team support a number of key Trust functions that students usually have little training on before they qualify as nurses. In 2017, the Team began to take University of Leeds Nursing Students for two-week placements, in order to provide experience in a number of different departments, such as, Complaints and the Friends and Family Team, Bereavement Services, Volunteering Services, PALS, the Interpreting Team and the Patient, Carer, and Public Involvement Team. In each of these areas they gain knowledge that they can take back to their clinical practice to improve the care they deliver to our patients in the future.

Working with Healthwatch

During 2017/18, we continued to work in partnership with Healthwatch Leeds to plan good ways to seek the views of patients and the public from across Leeds to understand the issues that matter most to patients. This has helped the Outpatient Management Team to plan the improvements such as the upgrade of the Self-Check-In machines, which many patients reported problems and frustrations with.

In February 2018, the Trust also took part in a Leeds-wide workshop, facilitated by Healthwatch, aiming to bring organisations together from across the city to seek the views of patients and the public on a number of different

topics. Some of the findings have resulted in the Trust to undertaking longer term projects to improve experiences which are underway.

Engaging with Our Members

The Trust now has over 25,930 members. Over the past year our members have played an important role in the following;

- Developing 'Always Events', which have been supported by hearing feedback about the experience of spending time here as a patient
- Sharing views on a proposal to remove payphones from outpatient environments
- Providing feedback on an End of Life Care booklet that supports people to understand the choices available to them at this difficult time
- Providing views on the content of the Trust Complaints policy
- A workshop in February 2018, where Trust plans for a new healthcare building were described.

Looking forward, in February 2018 contact was made with members, asking for their support in the following areas:

- Seeking feedback on the content of the Patient Safety Boards on display in Trust wards and departments.
- Seeking feedback on a proposed cancer pathway
- Seeking patients' thoughts about researchers having access to information about them, in order to improve wider community health.

Our members are kept informed via two issues of our member magazine per year, called Connect, which provides information on Trust developments and Patient and Public Involvement activities, LTHT Membership events known as 'Medicine for Members', of which there were 10 sessions in 2017, and direct contact made via our membership database. They are also able to provide feedback via surveys throughout the year.

National Patient Surveys

The Trust takes part in a number of National Patient Surveys which gives us valuable feedback, and allows us to see whether actions we have put in place in response to previous surveys are having the desired effect and improving our services.

Children and Young Peoples Survey

We take part in the Children and Young People's Inpatient and Day Case Survey every other year. In the 2014 Survey we scored less well than we would have liked for a number of questions relating to the way we communicate with the parents of our patients. As a result of this feedback we developed an action plan which would help us make the care we give children more family centred. The 2016 survey demonstrated that we had significantly improved on our 2014 survey results for these questions. LTHT also scored significantly better than 70 comparator Trusts for 24 questions resulting in us being the 4th most improved Trust in 2016.

Some of the actions we have taken as a result of the 2016 survey are:

- Working with Charitable Trustees to access funding to improve the parents accommodation on L42
- Improving patient information leaflets for surgical patients (including simplified fasting instructions)
- Working with Clinical Nurse Specialist Teams to ensure patient information is available and accessible in electronic format
- Delivering Motivational Interviewing Training for staff (in response to feedback about the way doctors nurses communicate with young people).
- Developing the 'Super Sibs' initiative on NNU to support parents with the care of siblings whilst they are visiting the Unit
- We held a Children & Young People's Conference October 2017 to provide opportunities for children & young people to network and learn from their peers. A second similar conference is planned for October 2018.

National Cancer Patient Experience Survey 2016

The 2016 National Cancer Patient Experience Survey was published in July 2017 and sampled adult patients undergoing cancer treatment as inpatients or day cases between April and June 2016. LTHT scored better than the expected range for 11 questions, worse for only 1. We also improved our performance significantly against our 2015 survey for 2 questions. There were no questions in the survey for which we performed significantly worse. The Trust was ranked 17 out of 147 Trusts in the country and was the 10th most improved Trust of 147 Trusts.

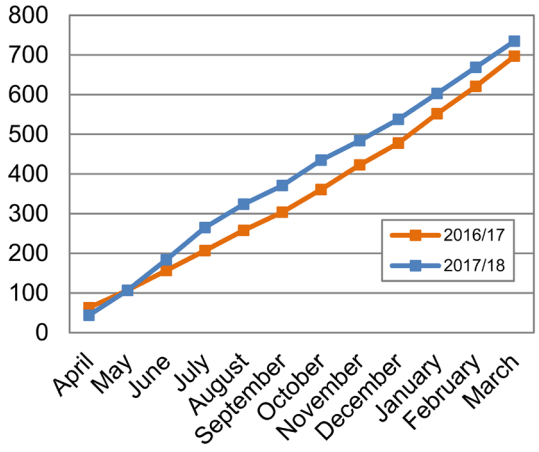
Key actions we have taken following the survey include;

- New patient information packs to help provide the right information at the right time for patients
- Inclusion of information in all clinic letters explaining that patients are able to bring a relative or friend to their appointments, this was following a patients saying they weren't aware they could bring someone
- We have worked with the cancer charity Breast Cancer Now and undertaken a more detailed survey to further understand some of the issues that were raised
- All MDTs have developed an action plan for any area where the results were 5% or more below the national average, and all ward related issues have been shared with the clinical teams and every relevant triumvirate team.
- We will be undertaking a focus group with some of the haematology patients who responded to the survey to more fully understand some of the issues raised in relation to understanding diagnosis and treatment options

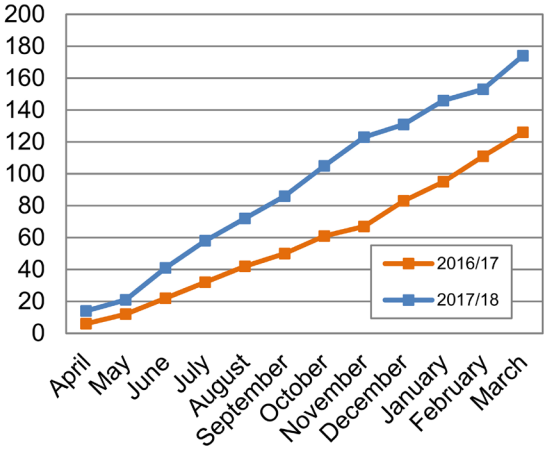
Complaints

In 2017/18, we have continued to work with clinical areas to both reduce the number of complaints received and reduce the length of time we take to formally respond to complainants either in writing or by meeting.

Number of complaints received (cumulative)



Number of complaints reopened (cumulative)



Key Achievements in 2017/18

We have delivered a number of bespoke training sessions to clinical teams across the Trust to increase their knowledge in complaints handling and letter writing skills.

Following feedback from complainants that they were not always kept up to date with the progress of their complaint, we have introduced Keeping in Touch Tuesdays (KitKat). This new initiative has resulted in a greater satisfaction for our complainants and better relationships being built between themselves and the complaints team.

We have been collecting examples of learning from complaints and are collating a database of actions taken at the Trust in response to feedback. This feedback will be shared Trust wide.

There has been an increase in complaints resolved through recorded meetings at the Trust which have been found to not only speed up the complaints process but also increase the likelihood of complainants being satisfied with their response on their first contact.

We are aware of fewer complainants contacting the Parliamentary Ombudsman than the previous year, which we believe is due to more complainants being satisfied with the Trust's handling of and resolution of their complaint.

Aims for 2018/19

- We will continue to share lessons learned from complaints across the Trust.
- We will offer all complainants the opportunity to feedback about their experience of making a complaint and will ensure this feedback is used to improve our practices.

You said: A complaint was received relating to the care being provided at the Trust Fertility clinic.

We did: A training package was implemented which focused on all nursing staff ensuring clinics were better prepared for patients, and nursing teams were aware of patients' history before they arrived. The team also produced an anonymous case study which was shared across the clinical service unit to ensure that lessons were shared across the wider team

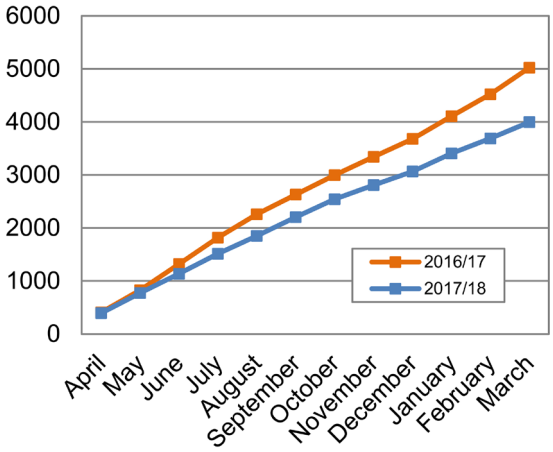
You said: The Trust received feedback from a relative who had experienced a lack of compassion when dealing with delays obtaining a death certificate of a loved one.

We did: The Bereavement team have been working with clinical teams to improve communication and timeliness of death certifications. A learning bulletin was also shared within the clinical areas to ensure that lessons were learned across all ward areas.

PALS

During 2017/18, the Trust PALS service has seen a decrease in the number of PALS concerns received. We believe that some of the reduction is a response to our 'Speak to Sister' initiative which aims to resolve concerns locally before they become more serious and require formal investigation. The graph below compares the number of PALS concerns received in 2016/17, with those received in the same months in 2017/18.

Number of PALS Concerns received in 2017/18



Key Achievements in 2017/18

Some of the lessons learned or actions taken in response to PALS concerns are summarised below:

- A patient raised a concern that Switchboard staff were not very helpful and passed him from department to department. Managers played the voice recordings of the call to staff so they could hear what went wrong and then they discussed how the call could have been handled better
- A patient had an appointment in Bexley Wing. It was her first appointment and she was expecting bad news. She was waiting a long time and this increased her fear and anxiety to the extent that she became tearful and upset. As a result of her feedback the clinic staff now identify first attenders on the

clinic list and extra care is taken to track their progress through the department and their well-being. In addition the team are working with the lady concerned to raise some money for patient bleepers so that when delays are expected patients can leave the department without fear of missing their 'slot'.

- In response to a male patient's concerns about dignity and clothing storage in Radiotherapy the team are providing hangers and lockers and have sourced a different style of gown to be worn whilst undergoing treatment.

Aims for 2018/19

We are looking at ways to establish a mechanism to share good practice more widely, something we already do with improvements that have come about in response to patient surveys and FFT data. In 2018/19 we will be providing CSUs with a live PALS 'dashboard' which will enable them to identify any recurring themes in a timely manner so they can focus their improvement work on these areas.

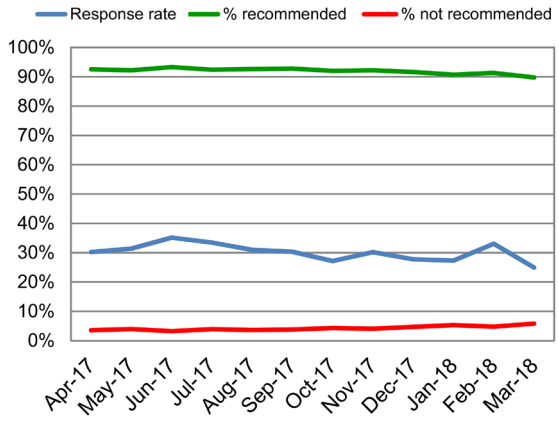
Friends and Family Test

The Friends and Family Test (FFT) at Leeds Teaching Hospitals is now available in a number of formats, which allow our patients to have more choice in how they provide feedback to us about their experiences at the Trust.

Some of the achievements this year have included the following;

- A higher number of patients providing feedback, and Trust staff being able to use this feedback in a much more useful way.
- The Trust achieved some of its highest ever response rates in 2017 which demonstrates our staff commitment to ensure every patient has the opportunity to give feedback.
- We have successfully rolled out an electronic survey using hand held tablets: this is now available in every adult inpatient ward across the Trust.
- In collaboration with the Trust's Youth Forum, we have designed new children and young people's FFT cards – the design was inspired by our young patients and reflect the diverse families across our communities.
- In summer 2017, we ran a FFT workshop with a team from Maternity Services. This generated lots of innovative ideas about how more women could be encouraged to get involved in FFT, and also resulted in the Women's CSU now having FFT champions.
- Business cards, which include a QR code have now been made available. These allow patients to feedback from the comfort of their own home rather than feeling pressured to complete a survey on discharge.

Friends and Family Test Trust-wide performance April 2017 - March 2018



Aims for 2018/19

- We will support clinical service units to use their feedback more openly by developing a Trust wide 'You said we did' ethos.
- We will share best practice resulting from FFT across the Trust

4.3.4 Clinical Effectiveness

End of Life Care

End of life care affects everyone and over recent years there has been a shift in ownership / responsibility leading to this aspect of care becoming everyone's business.

Ensuring that dying patients and their families receive the best possible care remains a priority within LTHT. Our Trust - wide action plan outlines a programme of improvement work aligned to the National Ambitions for Palliative and end of life care (2015 - 2020), Nice quality standards and guidance for end of life care and feedback received, including from the CQC.

By working collaboratively as part of the Leeds citywide Palliative and EoLC Managed Clinical Network (MCN) we are progressing work, across organisational boundaries to our very best to achieve for everyone what we would want for our own families.

Key Achievements in 2017/18

- Streamlined timely transfer of care for patients from LTHT to the Hospices - average reduction of one day from first visit by palliative care to transfer to the hospice
- CSU improvement plans - led to wards adapting space to make quiet rooms for families to relax in while visiting their dying relatives
- Updated care of the dying person (adult) documentation launched November 2017 separated into nursing and medical /MDT booklets with updated prescribing guidance
- Development and recruitment into new bereavement CNS role
- Secured charitable funding and volunteers to provide comfort care packs for relatives staying with dying patients and decorative cloth bags to hold syringe pumps
- Successful quality improvement project as part of the National "Building on the Best project", improving the care of patients experiencing terminal agitation at the end of their lives, improving access to palliative care services for oncology and cardiac out patients
- Implementation of nurse verification of death to improve the timeliness of verification of death for families.

Members of our End of Life Care Team

Aims for 2018/19

- To implement a digital advance care planning platform linked to the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) across all adult CSUs, enabling future care plans and wishes to be shared To progress the MCN transfer of care work, to enable more patients to achieve their preferred place of care and utilise available hospice beds more efficiently

- To develop bespoke e-learning priority training modules for use across the trust
- To develop a sustainable model of best practice for bereavement care for LTHT's families in order to meet the needs of families who require additional support post bereavement
- To work with all CSUs and the discharge team to promote wider use of the Rapid Discharge Plan (RDP) to improve the transfer of care for patients to their preferred place of care at the end of life.

Discharge

Improving the quality of discharge of patients remains a key priority of the Trust. 2017 has been another very productive year in continuing the improvement of service. Listed below are some of the highlights:

- Same day discharge via trusted assessment for Re-ablement services delivered by Leeds City Council
- Implementation of the new Community Care beds Strategy for both rehabilitation of patients (intermediate Care) and Discharge to Assess Pathway, including an increase in overall beds capacity.
- Leeds integrated discharge service (LIDS) successful bid from the Better Care Fund for increased funding to expand the team, including Age UK delivered Hospital to Home Service.

The Leeds City Council re-ablement service completed their review and expansion of service so that patients could be assessed by the LIDS team and go home with support the same day. This service, implemented in June 2018, has seen huge success with an average of 50 patients per week discharged via this route. The patients are supported and assessed in their own home, instead of hospital, until they reach independence or longer term care needs are known.

November 2017 saw the launch of the new Community Care beds (CCB) in 7 intermediate care hubs across all regions of the city. Patients can receive rehabilitation therapy closer to home where possible or, if on a discharge to assess pathway, patients have time to recuperate and recover so that their long term care needs can be better assessed and implemented.

LIDS, including Age UK, were successful in bidding for funds to be able to expand the service across all areas of the Trust, including additional capacity opened for winter pressure. This additional resource will ensure that all patients' discharges can be progressed in a timely way with expert support and advice for patients and their families.

Aims for 2018/19

Our aim in 2018/19 is to reduce the number of patients in medicine and elderly wards who have been assessed as being medically fit for discharge who remain in hospital for longer than 21 days by 50%.

The Perfect Week and Multi-Agency Discharge Event

In response to the sustained bed pressures that Leeds Teaching Hospitals Trust is experiencing, we worked with system partners to hold a Perfect Week on the St James's site, in October 2017. It was perhaps the biggest system wide Leeds Way initiative that has been conducted so far, with over 700 individuals supporting our teams and working collaboratively to improve patient care.

The aim of the Perfect Week was to engage all health and care providers within Leeds with issues affecting patient flow both within and from LTHT, to:

- Improve our understanding of system issues for all partners
- Improve patient and staff experience
- Improve measurements of performance
- Ultimately improve patient flow across the health and care economy

91% of the delays highlighted during the week related to delays in discharging patients who were Medically Optimised For Discharged (MOFD). Collaborative working with system partners was essential in facilitating the resolution of individual patient delays and by the Friday of the week the number of Delayed Transfer of Care Patients within the hospital bed base was at the lowest it had been since August 2017.

Just 5% of escalated delays relate to operational issues within LTHT, including the late completion of e-DANs and Adult Therapy support for patients staying outside their speciality bed base.

Both internally and across the system teams are working to address the issues highlighted during the Perfect Week and improve information sharing and collaborative working across organisations.

Following on from the Perfect Week, which had highlighted significant difficulties in the discharge processes across Leeds, NHS Improvement invited us to host a Multiagency Discharge Event (MADE).

MADE brought together senior clinical and operational staff from the local health system to support improved patient flow, recognise and unblock delays, while challenging, improving and simplifying complex discharge processes in real time.

24 wards across St James's Hospital hosted MADE teams who looked at each patient individually to understand what needed to happen to improve the patient pathway and reduce any delays. The teams, comprised of individuals who worked for Adult Social Care, Leeds Community Care Trust and LTHT, used their collective knowledge and influence within their organisations to expedite milestones within each patient's journey.

Leeds Teaching Hospitals Trust in collaboration with organisations across the health system is working to implement the recommendations from MADE:

- Set out a system strategy to develop a "Homefirst" approach for discharge planning
- To develop Professional Standards 'system-wide' that will be monitored. Allowing the system to develop a clear single version of the truth (one list) of what is causing delays in order actions can be prioritised
- Work to agree and implement a "trusted assessor" model for mainstream care homes and community services
- Address unwarranted variation in the delivery of the SAFER patient flow bundle.

Hospital Mortality

There are two national trust-level mortality indicators:

- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the observed number of deaths following admission to the Trust and the expected number of deaths based on the England average, given the characteristics of the patients treated (risk adjusted). It is produced and published quarterly by NHS Digital.
- The Hospital Standardised Mortality Ratio (HSMR), developed and published by Dr Foster, compares the number of observed deaths at the Trust with a modelled (risk adjusted) expected number.
- The HSMR differs from the SHMI in a number of respects, including:
  - The SHMI includes all deaths, while the HSMR includes a basket of 56 diagnoses (around 80% of deaths).
  - The SHMI includes post-discharge deaths (30 day), while the HSMR focuses on in-hospital deaths.
  - The HSMR is adjusted for more factors than the SHMI, most significantly palliative care and social deprivation.
  - The SHMI is expressed as a rate where 1 is the national average; the HSMR is expressed as a rate where 100 is the national average.

The table below shows the Trust's latest published SHMI, for the period July 2016 to June 2017, also shown is the HSMR for the same period. The Trust continues to fall within the 'as expected' banding for both measures.

Trust SHMI & HSMR Oct 16 - Sept 17

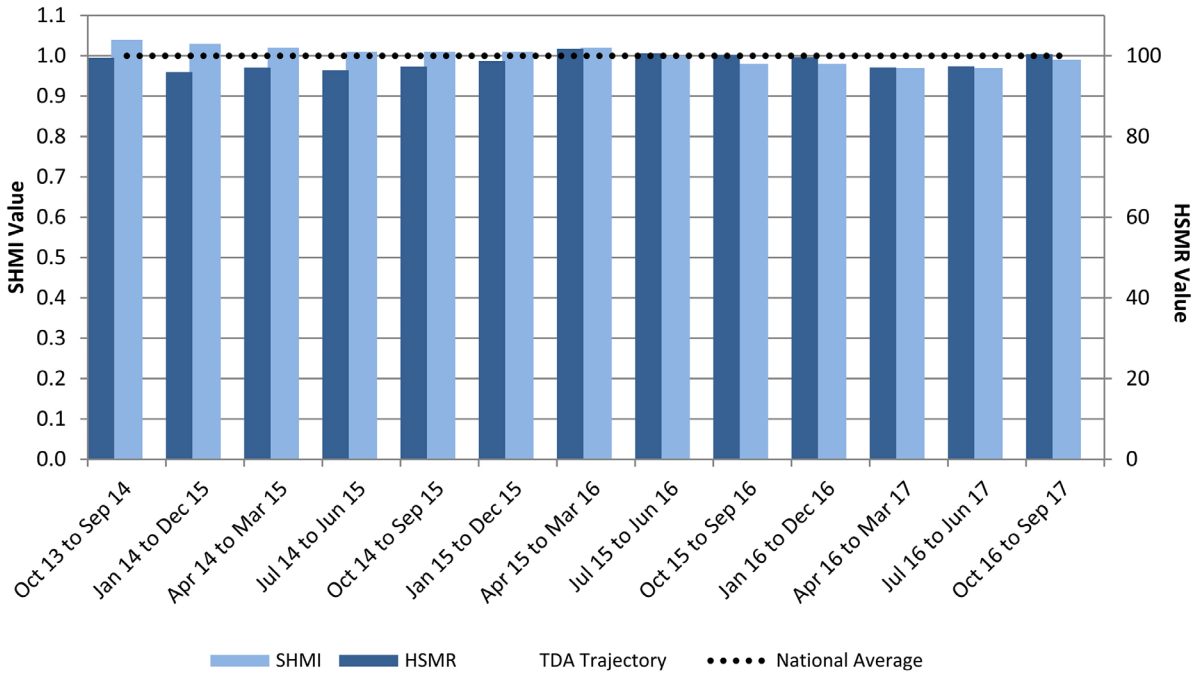
Trust level mortality, Oct 16 - Sept 17	Spells	Value	Observed deaths	Expected deaths	95% Confidence Interval
SHMI	128,491	0.9928	4,136	4,166	0.899-1.112
HSMR	60,317	100.46	2,467	2,456	93.89-106.36

Higher than expected	As expected	Lower than expected

SHMI Indicator by rolling 12 month reporting period

Indicator	Reporting Period	Trust Rate	National Average	National Range
SHMI	Oct 13 to Sep 14	1.04	1.00	0.597 - 1.120
	Jan 14 to Dec 15	1.03	1.00	0.655 - 1.243
	Apr 14 to Mar 15	1.02	1.00	0.670 - 1.243
	Jul 14 to Jun 15	1.01	1.00	0.661 - 1.209
	Oct 14 to Sep 15	1.01	1.00	0.652 - 1.177
	Jan 15 to Dec 15	1.01	1.00	0.669 - 1.173
	Apr 15 to Mar 16	1.02	1.00	0.678 - 1.178
	Jul 15 to Jun 16	1.00	1.00	0.694 - 1.171
	Oct 15 to Sep 16	0.98	1.00	0.690 - 1.164
	Jan 16 to Dec 16	0.98	1.00	0.691 - 1.189
	Apr 16 to Mar 17	0.97	1.00	0.708 - 1.212
	Jul 16 to Jun 17	0.97	1.00	0.726- 1.228
	Oct 16 to Sep 17	0.99	1.00	0.899 - 1.112

Trust level SHMI and HSMR (basket of 56 diagnoses) by rolling 12 month reporting period:



The Trust SHMI and HSMR rates have consistently fallen within the expected range.

The Trust uses tools provided by Dr Foster to review more current mortality rates, as the SHMI is published 9 months in arrears. The table below shows the Trust's most recent HSMR position which remains within the expected range;

Trust HSMR Feb-17 to Jan-18

February 2017 to January 2018	HSMR (basket of 56 diagnoses)	HSMR (all diagnoses)
Observed deaths	2,424	2,978
Expected Deaths	2,407	2,960
HSMR	100.7	100.6

For the reporting period October 2016 to September 2017 LTHT had a crude death rate of 29.1% of deaths reported in the SHMI with a palliative care coding. This figure is less than the National average of 31.5%, and within the National range of 11.5% to 59.8%.

Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust

Reporting Period	Trust Percentage	National Average	National Range
Oct 16 to Sep 17	29.1%	31.5%	11.5% - 59.8%
Jul 16 to Jun 17	29.9%	31.1%	11.2% - 58.6%
Apr 16 to Mar 17	29.6%	30.7%	11.1% - 56.9%
Jan 16 to Dec 16	28.1%	30.1%	7.3% - 55.9%
Oct 15 to Sep 16	28.2%	29.7%	0.4% - 53.3%
Jul 15 to Jun 16	26.0%	29.2%	0.6% - 54.8%
Apr 15 to Mar 16	24.2%	28.5%	0.6% - 54.6%
Jan 15 to Dec 15	23.6%	27.6%	0.2% - 54.7%
Oct 14 to Sep 15	22.4%	26.6%	0.2% - 53.5%

Weekend Care

Weekday and Weekend HSMR - Emergency Admissions

Trust HSMR - Emergency Admissions Feb-17 to Jan-18	Spells	Value	Observed deaths	Expected deaths	95% Confidence Interval
Weekday	27,586	99.9	1,754	1,756	95.3 - 104.7
Weekend	8.762	102.1	600	600	94.1 - 110.6

Higher than expected	As expected	Lower than expected

The table above shows the Trust HSMR for emergency patients split by weekday (Monday - Friday) and weekend (Saturday & Sunday) day of admission; both are within the expected range and there is no significant variation between the two.

Mortality Reporting and Learning from Deaths

National Guidance on Identifying, Reporting, Investigating and Learning from Deaths in Care was published by the National Quality Board in March 2017. LTHT was well placed to move forward with the immediate changes in view of the work overseen by the Mortality Improvement Group over the previous 18 months. We already had specialty mortality review processes in place including discussion at specialty mortality/governance meetings.

The Trust launched an updated Mortality Review Procedure in June 2017. A new screening tool to be used for all adult deaths was launched in June 2017, and Structure Judgement Review (SJR) is being rolled out as the preferred methodology for use by specialties for reviewing cases (Case Record Review - CRR), where appropriate. In the last quarter of 2017/18, the % of adult deaths screened had reached 83%, and 54% of detailed case record review used the SJR methodology.

In line with the national guidance, we have been discussing how we can report on the number of potentially avoidable deaths. This has been an interesting challenge as there is no clear indicator nationally of how this should be determined. We currently have an escalation process from our specialties' review of deaths, into a weekly Quality Meeting which includes the Deputy Chief Executive and Chief Nurse, and Chief Medical Officer, where there is cause for concern about the care provided. A decision is then made as to whether an 'incident investigation' is needed. We are now reporting each quarter on the number of deaths identified through Datix and the mortality review process as requiring a level 2 or serious incident investigation (level 3), as "potentially avoidable".

The collective learning from our clinical specialties is reviewed at our Mortality Improvement Group quarterly. The key themes identified included: communication, VTE prophylaxis; prompt senior review, and early recognition of end of life, in order to enable advanced planning. These issues had previously been identified through other mechanisms within the Trust and are all the subject of existing improvement programmes.

Our mortality data, and learning from deaths, will continue to be overseen by our Mortality Improvement Group, and reported to the Quality Assurance Committee and Trust Board.

	Number of Deaths	Number Screened**	%	Number Triggered for Case Record Review (CRR)*	% of those Screened that Triggered for CRR	Total Number of CRRs completed (including SJR)	Number of Structured Judgement Reviews	Number of Potentially Avoidable Deaths
2017/18 Q1	655 (201 from June 2017)	8	43%	22	26%	205	89	3*
2017/18 Q2	684	412	63%	117	28%	200	65	4*
2017/18 Q3	804	605	78%	200	33%	258	101	5*
2017/18 Q4	927	758	84%	206	27%	224	120	6*
TOTAL	**3070**	**1859**	**73%**	**545**	**29%**	**887**	**375**	**18***

* identified through Datix and the mortality review process as requiring a level 2 or serious incident investigation (level 3)

**Using PPM+ screening tool

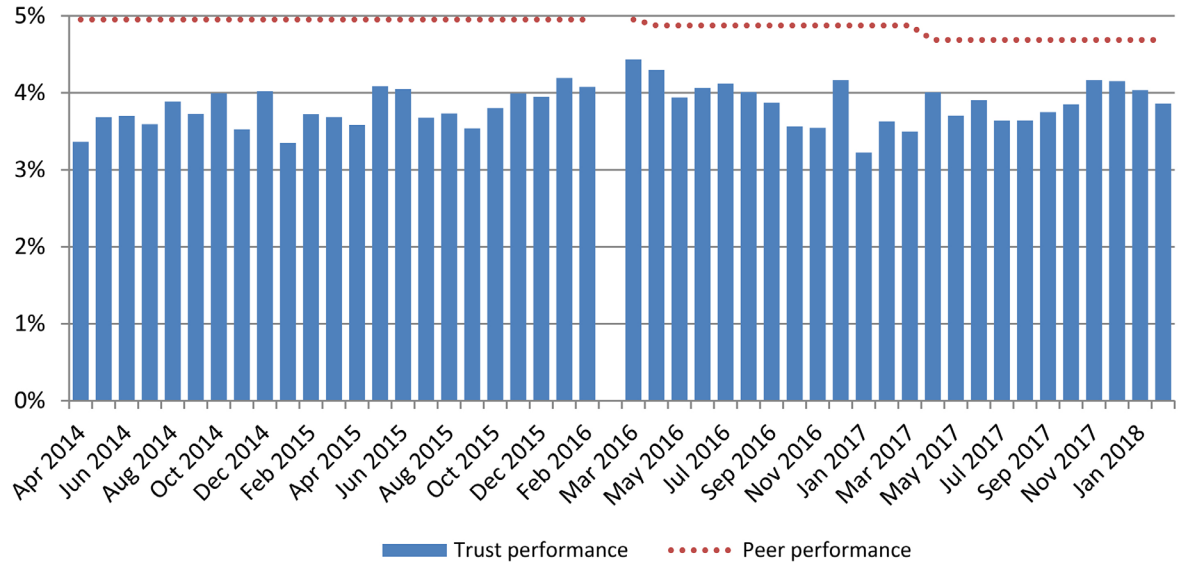
***% of deaths screened (of those using the PPM+ screening tool since its introduction in June 2017)

Readmissions

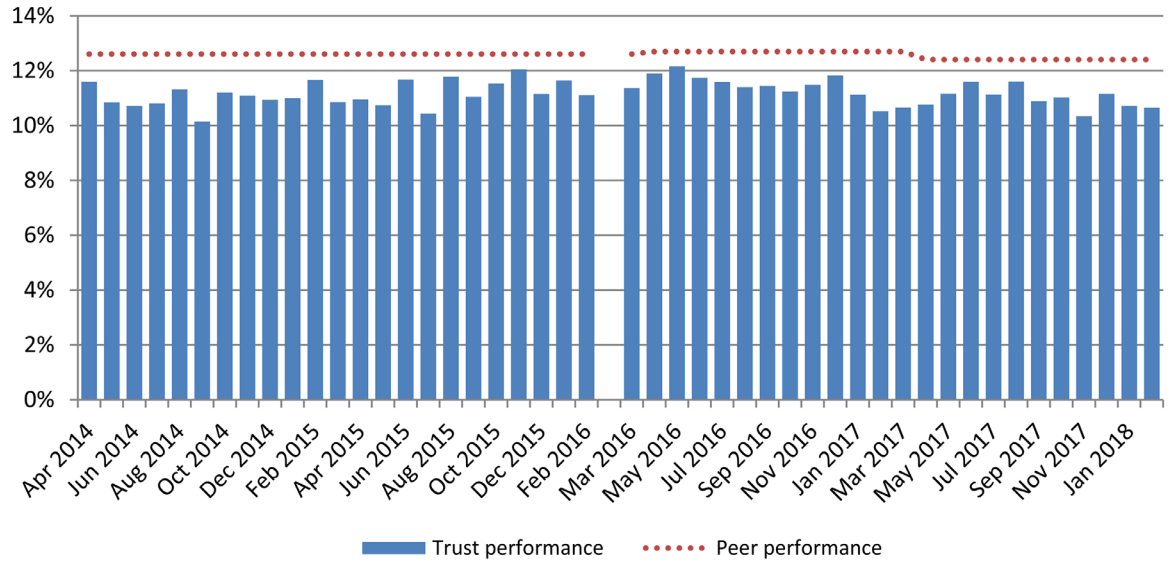
The Trust performs better than its peers with lower readmission rates following an elective or non-elective admission. Sometimes, after patients are discharged from hospital, they may need to be re-admitted again for a variety of reasons. Some readmissions are unavoidable, such as for patients returning following cancer treatment or for some cases the relevant care in the community may not be available. Nevertheless, it is important that hospitals closely monitor their readmission rates to ensure that these are as low as possible.

The charts below show monthly re-admission rates for patients who had originally been in hospital for planned care (elective) and those who had originally been in hospital as an emergency (non-elective). The average performance for our peer hospitals is also shown. Our rates are consistently lower than other teaching hospitals for both categories of patients.

Readmissions to the Trust within 30 days of discharge: elective spells



Readmissions to the Trust within 30 days of discharge: non-elective spells



Readmissions Audit

In June 2017 LTHT began joint working with the whole health and care economy to better understand the reasons patients were being readmitted to the hospital.

The purpose of the work was both to identify any further improvements for patient care, and to ensure up to date data was used to establish the financial penalty applied to LTHT.

LTHT consultants reviewed all patients readmitted for one week and identified a number of emerging themes.

Joint Clinical Reviews were conducted for a selection of cases from each theme, with staff members from all relevant sectors. These reviews focused on factors that would have avoided the readmission.

Out of a total of 237 readmissions it was jointly agreed that only 30 could have been avoided. Of these 30 it was agreed that 15 could have been avoided by the services within LTHT and 15 could have been avoided by services outside of hospital. Aside from the impact on patients, financially this would mean a reduction of the current annual penalty paid by LTHT from approx. £8.4m to £1.5m.

A number of potential pathway improvements were identified and an action plan for the Health and Care economy has been developed looking at:

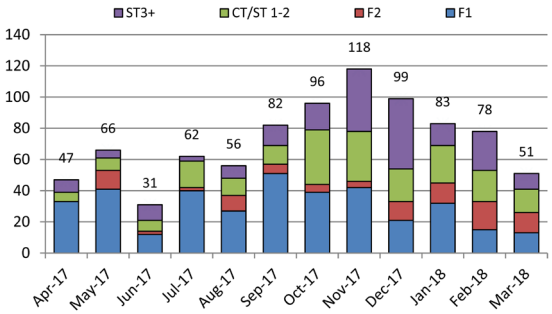
- Improving the communication between LTHT and Neighbourhood teams
- Developing a more joined up approach to Palliative Care
- Implementing a Frailty Unit within LTHT
- Improving collaborative working with the Community Respiratory Team
- Improving the support of addiction services with ED
- Improving services for people with mental health needs who present to A&E
- Improving the quality of data recording in LTHT

Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) aim to measure improvement in health following certain elective (planned) operations. These are: hip replacement, knee replacement, groin hernia and varicose vein. Information is derived from questionnaires completed by patients before and after their operation and the difference in responses is used to calculate the 'health gain'. It is therefore important that patients participate in this process, so that we can learn whether interventions are successful.

Over the last three years we have worked hard to improve our participation rates, the results of which can be seen in the chart below (please note that the 2016/17 data is still provisional; the final signed-off data will not be available until Summer 2018). Trust participation rates for hip and knee replacement are in line with the national average and for varicose vein are well above average. Groin hernia rates are now closer to National levels than in previous years.

PROMs - Pre-Operative Participation Rates - All procedures



Source: NHS Digital; 2016/17 YTD (January) as at August 2017

The following table shows the average Health Gain for each of the PROMs procedures for each of the scoring systems, for both LTHT and the England average; (note that the condition-specific systems are not applicable to certain procedures). Average Health Gain is measured by comparing the results of the pre-operative questionnaire with the post-operative questionnaire. The outcomes show that LTHT is within with the expected range across the various procedures.

PROMS Scores - Casemix-adjusted average Health Gain - April 2016 to March 2017, provisional data

	EQ-5D Index	EQ VAS	Oxford Hip Score	Oxford Knee Score
Hip Replacement Primary	0.42	11.66	21.37	N/A
England Average	*0.44*	*13.43*	*21.8*	*N/A*
Knee Replacement Surgery	0.28	6.74	N/A	15.66
England Average	*0.32*	*6.85*	*N/A*	*16.36*
Groin Hernia	0.11	0.93	N/A	N/A
England Average	*0.09*	*-0.24*	*N/A*	*N/A*
Varicose Vein	0.09	-0.79	N/A	N/A
England Average	*0.09*	*0.08*	*N/A*	*N/A*

Seven Day Service

The Trust has submitted data to the 6 monthly national Seven Day Services Survey since 2015. This has involved assessments against the four core standards:

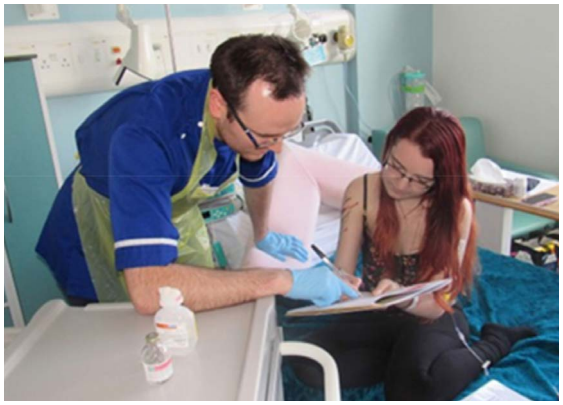
- Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
- Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically; ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.
- Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet relevant specialty guidelines such as critical care and interventional radiology.
- Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least daily, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The Trust has consistently demonstrated compliance with standards 5 and 6, and more recently with standard 8. Progress against standard 2 has also occurred however at the last survey in September 2017 performance was at 75%, below the expected level of 90%. Improvement has been seen across the Trust as a result of heightened awareness of the standards and improved documentation of ward rounds. In local areas, clinical teams have undertaken improvements in the frequency and timings of ward rounds, the clinical processes when patients are admitted to wards, and in prioritising patients for review on ward rounds who are approaching the 14 hour target. We anticipate that as a result of these improvements the Trust will demonstrate compliance with all 4 standards in the April 2018 survey results.

Medicines Optimisation

During 2018 we continue to promote our Leeds city wide campaign to encourage everyday conversations about medicines and how to get the best from them. The "me + my medicines" conversation prompt tool compliments our "Your Medicines-Your Health" programme of work in the Hospital.

This year we have supported more patients with chronic conditions, who are well enough and wish to, to continue to manage their own medicines whilst they are in hospital. We have changed our systems to support some patients to learn about the safe administration of specialist intravenous medicines (medicines given by a drip into a vein).



Patient checking their own intravenous medicines with their nurse whilst in hospital

Whenever a patient is transferred from one location to another it is really important that the relevant information about their medicines is shared, as this helps prevent mistakes. An electronic medicines prescribing and administration system is now in use for all adult patients who are cared for in the hospital and information in this system forms part of the single Leeds Care Record. All prescribing and administration of medicines for children in the hospital will be through the electronic system by the end of 2018.

4.3.5 Staffing

We know that great care is dependent on great staff. Our ambition is to make LTHT one of the best places to work. We have been growing our workforce, from 15,200 in March 2014 to 17,700 in December 2017. In 2017 we recruited 3,240 people, across a range of disciplines.

The right number of staff is an essential precondition to great care but is not enough on its own. We are embedding our values through The Leeds Way to drive staff engagement and use a number of different approaches to build engagement. From the 2017 Staff Survey we are proud to see that we are best performing Trust in England in terms of the number of staff having an appraisal. As a result of the feedback in 2016, we have improved out Health and Wellbeing offer, we have 75 health and wellbeing champions who work with their teams to share information and encourage them to make healthier choices. We have provided access to an Employee Assistance Programme which provides a range of confidential support services to our staff.

In 2017 Staff Survey, we continue to see further improvements in our staff survey results. We have 13 of our 32 key findings in the top 20% of Acute Trusts and 28 of our 32 key findings are average or above.

We have continued to expand our opportunities for apprentices and are on target to have 630 apprentices in post in 2017 across the Trust. We are proud that our programmes have won a range of awards and we have been recognised as the West Yorkshire and Harrogate Centre of Excellence in collaboration with Bradford District Care Trust, by Skills for Health.

Staff Friends and Family Test (Staff FFT)

Following the successful introduction of the Friends and Family Test (FFT), the facility was extended to staff for the first time from April 2014, to provide on-going feedback about the Trust. All staff are invited to participate in quarters 1, 2 and 4. The results of Q4 2016/17 are shown below.

Comparison of Friends and Family Test Results May 2014-March 2017

Results	Q1	Q4	Q4	Q4
	May 2014	March 2015	Mar 2016	March 2017
Response Rate (numbers of staff, students and volunteers)	750	1514	1546	3879
How likely are you to recommend LTHT to Family and Friends if they needed care or treatment?	72.7%	84%	82%	86%
How likely are you to recommend LTHT to Family and Friends as a place to work?	56.90%	68%	66%	70%

The results from the National Staff Survey for the equivalent question in 2017 are shown in the table below.

Results for Key Finding 'Staff recommendation of the organisation as a place to work or receive treatment'

Key Finding	Reporting period	Trust performance	National average
Staff recommendation of the organisation as a place to work or receive treatment	2014	3.58	3.67
	2015	3.72	3.76
	2016	3.84	3.76
	2017	3.86	3.75

Over the last four years the Trust's performance on the National Staff Survey for 'Staff recommendation of the organisation as a place to work or receive treatment' has improved significantly. We continue to perform better than the national average.

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

Key Finding	LTHT score 2014	LTHT score 2015	LTHT score 2016	LTHT score 2017	National Average for acute trusts 2017
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	86%	87%	86%	89%	85%

The score for this key finding shows us performing better than the national average.

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

Key Finding	LTHT score 2014	LTHT score 2015	LTHT score 2016	LTHT score 2017	National Average for acute trusts 2017
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	26%	26%	23%	24%	25%

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

Volunteering

Our aim is that volunteer roles in our Trust are truly patient led and are from a wide range of communities. We also aim to provide more opportunities for volunteers in their training and development needs.

Since April 2017, 158 volunteers new have been recruited across the Trust, to both existing and new roles. Some new roles include;

- Hospital Guides - Meet and Greet Volunteers who provide front of house support and signposting for patients around our hospital sites.
- The Children's Hospital - has launched a 'Scouts and Guides' play scheme, as well as a 'Supersibs' volunteer led crèche for siblings of premature babies.
- Model Ward - Acute Surgical wards developed a 'Model Ward', aiming to understand how volunteers can be successfully used in a ward. This will continue in 2018/19.
- Emotional Support and Spiritual Care - in our Emergency Departments, providing friendship, emotional support and signposting to support services where required.
- Peer Support and Activities - Volunteer ambassadors, who have experienced a stroke themselves, provide much needed emotional support to patients on our Acute Stroke Unit.

We hold volunteer focus groups every three months, providing more specialised training than ever before and giving every volunteer at the Trust an opportunity to feedback. We have also held two celebration events this year in June 2017 and a special Christmas event that took place in December 2017.

Volunteering Christmas celebration event

LTHT has signed up to be part of a learning network led by 'Helpforce', a national initiative aimed at harnessing the potential of volunteers to assist the NHS. This national networking opportunity allows the Trust to work in collaboration with other Trusts and continue to build on our successes.

Helpforce & LTHT staff

Nursing Workforce

Nurse Staffing

In 2014 the Trust committed to investing £14 million in additional nursing staff. In 2017/18 we continued to recruit across the registered and unregistered workforce to maximise this investment. The Trust has now embedded the new provider of the LTHT Staff Bank to increase financial efficiency and optimise staffing levels.

Ward staffing establishment reviews have been completed for all CSUs to review staffing requirements and to explore opportunities to modernise the workforce. This includes changing the workforce model to increase senior nursing numbers to attract experienced staff, integrate allied health professionals or to change skill mix to better reflect the range of skills and roles to deliver high quality care.

Recruitment: Registered Staff – Nurses, Midwives and Operating Department Practitioners (ODPs)

In 2017/18, we attended a number of national recruitment fairs and university engagement events across the country. These are now attended in conjunction with our city partners, promoting Leeds as a first class place to pursue a career in nursing and as a place to live. The feedback on this approach has been positive. We attend local recruitment events at Universities and Higher Education Institutes to recruit both qualified staff and apprentices. Internally, a number of CSU or site-specific recruitment campaigns and events have taken place, for example Theatres, the Children's Hospital, and the Acute Medicine CSU.

The Trust continues to work with the local universities and healthcare partners and during 2017/18 over 220 newly qualified staff joined the Trust, alongside 433 Band 5 nursing staff.

Recruitment: Support Staff – Clinical Support Workers, Assistant Practitioners and Nursing Associates.

The Trust has a full range of developmental opportunities for support staff aimed at enhancing career progression and retention.

In 2017/18 over 270 apprentices joined the Trust to commence training to become CSWs via the Trust's apprenticeship initiative, The programme will continue to recruit up to 25 apprentices in each of 10 cohorts into 2018/19.

The Level 3 apprenticeship programme to train Senior CSWs has now been established, with 45 starting the programme in 2017/18. A further 75 places will be available for 2018/19.

The Assistant Practitioner Training Foundation Degree Programme, continues, and is now provided as an apprenticeship. The programme is being adapted to include modules on therapy skills to enhance the transferability of the role.

The Trust, as part of a West Yorkshire Pilot Partnership across Leeds, Bradford and Airedale, is a pilot site for the training of Nursing Associates. This new role will bridge the gap between registered and unregistered nursing staff, with responsibility for all elements of care. The trainees work towards a Foundation Degree and access placements across the whole health economy. Further programmes are being planned for 2018/19.

Recruitment: Advanced Practice

In 2017/18, Health Education Yorkshire & Humber funded 27 advanced practice trainees and continued to support academic programmes for advanced practice. The number of trainees and completed practitioners in the Trust is now over 80, with interest for widespread development of the role across the CSUs.

Temporary Staff

Bank and agency staff continue to provide an essential component of the workforce. In 2017/18 the Trust has worked to recruit to the LTHT Staff Bank, to reduce reliance on agencies. The Trust has seen a reduction in agency spend and a consistent increase in the bank supply. In 2018/19 the Trust aims to further increase temporary shift fill and reduce the agency spend through closer agency management.

Guardians of Safe Working

The Trust's Guardians of Safe Working are responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. Their role is:

- To address concerns relating to hours worked.
- To support safe care for patients by ensuring doctors do not work excessive hours.
- To use powers to impose financial penalties when safe working hours are breached.

The 2016 TCS requires trainees who work over and above their contracted hours, or are unable to take adequate rest, or attend education or training to complete an exception report, which are reviewed by the Guardians every morning. All trainees have now transitioned to the 2016 TCS and the Trust has received 910 exception reports from 191 trainees, dating from 01 April 2017 to 31 March 2018.

Late finishes are the most common type of exception report, accounting for 63% of reports to date (see pie chart below).

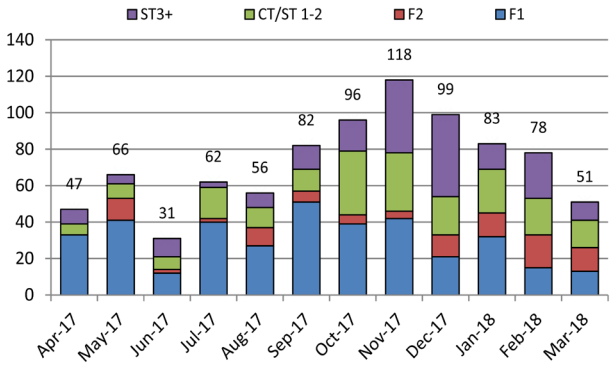
Trust Board and Research, Education, and Training (RET) Committee reports over the last 12 months focused on:

- Exception reporting being currently at 12% of trainees. Approximately 40% are dealt with by Educational supervisors.
- The effect of rota gaps on trainees working hours, leading to late finishes and inability to take breaks.
- The interdependence of different rotas in terms of the workforce available each day.
- How the quality of handover and the presence of a senior doctor can improve the ability of trainees to prioritise their workload.
- With the current number of doctors available in many specialties, there is little capacity for covering sick leave.
- In some specialties, work schedules do not reflect the actual hours worked by the junior doctor, and early work schedule reviews have been required.
- Qualitative information from exception reports indicate that a trust wide review of how ward rounds are conducted could be beneficial.
- In the last 6 months we have had specific challenges in Neurosurgery. Neurosurgery trainees transitioned to the 2016 TCS in October 2017 and make up 38% of exception reports from 01 October 2017 to 31 January 2018, logging 274 hours in excess of their contracted hours.

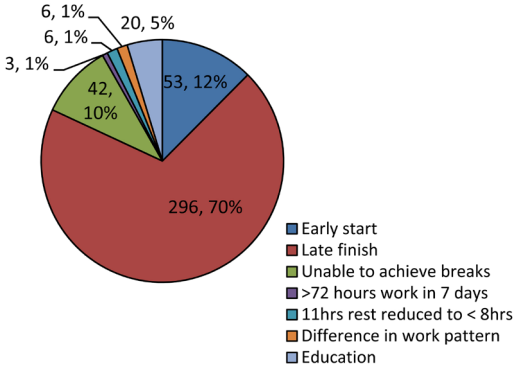
All exception reports are sent to the appropriate senior managers in each CSU on a monthly basis. On an individual basis we have engaged with junior doctors and their educational supervisors where particular concerns have been highlighted.

A lot of the information and detail we have received from junior doctors who have exception reported indicates a strong desire in those individuals to improve the system for all junior doctors.

Number of exception reports by month and grade



Exception reports by type



Freedom to Speak Up

Since October 2013 the Trust has taken a number of actions to review and strengthen whistleblowing arrangements, including strengthening the previous Whistleblowing Policy, now called the Freedom to Speak Up Policy.

In October 2016 LTHT appointed Joe Cohen and Julia Roper as Trust Freedom to Speak Up Guardians. Our new policy, and Freedom to Speak Up Guardians (FTSUGs) were formally launched by the Chief Executive in June 2017.

Freedom to Speak Up Guardians, Julia Roper and Joe Cohen

We currently also have 19 specially trained Freedom to Speak Up Leads in the Trust (renamed from the previous whistleblowing leads) who are available to listen to concerns raised by staff, and ensure appropriate action is taken. The Trust Guardians are also responsible for providing assurance to the Board and embedding an open and transparent culture. We also have a Non-Executive Director with responsibility and oversight for Raising Concerns.

During the period April 2017 to March 2018 a total of 22 concerns were raised centrally in the organisation compared with 19 in the previous 12 months.

Broad themes covered by Freedom to Speak Up concerns

Theme	Number 2016/17	Number 2017/18
Behaviour/relationship	9	10
Process	4	1
Patient Safety / Quality	3	8
Leadership	2	0
Other	1	3

Please note - the activity as detailed above reflects only cases reported centrally. Concerns raised with local managers are not logged centrally.

All concerns have been followed up and feedback is provided to the individual staff members. Of the concerns raised in 2017/18, 9 remain open, with investigations/action in progress.

Some concerns are followed up through the appropriate HR process e.g. grievance or bullying and harassment.

4.3.6 Integrated Care Improvement Programme

Building on the work started as part of the Integrated Care Improvement Programme led by the Leeds Institute for Quality Healthcare (LIQH), the Trust's priorities in 2016/17 were on two pathways linked to CQUINS, in collaboration with Leeds Community Healthcare;

Respiratory Pathway CQUIN

We successfully achieved all elements of the Respiratory Improved Care Pathway CQUIN in 2016/17. This project built upon previous work by the key stakeholders supporting people with respiratory conditions in Leeds. A comprehensive review was undertaken and a plan produced, underpinned by the NICE Quality Standards for Chronic Obstructive Pulmonary Disease and Asthma, to optimise respiratory care in the city

The Integrated COPD Service focused on improving key points in the patient pathway which traditionally reflect a 'handover' of care between LTHT and LCC. A single electronic referral form and triage matrix was developed to streamline the pathway for patients into the COPD service. This is accessible across the hospital and community networks and sits alongside established patient information systems. The roll out was supported by training and support for staff , and patient information about the service.

Staff from LTHT Acute Medicine and Respiratory Services worked with Community Respiratory colleagues to review the processes around discharge from hospital to ensure comprehensive and timely information is available to support seamless care after a hospital admission.

Cardiology Pathway CQUIN

We successfully achieved all elements of the Cardiology Improved Care Pathway CQUIN in 2016/17. Informed by the relevant NICE guidance, a comprehensive review of Acute Coronary Syndrome pathways including post treatment rehabilitation and medication titration was completed. The project also brought into being the first ever integrated review and plan for Heart Failure care across Leeds.

This work has enabled more patients to access cardiac rehabilitation across the Trust and promoted mental wellbeing as a key consideration during heart attack rehabilitation. The introduction of an innovative Consultant Pharmacist led medicines optimisation clinic has ensured more patients receive the maximum benefit from their prescribed medications, take fewer medications overall, and gain a greater understanding of their treatments

The hospital and community Heart Failure teams have set up the first ever Heart Failure MDT involving a truly multidisciplinary team. The MDT serves as a point of referral and a forum to allow supportive appropriate decision making in complex patients. The hospital Heart Failure team now provide a more informative service for GPs and Primary care through 'Advice and Guidance', alongside a virtual, Consultant Cardiologist led,clinic, to support Community Cardiac Nurses reviewing increasingly complex patients.

In addition the project has expanded the capability of the community IV diuretic service to include those patients eligible for early discharge whilst on IV diuretics reducing the time spent in hospital for these patients.

4.3.7 Performance Against National Priority Indicators

The Trust's performance against the national priority indicators is summarised in Appendix E.

4.4 Statements of Assurance from the Trust Board

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

4.4.1 Review of Services

During 2017/18 the Leeds Teaching Hospitals NHS Trust provided NHS services across 120 specialist areas, known as "Treatment Functions", and/or sub-contracted NHS services to a core population of around 780,000, and provided specialist services for 5.3 million people.

The income generated by the NHS services reviewed in 2017/18 represents all of the total income generated from the provision of NHS services by the Leeds Teaching Hospitals NHS Trust for this period.

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

4.4.2 Participation in Clinical Audit

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

The Department of Health recommended 81 specific national audits that all hospitals in England should contribute data to, if relevant to the services they provide. The Trust contributed data to 97% (74) of the recommended national clinical audits and 100% (5) of the confidential enquiries that it was eligible to participate in.

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

The Trust did not participate in the Inflammatory Bowel Disease (IBD) audit, the COPD audit, or the National Cardiac Rehabilitation Audit, for the following reasons:

- The Trust has been working to develop its IT system by linking with clinical colleagues to improve data capture and support quality improvement for IBD. Due to a number of technical delays associated with functionality it has not been possible to submit data to the IBD Registry for 2017/18.
- Throughout 2017/18 the Trust has been transitioning its processes and technology for the accurate data capture and quality improvement of COPD. Due to a number of delays associated with the complexity of the work, it has not been possible to submit data for the 2017/18 period. The Trust will be participating 2018/19. Cardiac Rehab have not participated - statement as follows:
- The National Cardiac Rehabilitation Audit requires a unified approach between LTHT and Community Cardiac Rehabilitation

The reports of 33 national clinical audits, and 416 local clinical audits, were reviewed by the Trust in 2017/18. Examples of actions arising from this work that the Trust has implemented or intends to implement to further improve the quality of care are provided on the following pages.

Enhanced Care Audit

Enhanced care is fundamental in ensuring that patients receive the care best suited to their needs, and that it is provided by the best person to ensure safe and effective care. Risk assessments enable staff caring for patients to identify the level of care each patient requires. Two audits were carried out in 2017/18 across LTHT to ensure enhanced care was being utilised appropriately. The results showed that the enhanced care documentation was being used well. The results also highlighted an area that required focus was sign off of extra staff where risk assessments indicated additional support was needed. Sign off of extra staff by Matrons or Heads of Nursing is important as it allows staffing levels to be maintained across other clinical areas. Additional guidance was provided to Matrons and Heads of Nursing in light of these results, and further audits are planned for 2018/19.

National Vascular Registry

The National Vascular Registry 2017 Annual Report (published in November 2017) looked at the care provided to, and clinical outcomes of, patients undergoing major vascular interventions. The report allowed Trusts to compare their performance across these interventions. The results showed that patients with carotid disease had a relatively short waiting time between vascular assessment and surgery in LTHT, and that mortality for patients undergoing vascular surgery was within the expected range. The results also showed that the length of treatment pathways for vascular conditions was a concern nationally, and that LTHT waits were generally within the centre of the national distribution, being neither poor nor exemplary. In order to shorten waits for surgery, LTHT's Vascular Service is streamlining outpatient investigation pathways, increasing vascular specialist nurse capacity, and introducing "hot clinics" for rapid investigation of urgent patients. These clinics will have the additional benefit of avoiding unnecessary admissions.

Charcot Arthropathy Offloading Audit

Diabetes can involve complications that lead to patients being susceptible to problems with their feet and lower limbs. LTHT's Diabetic Limb Salvage Service (DLSS) runs a clinic that treats high risk diabetic patients who have ulcerations, or acute Charcot arthropathy. In August 2015, NICE published guidance on the prevention and management of diabetic foot problems. It recommended that if acute Charcot arthopathy is suspected, treatment should be offered with a non-removable offloading device; if a patient's circumstances mean a non-removable device is not advisable, a removable offloading device should be considered. The DLSS aims to provide treatment in line with NICE's recommendations within two weeks of patients being referred. An audit was carried out on all patients seen in 2017 to ensure the NICE guidance and local standards were being met, and the findings showed that all patients with suspected acute Charcot arthropathy were treated within two weeks with an appropriate non-removable or removable offloading device.

Re-Audit of Paediatric Cardiology Discharge Letters

Discharge letters form a vital part of effective and safe sharing of information with healthcare professionals continuing to care for patients after they are discharged from LTHT. An audit of discharge letters from Paediatric Cardiology was carried out at the end of 2016. The findings showed that 36% of patients had a discharge letter, that on average it took six days for the discharge letter to be completed, and that 61% of letters were sent to all the relevant healthcare professionals. To improve these results, a new discharge letter pathway was introduced to Paediatric Cardiology in June 2017. A re-audit between September and November 2017 showed that discharge letters were completed for 85% of patients, and that 72% of the letters were sent to all the relevant healthcare professionals. It was also noted that letters were taking slightly longer to be produced under the new pathway. Alterations to the pathway were therefore agreed to improve the results, and a further re-audit is planned in April 2018.

4.4.3 Information Governance and Data Quality

Statement on relevance of Information Quality and actions to improve

Information Governance is a framework for handling information in a confidential and secure manner.

The Trust ensures that it holds accurate, reliable, and complete information about the care and treatment provided to patients. Clear processes and procedures need to be in place to give assurance that information is of the highest quality. High quality information is important for the following reasons:

- It helps staff provide the best possible care and advice to patients based on accurate, up-to-date and comprehensive information.
- It ensures efficient service delivery, performance management and the planning of future services.
- It ensures the quality and effectiveness of clinical services are accurately reflected.
- It ensures the Trust is fairly paid for the services we provide and care we deliver.

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2017/18.

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

NHS Number and General Medical Practice Code Validity

We continue to use the national data quality dashboard tool to support a review of the accuracy and quality of data submitted, and benchmark against the rest of the NHS. As with previous years, we submitted records during 2017/18 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 2017 to March 2018 which included a valid NHS number can be seen in the table below.

Percentage of records in the published SUS Data Quality Dashboard which included a valid NHS number

Type of care in the NHS	% of records	% above the national average
Admitted patient	99.8%	0.4%
Outpatient	99.9%	0.4%
Accident and emergency	95.8%	-1.3%

The percentage of records in the published SUS Data Quality Dashboard for the period April 2017 to March 2018, which included a valid General Medical Practice Code can be seen in the table below:

Percentage of records in the published SUS Data Quality Dashboard which included a valid General Medical Practice Code

Type of care in the NHS	% of records	% above the national average
Admitted patient	100%	0.1%
Outpatient	99.9%	0.1%
Accident and emergency	99.8%	0.5%

Clinical Coding

It is the responsibility of the Clinical Coding team to ensure that the clinical information recorded for our patients is complete, accurate and reflective of the care and treatment. High quality Clinical Coding is important for the management of our clinical services and the recovery correct reimbursement of income for the care we deliver.

The Trust has a continuous programme of audit and training in place to ensure high standards of Clinical Coding are delivered. The programme involves audits by CSU to ensure a general overview of all areas.

In line with the IG Toolkit, a 200 FCE (Finished Consultant Episode) Clinical Coding audit was undertaken. This was a general audit of 19 specialties.

Clinical Coding Audit Findings

Overall percentage of correct coding:

	Total from episodes audited	Total correct	% correct
Primary diagnosis	200	182	91.0%
Secondary diagnosis	1250	1164	93.1%
Primary procedure	90	81	90.0%
Secondary procedure	230	220	95.7%
Overall	**1770**	**1647**	**93.1%**
HRG derived (episode level)	200	168	84.0%

In order to achieve Level 2 accreditation for the IG Toolkit, coding accuracy needs to be 90% on primary diagnosis and primary procedures, and 85% on secondary diagnosis and procedures.

Recommendations from this audit include:

- The Trust is reviewing its internal clinical coding training capacity, and the overall resources in the coding department.

Timeliness of accurately coded data in LTHT 2014-2018

	Jan 2014	Jan 2015	Jan 2016	Jan 2017	Jan 2018
Month End	76.2 %	86.95%	94.9%	96.2%	98.1%
5th Working day (after month end)	89.3%	98.6%	97.6%	98.89%	100%
Payment by Results Flex Date	95.5%	100%	98.7%	99.96%	100%
Payment by Results Freeze Date	100%	100%	100%	100%	100%

The timeliness of accurately coded data is of particular importance to the Trust in terms of income recovery via the National Payment by Results (PbR) process. There is sustained improvement in the timeliness of the coded information.

Information Governance (IG) Toolkit

The Information Governance (IG) toolkit is an annual self-assessment audit that the Trust is required to complete to ensure that the necessary safeguards are in place for managing patient and personal information.

A scoring system ranks a Trust from level 0 to 3, with 0 being the lowest score. Leeds Teaching Hospitals NHS Trust is required to achieve a minimum standard of level 2 against all 45 standards, which we achieved. Initiatives included within the measured areas include:

- Information Governance Management
- Confidentiality & Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance.

The IG toolkit is self-assessed by the organisation and, in 2017/18 the Trust maintained its overall level 2 rating. This demonstrates to patients and service users that the Trust has robust controls in place to ensure the security of patient and staff information.

IG Toolkit Final Ratings

Assessment	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Grade
Version 14.1 (2017-2018)	0	0	27	18	45	80%	Satisfactory
Version 14 (2016-2017)	0	0	29	16	45	78%	Satisfactory
Version 13 (2015-2016)	0	0	24	21	45	82%	Satisfactory
Version 12 (2014-2015)	0	0	25	20	45	81%	Satisfactory
Version 11 (2013-2014)	0	0	23	22	45	82%	Satisfactory

4.4.4 Goals agreed with Commissioners (CQUINS)

2017/19 CQUIN

Quarter Requirements	Q1 Signed off Performance	Q2 Signed off Performance	Q3 Signed off Performance	Q4 Signed off Performance
National				
Improving Staff Health & Wellbeing **1a. Staff Survey** Target: Achieve a 5% point improvement in two of the three NHS annual staff questions.	Not applicable			Achieved required improvement on 1 of 3 questions
Improving Staff Health & Wellbeing **1b. Healthy food for NHS staff, visitors and patients** Target: Maintain 4 changes from 2016/17 & Introduce 3 new changes 2017/18 (re sugar content)	Not applicable			
Improving Staff Health & Wellbeing **1c. Improving the uptake of flu vaccinations** Target > 70%	Not applicable			Achieved 80.3%
Reducing the impact of serious infections **2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings** Target > 90%	82%	90%	91%	92%
Reducing the impact of serious infections **2b. Timely treatment of sepsis in emergency departments and acute inpatient settings** Target > 90%	61%	**72%**	**74%**	**77%**
Reducing the impact of serious infections **2c. Assessment of clinical antibiotic review between 24-72 hrs of patients with sepsis who are still inpatients at 72 hrs** Targets are: Q1 > 25%, Q2 > 50%, Q3 > 75%, Q4 > 90%	82%	90%	94%	98%
Reducing the impact of serious infections **2d. Reduction in antibiotic consumption per 1,000 admissions** Target 2% reduction for each category	Total = 0% Carbapenem = -5% Pip-Tazo = -72%	Total = -1% Carbapenem = 0% Pip-Tazo = -65%	Total = 3.4% Carbapenem = 13% Pip-Tazo = -49%	Total = 4% Carbapenem = 15% Pip-Tazo = -43%
3. Improving services for people with mental health needs who present to A&E (Joint CQUIN with LYPFT and other partners, primary care, police, ambulance, substance misuse etc) Target 20% reduction in attendances at A&E for specified cohort of patients	Joint report approved	Joint report approved	Joint report approved	Achieved 31% reduction in attendances for cohort
4. Offering Advice & Guidance Providers to have A&G services for non-urgent GP referrals, allowing GPs to access Consultant advice prior to referring patients to secondary care. Target A&G operational for 35% of total GP referrals by 1 Jan 2018	Approved	Approved	Approved	
5. NHS e-Referrals (1 year CQUIN - 2017/18) GP referrals to consultant led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service Target All 1st OP appointment slots to be available on NHS e-Referrals by 31 Mar 2018	Approved	Approved	Approved	

6. Supporting Proactive and Safe Discharge Part a) Increasing % patients admitted via non-elective route discharged to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3/Q4 16/17) OR an increase to 47.5% across Q3 & Q4 17/18	Not applicable	Joint report approved	Not applicable	Achieved 47.6%
6. Supporting Proactive and Safe Discharge Part b) Implement new Emergency Care Dataset (ECDS) on 1 October 2017	Approved	Not applicable	Position statement submitted outlining mitigating factors	Not applicable
7. Risky behaviours Alcohol & Tobacco (1 year CQUIN 2018/19)	Not applicable in 2017/18			
NHS England Spec Comm				
Hepatitis C: Trigger B1 - ODN MDT decisions aligned to NHS England published run-rate Target: 789 treatment initiations as at Oct 2017; (previously 849)	Trigger B1, B2 & B3 Assessed bi-annually	Apr-Sept Target = 411 Actual = 335		Oct-Mar Target = 378 Actual = 247
Hepatitis C: Trigger B2 - ODN Treatment cost per patient relative to lowest acquisition cost				
Hepatitis C: Trigger B3 - ODN Prioritisation of patients with highest clinical need. Includes setting up data flows from labs and reporting on the % of those offered an assessment within 3 months				
Hepatitis C: Trigger B4 - ODN Effectiveness in sustaining benefits of treatment, including signed agreement with partners on opt-out testing (months 7-12) Target: 85% of patients followed up 12 months post treatment	Trigger B4 Assessed at year-end	Not applicable	Not applicable	
Hepatitis C: Trigger B5 - Completeness and Data Quality in the ODN 'registry' Target: 85% completion of data on registry	To be assessed on 22 Dec	Not applicable	Achieved requirements	
Hepatitis C: Governance & Partnership working	Approved	Report submitted	Report submitted	
BI4 Improving Haemoglobinopathy Pathways through ODN Networks	Approved	Approved	Approved	
TR3 Spinal Surgery: Networks, Data, MDT Oversight	Approved	Approved	Approved	
IM3 Auto-immune Management	Approved	Approved	Approved	
WC3 CAMHS Screening	Value of CQUIN is less than resource required to deliver it			CQUIN income foregone
GE3: Medicines Optimisation	Approved	Approved		
CA2 Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)	Approved	Approved	Approved	
WC4 Paediatric Networked Care	Approved	Not applicable	Approved	
IM2 Cystic Fibrosis Patient Adherence (Adult)	Value of CQUIN is less than resource required to deliver it			CQUIN income foregone
Local QIPP Incentivisation scheme	Approved	Approved	Approved	

Not achieved
Partial achievement
Local assessment - partial achievement to be signed off
Local assessment - achieved to be signed off
Achieved

2.5% contract income was allocated to the CQUIN scheme in 2017/18; payment agreed with commissioners following quarterly submission.

4.5 Participation in Clinical Research

The Trust has an ambitious strategy for research and innovation, aimed at harnessing the significant advances in clinical science for the benefit of Trust patients by improving access to world-leading research studies.

In 2017 we opened the new Research and Innovation Centre on the St. James's University Hospital Campus which brings together the core Research and Innovation team together with a number of the Trust's other core research functions under one roof.

Research and Innovation Centre

One of our strategic goals is to ensure that all our specialist services are research-intensive. Working in partnership with the University, the Trust has strengthened its research programmes, with a number of key national programmes being re-funded, and it has also managed to win funding for participation in a number of new national initiatives.

The **NIHR Leeds Clinical Research Facility** received a significant uplift in its funding from NIHR for the next 5 year period and continues its impressive trajectory of work. The Leeds Clinical Research Facility is amongst the top 5 performing NIHR Clinical Research Facilities nationally (of 18 CRF's) in almost all metrics assessed. The Facility conducts early phase research with leading-edge medicines and technologies across a range of diseases, with cancer particularly prominent.

Taking over from the NIHR Leeds Diagnostic Evidence Co-operative, the **NIHR Leeds In Vitro Diagnostic Co-operative** started in January 2018. Its focus is on supporting the development of In Vitro Diagnostics across Cancer, Infectious Disease, Musculoskeletal Disease and Renal Medicine, with a particular focus on supporting the development of clinical and economic evidence to help accelerate the deployment of technologies into NHS practice.

The **NIHR Surgical MedTech Co-operative** succeeds the NIHR Colorectal Therapies Health Technology Co-operative, focusing on the development of medical devices for use in Colorectal, Vascular and Hepatopancreatobilliary (HPB) surgery. It works with patients and clinicians to identify unmet needs in surgery, bringing them together with technical partners from engineering, nanotechnology and biotechnology backgrounds to develop and evaluate solutions to the challenges.

Leeds was awarded funding for the **NIHR Leeds Bioresource Centre** in December 2017. Part of a national network, the Bioresource centre aims to create a national register of patients (particularly those with "rare diseases") who can be recalled for participation in future clinical trials. This will give patients at the Trust an opportunity to participate in more trials in the future.

The **Innovate UK Northern Alliance Advanced Therapies Treatment Centre** is a consortium which includes 6 NHS bodies across the North of England and Scotland and 11 private sector companies from across the UK. The purpose of the centre is to increase the number and scale of Advanced Therapy (cell and gene therapies) trials across the UK and to work through some of the challenges which face these therapies becoming routinely commissioned by the NHS in the future. Funding for the centre comes from the Life Sciences Industrial Strategy Challenge Fund, and the centre was one of three funded by Innovate UK across the UK.

Research Performance

The Trust conducts a large number of clinical trials and other research studies across all specialties. This portfolio of studies is kept under active review to ensure a balance between delivering large simple studies and the Trust's leading role in delivering complex studies which involve smaller numbers of patients.

During 2017/18, the Trust was the 2nd highest performing trust in England for recruiting into clinical research projects recognised by the National Institute for Health Research (NIHR). This year we involved 19,179 patients in 451 research studies - the most patients that the Trust has ever involved in studies in a single year.

The Trust also continues to lead the way nationally against NIHR initiation and delivery targets for clinical trials. This demonstrates that we are recruiting patients into trials in a fast and effective manner. During 2017/18 we exceeded both the 70 day initiation target (84.6% - 7th in England) and the recruitment to time and target metric for commercial studies (83.1% - 2nd in England) set by NIHR.

Research and Innovation Ambassadors

Patient Research Ambassadors (PRAs) are Trust volunteers who help R&I ensure the patient experience of participating in research is clear and simple. There are currently 12 PRAs and they are part of the public-facing team for research to help raise awareness of research taking place within research active departments. This means attending outpatient clinics and talking to patients about the studies that are currently open and hosting study specific stands in the main reception areas across the Trust. The PRAs assisted in celebrating International Clinical Trials day on 19 May 2017 by hosting stands alongside research teams in the main reception areas in the Trust to promote the diversity of research taking place in the Trust.

4.6 What Others Say - Engagement with our Regulators 2017/18

4.6.1 Care Quality Commission

We continued to work with partners, including commissioners at NHS England and NHS Leeds CCG and with regulators at NHS Improvement and the Care Quality Commission.

The Leeds Teaching Hospitals NHS Trust was required to register with the Care Quality Commission (CQC) under Section 10 of The Health and Social Care Act 2008 from 1 April 2010.

The Trust is required to be compliant with the fundamental standards of quality and safety. The Trust's current registration status is registered with the CQC without conditions (compliant).

The CQC last undertook a planned inspection in May 2016. This was a follow up visit following the comprehensive inspection that had been undertaken in March 2014. The CQC published their final reports on 27 September 2016, and we were delighted to have been rated as Good.

Key Question		Rating
Safe		Requires Improvement
Effective		Good
Caring		Good
Responsive		Good
Well led		Good

Overall rating		**Good**

An action plan was developed to address the recommendations from the CQC reports.

Progress on implementation of the actions was overseen by NHS Improvement and reported to the Quality Assurance Committee and Trust Board. The plan was also monitored in conjunction with our local CQC Inspection Manager through routine engagement meetings with the Trust, and through routine joint quality meetings with the CCG.

The CQC undertook an unannounced inspection visit at St James's Hospital on 20 December 2017. The focus of their inspection was on the care of patients in non-designated areas, specifically medical and elderly patients in the Emergency and Specialty Medicine (ESM) CSU. This has been a shared concern across the NHS and related directly to the flow of patients across the healthcare system, both locally and nationally. A risk assessment framework has been developed by the corporate nursing team and implemented through CSUs to ensure that patients are assessed before being identified to be cared for in non-designated areas and this is subject to a programme of audit led by the corporate nursing team.

The draft report was received by the trust on 8 May 2018, which included 7 areas for improvement linked to 5 Regulations (Requirement Notices). This has been reviewed and checked for factual accuracy and returned to the CQC. The trust will produce an action plan in response to the recommendations when the final report is published by the CQC. The report will be publicly available on the CQC website. The action plan will be monitored through the Quality Assurance Committee, joint quality meeting with commissioners and engagement meetings with the CQC.

During 2017/18 the Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008.

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; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

27/6/18 ..... Date ..... Chair

27/06/18 ..... Date ..... Chief Executive

Appendix B: Statements from Local Stakeholders

Joint comments from Healthwatch Leeds, and the Overview and Scrutiny Committee for Health, Public Health and Social Care in Leeds

Was the patient, service user, carer and public involvement clear?

Good involvement of patients, service users, carers and the public was clearly demonstrated. It is evident that LTHT are using a variety of approaches including use of friends and family feedback, involving patients in staff triaging and work with Healthwatch. The patient experience sub group is used to demonstrate the outcomes of service user involvement.

Did we understand how the engagement has influenced the priorities and actions in the QA?

We felt that this was very clearly explained with examples of how patient engagement has made a difference. It is clear that LTHT is committed to listening to people and acting on what people say.

Are there plans for accessible versions?

It seems that this is proving to be a challenge, given the size of LTHT. Although they have a new member of staff working on an easy read document it is proving difficult to get range of info into simpler document.

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Thank you for providing the opportunity to feedback on the Quality Account for Leeds Teaching Hospitals NHS Trust for 2017-18. This account has been shared with key individuals across the newly formed Leeds Clinical Commissioning Group (formerly Leeds West CCG, North CCG and South & East CCG) and this response is on behalf of the new organisation.

We acknowledge that the report you provided for review and comment is in draft form and additional information will be added and amendments made before final publication, so please accept our observations on that basis.

The account is presented in an easily readable style with a good mix of real life examples, local improvements with the mandatory national elements. It provides a good representation of the Trust's achievements and its commitment to delivering high quality care.

The Leeds Improvement Method has continued to grow and gather momentum from its development last year. The inclusion of patients, carers and families, facilitation of a co-production methodology and the ethos that everybody is empowered to make improvements is laudable. The number of patients attending 'Making Quality Count' sessions and completing the full QI training is impressive and demonstrates a real commitment to involving patients in quality improvement. The programme is clearly having a positive impact and the evidence presented of successes within the different Value Streams is powerful. We are pleased to see that quality improvement is given such a high profile in the Trust and is at the heart of Trust activity.

We note the continued work in Acute Kidney Injury and Sepsis, and are particularly pleased to hear of the intention to appoint a sepsis nurse to support the ongoing work of the sepsis team. It will be important to see the impact of this over the coming year.

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The work to address the deteriorating patient is admirable and the subsequent 25% reduction in cardiac arrest calls shows the effect of the work done. We are similarly encouraged to see the dedicated approach to reducing in-patient falls is paying off with an impressive 62% reduction in falls resulting in harm.

Safety huddles are crucial to supporting all of the work described above and their introduction is commendable. We hope the measurable improvements in patient safety help to further engage staff and embed the importance of 'huddling' across the organisation. The work by the portering team to introduce safety huddles to support services is excellent and well deserving of the national recognition gained.

The continued drive to reduce avoidable pressure ulcers is welcomed, especially the focus on more prompt investigating and learning and the collaboration with the community trust. We feel the steering group is well set up to support the reduction ambitions for category 3 and 4 pressure ulcers over the next twelve months.

We congratulate the Trust on being shortlisted for an award for excellence in Parkinson's care. The collaboration with patients and carers is admirable and the reduction in delay for patients receiving their first dose of medication achieved is a great success.

The Trust's Maternity work shows a proactive stance being taken with involvement in national initiatives to improve safety. The reduction in stillbirth rate is worthy of note, however it would be useful to also identify progress against the Saving Babies Lives Stillbirth Care Bundle or Each Baby Counts national priorities. We are particularly pleased to see a significant improvement in number of perineal tears by 75%, as this is an area that the Trust had previously seen slow progress.

Healthcare Associated Infection remains a challenging area. It is good to see the collaborative approach to the challenge of the national gram –ve bacteria reduction ambitions whilst continuing work to further reduce MRSA and Clostridium difficile infections.

The Trust's position in relation to national and peer performance for medication related incidents causing harm is very impressive and reassuring, and we look forward to the Trust sustaining this position.

There appear to be a lot of initiatives in improving safeguarding education and the approach to raising and maintaining awareness of safeguarding is commendable.

The approach to sharing learning from serious incidents and complaints is welcomed. The use of Quality and Safety Matters briefings and a staff conference are good examples of investment in collaboration and sharing. It is also good to note the use of a variety of different media to engage staff and support widespread learning. The LIST initiative is

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evidence of a supportive approach to staff involved in incidents. It would be useful to see some evaluation from this including the uptake and what the feedback and experience is from staff who have accessed it.

The Trust demonstrates an open and honest approach to incidents and never events, and it is reassuring to see significant assurance given by the internal audit on the Duty of Candour process.

The account describes a wide range of initiatives to involve and improve the experience of patients which is impressive and shows an inclusive approach to all groups. It demonstrates the importance of engagement to improve services and we are pleased to acknowledge the achievement of the Trust receiving the 'Commitment to Carers' kitemark. It is also notable that nursing students are now undergoing placements with the Patient Experience Team. This is an excellent way of raising the profile of experience and embedding this vital component of care into the perspectives of future clinicians.

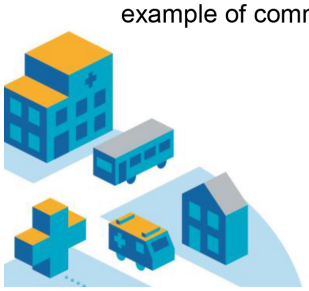
The introduction of two 'Always Events', particularly in improving the night time experience for patients which has traditionally been an issue for many people staying in hospital, is highly commendable and we will be keen to see the progress and impact made.

It is pleasing to hear that fewer complaints are going to the ombudsman and to see the work being done on improving the complaints handling process and experience for complainants. There are also some good examples of PALS queries and how these have been addressed. However, it would have been helpful if the Trust had provided some explanation on why numbers of re-opened complaints have increased despite the improvement work undertaken and whether there are any themes to look at in 2018/19.

It is particularly good to note the introduction of children's and young people's FFT cards and the improvements in response rates overall. We hope that having FFT champions in some areas to raise the profile is beneficial and can be spread to other areas.
The drive for continuous improvement is evident in work to improve in areas where performance is already good compared to peers, namely the work on readmissions.

Trust's performance in the staff Friends and Family Test results show an impressive improvement since 2014 and continues to be above national average performance. This is testament to the Trust's focus on involving, valuing and understanding staff.

The commitment to recruiting staff and developing new roles to support career progression is welcomed. It is unclear whether turnover rates are challenging but recruitment appears to be successful overall. The expansion of the range of volunteer roles is also good to see and the support they provide the Trust and receive is a good example of community engagement.



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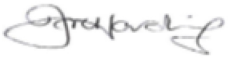
The wellbeing of staff is also an evident priority and we welcome the Guardians of Safe Working initiative which shows a supportive approach and is key to understanding the challenges faced by staff that could lead to disillusionment and burn out. We hope this helps to support the health, wellbeing and retention of staff.

It is encouraging to see the Freedom To Speak Up Guardians in place in the organisation, but it would be useful to understand if any actions have been implemented in response to the increase in concerns raised, particularly those relating to patient safety and quality.

We are supportive of the 2018/19 quality priorities which have a strong focus on key improvements in patient safety, effectiveness and experience. We appreciate the opportunity to review the account and hope that this is accepted as a fair reflection. We commend the Trust on its commitment to working with the CCG in a collaborative and transparent manner, and we look forward to continuing to work in partnership over the coming year.

Yours sincerely,



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Appendix C: Glossary of Terms

Acute Hospital Trust: an NHS organisation responsible for providing healthcare services.
Always Events: aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time.
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.
Birth-rate+: a midwifery workforce planning tool, which allows midwives to assess their "real time" workload in the delivery suite.
Board (of Trust): the role of the Trust's Board is to take corporate responsibility for the organisation's strategies and actions.
Breakthrough Series Improvement Collaborative: a model for achieving improvements in the quality of healthcare.
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 Commissioning Group (CCG): clinically led NHS bodies responsible for the planning and commissioning of health care services for their local area.
Clinical Audit: clinical audit measures the quality of care and services against agreed standards, and suggests or makes improvements where necessary.
Clinical Service Unit/Clinical Support Unit (CSU): the Trust is made up of 19 CSUs, which are groups of specialties that deliver the clinical services the Trust provides.
***Clostridium Difficile* Infection (CDI):** a type of bacteria which causes diarrhoea and abdominal pain, and can be more serious in some patients.
Commissioning for Quality and Innovation (CQUIN) payment framework: a framework which makes a proportion of providers' income conditional on quality and innovation.
Critical Care Step-Down: an intermediate level of care between the Intensive Care Unit (ICU) and general medical-surgical wards.
Datix: patient safety and risk management software for healthcare incident reporting and adverse events.
Department of Health (DoH): a department of the UK Government with responsibility for Government Policy for health, social care and NHS in England.
Dr Foster Hospital Guide: annual national publication from Dr Foster containing data from all NHS Trusts in England & Wales highlighting potential areas of good and poor performance. The Guide's focus changes each year but consistently contains measures of hospital mortality.
e-DAN: an electronic discharge advice note.
eMeds: an electronic system for prescribing and administration of medicines.

e-Obs: a digital method of recording the observations of patients' vital signs.
Employee Assistance Programme: staff advice, information & counselling service able to assist with financial, legal, family and personal issues.
Enhanced care: additional support provided to patients who require an extra level of care to ensure safety.
Friends and Family Test: a national NHS tool allowing patients to provide feedback on the care and treatment they receive and to improve services. It asks patients whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment.
Gram-negative bacteria: a class of bacteria that includes those that can cause, amongst others, pneumonia, bloodstream infections and surgical site infections in healthcare settings. Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics.
HDU: High Dependency Unit; a level of care between intensive care and general wards.
Healthwatch Leeds: Healthwatch is the independent consumer champion that gathers and represents the public's views on health and social care services in England. It ensures that the views of the public and people who use the services are taken into account.
Hospital Standardised Mortality Ratio (HSMR): an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Hospital Episode Statistics (HES): a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.
IHI Model for Improvement: Institute for Healthcare Improvement. Combines with Lean Methodology to form the Leeds Improvement Method.
Information Governance Toolkit: the NHS Information Governance Toolkit ensures necessary safeguards for, and appropriate use of, patient and personal information.
Kaizen Promotion Office (KPO): established to drive the improvement work of the organisation in collaboration with the Virginia Mason Institute.
Lean methodology: a methodology to ensure we provide the highest quality care for patients, whilst reducing inefficiencies and getting the best value for public money.
Leeds Care Record: the Leeds Care Record gives health and social care professionals directly in charge of your care access to the most up-to-date information about you by sharing certain information from your records between health and social care services across Leeds.
Leeds 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 Involving People: an organisation that represents the independent voice of people through the promotion of effective involvement. It involves the community in the development of health and social care services by ensuring their opinions and concerns are at the centre of decision making processes.
MBRRACE: Maternal, Newborn and Infant Clinical Outcome Review Programme. Aims to study to collect data on patient care to inform service improvements in maternity services nationally.
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.
MSSA related infections: infections as a result of methicillin-susceptible S. aureus (bacteria).
National Child Protection Information System (CP-IS): a project to help health and social care staff to share information securely to better protect vulnerable children.
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 maternity Better Births a nationwide initiative to improve outcomes of maternity services in England.
National Payment by Results (PBR): the payment system in England under which commissioners pay healthcare providers for each patient seen or treated.
National Reporting and Learning System (NRLS): enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.
Never Events: serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Patient Advice and Liaison Service (PALs): offers support, advice and information on NHS services to patients, their carers, the general public and hospital staff.
Patient 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.
Perfect Week a national initiative designed by the Emergency Care Intensive Support Team (ECIST) to help improve Patient Flow and Patient Experience.
Perinatal Mortality Review Tool: a data collection tool which aims to support standardised perinatal mortality reviews across NHS maternity and neonatal units.
Rapid Discharge Plan (RDP): a patient-specific plan to facilitate safe, urgent transfer of care for patients expressing a wish to die at home.
RCA process: Root Cause Analysis. A method of problem solving used for identifying the root causes of faults or problems.
RESPECT: A Recommended Summary Plan for Emergency Care and Treatment, that is agreed by a patient and their healthcare professional. It includes recommendations about the care an individual would like to receive in future emergencies if they are unable to make a choice at that time.

Safety Thermometer data collection tool: a local improvement tool for measuring, monitoring and analysing patient harms and harm free care.
Secondary Uses Service: provides anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
Seven Day Hospital Services: the ambition of the initiative is for patients to be able to access hospital services which meet four priority standards every day of the week.
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 'Leeds Way' is the Values of Leeds Teaching Hospitals Trust created by staff. It defines who we are, what we believe and how we will work to deliver the best outcomes for our patients. The Values are Fair, Patient Centred, Collaborative, Accountable and Empowered.
The National Bereavement Care Pathway (NBCP): a project to help professionals support families in their bereavement after any pregnancy or baby loss.
Trust Members: Trust Members have a say in the services the Trust offers and help us understand the needs of our patients, carers and local population, in order to improve our services. Anyone aged 16 years or over living in England or Wales can become a member.
Trust's Youth Forum: designed to allow young people to put across their points of view about the Trust and share their experiences and opinions of hospital in general.
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).
WYAAT: West Yorkshire Association of Acute Trusts.

Appendix D: Trust Participation in NCEPOD and National Audits

Summary tables of participation in NCEPOD Studies and DoH recommended national audits

National Confidential Enquiry	Participation Rate*
Acute Heart Failure	77.9%
Cancer in Children, Teens and Young Adults	100%
Chronic Neurodisability	93%
Young People's Mental Health	75%
Perioperative Diabetes	NYA **

National Audit	Participation Rate*
Adult Cardiac Surgery	100% ***
Bowel Cancer (NBOCAP)	99%
Cardiac Rhythm Management	100% ***
Case Mix Programme	100%
Congenital Heart Disease (Paediatric Cardiac Surgery	100%
Cystectomy Audit	98%
Endocrine and Thyroid National Audit	NYA
Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database	93.6%
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Inpatient Falls	100%
Fractured Neck of Femur	93%
Female Stress Urinary Incontinence	19%
Head and Neck Oncology Audit	NYA
Inflammatory Bowel Disease (IBD) Registry Biologics Audit	Non-Participation 17/18
Learning Disability Mortality Review Programme	NYA
Major Trauma: The Trauma Audit & Research Network (TARN)	94%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	100%
Myocardial Ischaemia National Audit Project	100% ***

National Audit of Breast Cancer in Older Patients	NYA
National Audit of Care at the End of Life (NACEL)	100%
National Audit of Dementia: Spotlight Audit on Delirium	NYA
National Bariatric Surgery Registry (NBSR)	NYA
National Cardiac Arrest Audit (NCAA)	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Non-Participation 17/18
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	100%
National Comparative Audit of Blood Transfusion Programme: Transfusion Associated Circulatory Overload Audit	100%
National Comparative Audit of Blood Transfusion Programme: Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	100%
National Comparative Audit of Blood Transfusion Programme: Audit of O Negative Red Cells	**
National Diabetes Core Audit	100%
National Diabetes Foot Care Audit	Participated Denominator unknown
National Diabetes Inpatient Audit	100%
National Diabetes Transition Audit	100%
National Emergency Laparotomy Audit	99%
National Heart Failure Audit	NYA
National Joint Registry (NJR)	95% ***
National Lung Cancer Audit (NLCA)	NYA
National Maternal and Perinatal Audit (NMPA)	98%
National Neonatal Audit Programme (NNAP)	100%
National Ophthalmology Audit	100% (HES data)
National Paediatric Diabetes Audit (NPDA)	100%
National Pregnancy in Diabetes Audit	100%
National Prostate Cancer Audit	NYA

National Vascular Registry	96% ***
Nephrectomy Audit	111%
Neurosurgical National Audit Programme	100% (HES data)
Oesophago-gastric Cancer (NAOGC)	NYA
Paediatric Intensive Care (PICANet)	100%
Pain in Children	100%
Patient Reported Outcomes Measures - Hernia	No longer mandated
Patient Reported Outcomes Measures - Hip replacements	92.8%
Patient Reported Outcomes Measures - Knee Replacements	98.2%
Patient Reported Outcomes Measures - Varicose veins	No longer mandated
Percutaneous Coronary Intervention (PCI)	100%***
Percutaneous Nephrolithotomy	54%***
Procedural Sedation in Adults (Care in Emergency Departments)	100%
Radical Prostatectomy Audit	96%
Sentinel Stroke National Audit Programme (SSNAP)	95%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	NYA
UK Parkinson's Audit	100%
Urethroplasty Audit	104%

* Participation rate is calculated as the number of patients for whom data have been submitted as a proportion of the number for whom data should have been submitted.

** Study currently taking place; participation rate not available.

*** Participation Rate estimated. Based on internal calculations in the absence of data not yet published nationally

NYA Not Yet Available. Estimates not submitted, comparative data not available internally.

Summary table of participation in other national audits

National Audit	Participation Rate*
Adult Bronchiectasis	NYA
Breast and Cosmetic Implant Registry (BCIR)	63%
Bronchoscopy	NYA
Falls and Fragility Fractures Audit Programme (FFFAP): Physiotherapy Hip Fracture Sprint Audit	Participated Denominator unknown
Female Genital Mutilation	Participated Denominator unknown
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Participated Denominator unknown
National 2017 Survey and Audit of Psychological Wellbeing and Support and Use of Alcohol and Other Drugs	NYA
National Audit of Cardiac Rehabilitation	NYA
National Audit of Small Bowel Obstruction	NYA
National Psoriasis Re-audit	100%
Paediatric Bronchiectasis	100%
Perioperative Quality Improvement Programme	NYA
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Antibiotic Consumption	NYA
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Antimicrobial Stewardship	NYA
Seven Day Hospital Services Self-Assessment Survey	Participated Denominator Unknown
Society for Acute Medicine's Benchmarking Audit (SAMBA)	NYA
Surgical Site Infection Surveillance Service	Participated Denominator Unknown
UK Cystic Fibrosis Registry	100%
UK Renal Registry	100%

Appendix E: CQUINS 2017-19

National CQUINS

1. Improving Staff Health and Wellbeing	1a. Improving staff health and wellbeing - Staff Survey
	1b. Healthy food for NHS staff, visitors and patients
	1c. Improving the uptake of flu vaccinations
2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis	2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings
	2b. Timely treatment of sepsis in emergency departments and acute inpatient settings
	2c. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours
	2d. Reduction in antibiotic consumption (per 1,000 admissions)
3. Improve services - mental health needs who present to A&E	3. Improving services - people with mental health needs presenting to A&E
4. Offering advice and guidance	4. Advice and guidance (NHSE to provide guide to support scheme)
5. NHS e-Referrals	5. NHS e-Referrals (1 year CQUIN - 2017/18)
6. Supporting proactive and safe discharge	6. Supporting proactive and safe discharge
7. Risky behaviours, alcohol and tobacco (1 year CQUIN 2018/19)	Tobacco screening, brief advice, referral and medication offer Alcohol screening, brief advice or referral

NHS England Specialist Commissioning CQUINS

BI1 Improving HCV Treatment Pathways through ODNs	Providers participation in ODN & HCV patient access to treatment to accord with ODN guidelines
BI4 Improving Haemoglobinopathy Pathways through ODN Networks	Improve access by developing ODN and ensuring compliance with guidelines
TR3 Spinal Surgery: Networks, Data, MDT oversight	Setting up regional MDT; entering data into British Spinal Registry or Spine Tango: no surgery without MDT sanction
IM3 Auto-immune Management	Review specialised patient cases across Networks by MDTs, with data flowing to registries
WC3 CAMHS Screening	SDQ screening for paed inpatients with listed LTCs
GE3 Medicines Optimisation	To support procedural and cultural changes required fully to optimise use of medicines commissioned by specialist services
CA2 Nationally Standardised Dose Banding for Adult Intravenous Anticancer Therapy (SACT)	Standardisation of chemotherapy doses through a nationally consistent approach
WC4 Paediatric Networked Care	This scheme aims to align to the national PIC service review
IM2 Cystic Fibrosis Patient Adherence (Adult)	Improved adherence and self-management by patients etc
Local QIPP Incentivisation Scheme	Engagement with NHSE local QIPP proposals and delivery of agreed savings

Appendix F: Performance against National Priority Indicators

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Section A - National Operational Standards													
RTT Incomplete	>=92	87.87	88.72	88.72	89.00	88.53	88.28	88.64	89.29	88.68	88.37	88.51	87.66
RTT Failing Specialties: Incomplete	=0	8	7	7	7	8	7	7	6	7	7	7	7
A&E Performance	>=95	91.72	88.29	91.80	87.69	87.71	86.73	85.76	81.74	74.69	72.19	71.64	70.87
Diagnostic Waits	>=99	99.57	99.76	99.75	99.77	99.77	99.85	99.86	99.82	99.34	97.90	99.82	99.72
Cancelled Ops: Not rebooked within 28 days	=0	24	15	15	19	19	19	7	17	44	59	39	32
Cancer: 62 Day: GP/Dentist Referrals	>=85	72.8	78.5	77.1	78.9	83.4	74.9	75.2	75.0	76.7	83.5	78.9	82.60
Cancer: 62 Day: Screening	>=90	90.9	93.8	93.4	95.0	91.5	89.8	78.6	80.8	95.0	93.3	86.1	93.60
Cancer: 31 Day: 1st Treatment	>=96	96.4	97.9	96.4	96.3	97.8	96.2	96.4	97.3	96.0	96.3	98.4	97.30
Cancer: 31 Day: Subsequent Surgery	>=94	94.5	99.3	98.0	95.7	96.6	95.0	95.3	94.1	94.2	95.1	98.0	97.40
Cancer: 31 Day: Subsequent Drug	>=98	100.0	100.0	100.0	100.0	100.0	99.6	100.0	100.0	100.0	100.0	100.0	100.00
Cancer: 31 Day: Sub Radiotherapy	>=94	100.0	100.0	100.0	100.0	100.0	100.0	99.8	100.0	100.0	100.0	100.0	98.60
Cancer: 14 Day: Urgent GP Referrals	>=93	93.4	96.4	95.2	95.3	94.6	95.6	94.7	96.1	94.7	91.9	94.4	89.10
Cancer: 14 Day: Breast Symptoms	>=93	93.3	95.3	96.4	97.1	95.3	96.7	94.1	95.1	93.2	95.6	93.6	86.20
Mixed Sex Accommodation Breaches	=0	0	0	0	0	0	0	0	0	0	0	0	0
Section B - National Quality Contract Requirements													
HCAI: MRSA	=0	1	1	2	0	0	0	0	1	0	0	1	0
HCAI: CDiff	<=118	9	9	9	13	12	6	17	11	6	7	16	9
VTE Risk Assessment	>=95	92.2	94.1	94.1	94.9	94.3	94.2	91.9	91.1	93.8	92.0	91.7	90.9
VTE RCA Completion Rate	=100	100.0	100.0	100.0	100.0	100.0	95.8	100.0	97.3	100.0	92.1		
RTT Incomplete 52+ Week Waiters	=0	0	0	0	2	2	1	0	1	4	22	45	76
Cancelled Ops: Urgent Cancels 2nd/Sub	=0	0	0	0	0	0	0	0	0	0	0	0	0
Ambulance Handovers: 30 - 60 mins	=0	63	71	59	23	18	24	60	38	106	124	75	99
Ambulance Handovers: Over 60 mins	=0	2	6	2	2	0	1	4	0	1	6	3	2
A&E 12 Hour Trolley Waits	=0	0	0	0	0	0	0	0	0	0	0	0	0
Friends and Family Test: Response Rate - Inpatients	-	34.35	37.30	43.85	42.84	38.34	40.58	36.71	35.89	32.66	32.16	36.07	27.93
Friends and Family Test: Response Rate - A&E	-	24.39	22.89	23.92	22.52	20.53	17.42	15.59	22.00	22.05	21.19	29.22	22.09
eDAN: Completed	-	90.97	90.19	90.50	89.60	90.70	90.90	91.15	92.28	91.21	91.24	92.46	90.55
eDAN: Sent to GP within 24 hrs	>=90	86.5	85.1	86.5	86.0	87.2	87.1	87.7	89.3	87.6	88.3	89.1	87.3
Complaints: Total	-	44	63	77	81	59	47	64	49	54	65	66	66
Complaints: % Responded to within target time	-	27.42	24.68	31.40	36.36	31.07	22.95	26.09	29.07	25.35	33.80	39.06	38.24

Section C - NHSE Quality and Contract Requirements													
Serious Incidents (SUIs)	-	5	7	6	7	6	3	7	10	13	4	8	9
HCAI: MSSA	<=59	6	7	7	5	11	4	7	9	2	8	7	9
Gynae Cytology 14 Day TATs	>=98%	49.42	72.84	98.40	93.41	95.82	98.57	99.54	99.15	99.11	43.71	0.15	0.15
Harm Free Care	>=95%	95.15	94.72	94.40	95.06	95.35	95.49	96.35	96.27	94.64	94.90	94.97	94.27
Readmissions to PICU Within 48 Hours	<1	0.00	0.00	0.01	0.00	0.00	0.00	0.01	0.01	0.00	0.00	0.00	0.00
Section D - Local Quality and Contract Requirements													
Cancer: 62 Day: Consultant Upgrade	>=85%	77.8	89.5	91.3	93.9	46.9	59.3	70.9	81.0	71.4	69.1	76.8	71.2
OP FUP Backlog: More than 3 months overdue	-	7,140	6,956	7,148	8,219	6,237	5,926	5,849	6,592	5,832	5,796	5,529	5,432
OP FUP Backlog: More than 12 months overdue	-	36	36	31	31	30	32	29	29	28	29	31	31
Section E - Internal Monitoring													
Dementia Performance: Stage 1	>=90	99.51	100.00	99.81	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Dementia Performance: Stage 2	>=90	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Dementia Performance: Stage 3	>=90	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Pressure Ulcers (Grade 3) (developed)	-	6	2	6	5	1	5	4	4	5	1	3	4
Pressure Ulcers (Grade 4) (developed)	-	1	0	0	0	0	0	0	0	1	0	0	0
Urgent Biopsies and Non Gynae Cytology - 7 Day Target	>=45	63.95	69.58	69.31	71.79	70.04	75.24	70.70	53.81	67.05	65.65	57.48	64.98
All Histo and Gynae Cytology - 14 Day Target	>=80	78.72	78.56	83.51	84.03	82.56	78.56	77.60	72.06	79.55	74.83	66.72	76.63
OP Appts Cancelled 2 or More Times (Total)	-	2,387	2,503	2,558	2,390	2,680	2,530	2,625	2,337	2,944	2,582	3,111	2,633
OP Appts Cancelled 2 or More Times (By Hospital)	-	977	1,051	1,162	981	1,077	996	1,025	961	1,163	926	1,114	1,064
Research Studies Recruited to Time and Target	>=80												
Research Studies First Patient Recruited Within 70 Days	>=80												

Section 5

Financial Statements 2017/18

Financial Statements

5.1 Independent Auditor's Report to the Directors of the Leeds Teaching Hospitals NHS Trust

We have audited the financial statements of The Leeds Teaching Hospitals NHS Trust ('the Trust') for the year ended 31 March 2018. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the NHS Trusts in England ("the Accounts Direction").

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of the audit report

This report is made solely to the Board of Directors of The Leeds Teaching Hospitals NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

- Other information The directors are responsible for the other information. The other information comprises the infomlation

included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NIHS Improvement; or
- we issue a report in the public interest under schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under schedule 7(2) of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in these respects.

Respective responsibilities of the Directors and the Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Chief Executive is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

As explained in the Annual Governance Statement, the Accountable Officer is also responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities.This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by schedule 13(10)(a) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate

We certify that we have completed the audit of the financial statements of The Leeds Teaching Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Gareth Davies

for and on behalf of Mazars LLP,

Tower Bridge House, St Katharine's Way
London, E1W 1DD

25 May 2018

5.2 Leeds Teaching Hospitals NHS Trust Annual Accounts 2017/18

Statement of Comprehensive Income for the year ended 31 March 2018

	Note	2017-18 £000s	2016-17 £000s
Operating income from patient care activities	3	1,034,222	975,548
Other operating income	4	204,045	197,379
Operating expenses	5, 7	(1,252,602)	(1,200,262)
Operating (deficit)		**(14,335)**	**(27,335)**
Finance income	10	90	68
Finance expenses	11	(14,569)	(1,699)
PDC dividends payable		(5,832)	(7,926)
Net finance costs		**(20,311)**	**(9,557)**
Other (losses) / gains	12	(149)	96
(Deficit) for the year		**(34,795)**	**(36,796)**
Other comprehensive income			
Impairments	6	(9,749)	(21,378)
Total comprehensive (expense) for the year		**(44,544)**	**(58,174)**
Financial performance for the year			
Retained (deficit) for the year		(34,795)	(36,796)
IFRIC 12 adjustment (including IFRIC 12 impairments)		26,852	16,038
Impairments (excluding IFRIC 12 impairments)		28,565	18,229
Adjustments in respect of donated asset reserve elimination		(1,742)	628
Adjusted retained surplus / (deficit)		**18,880**	**(1,901)**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000s	31 March 2017 £000s
Non-current assets			
Intangible assets	13	6,085	6,518
Property, plant and equipment	14	506,256	565,856
Trade and other receivables	18	12,939	10,495
Total non-current assets		**525,280**	**582,869**
Current assets			
Inventories	17	16,727	16,022
Trade and other receivables	18	75,066	65,846
Cash and cash equivalents	20	15,029	19,967
Total current assets		**106,822**	**101,835**
Current liabilities			
Trade and other payables	21	(106,401)	(98,202)
Borrowings	23	(51,279)	(11,987)
Provisions	25	(967)	(864)
Other liabilities	22	(7,804)	(7,084)
Total current liabilities		**(166,451)**	**(118,137)**
Total assets less current liabilities		**465,651**	**566,567**
Non-current liabilities			
Borrowings	23	(226,765)	(283,817)
Provisions	25	(5,399)	(5,728)
Other liabilities	22	(170)	(259)
Total non-current liabilities		(232,334)	(289,804)
Total assets employed		**233,317**	**276,763**
Financed by			
Public dividend capital		335,986	334,888
Revaluation reserve		43,026	55,880
Income and expenditure reserve		(145,695)	(114,005)
Total taxpayers' equity		**233,317**	**276,763**

The notes on pages 212 to 246 form part of these financial statements.

The accounts on pages 208 to 246 were approved by the Board of Directors on 24th May 2018 and signed on its behalf by:

Name:	Julian Hartley	Simon Worthington
Position:	Chief Executive	Director of Finance
Date:	24 May 2018	

Statement of Changes in Equity for the year ending 31 March 2018

	Public Dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**334,888**	**55,880**	**(114,005)**	**276,763**
(Deficit) for the year	-	-	(34,795)	**(34,795)**
Impairments	-	(9,749)	-	**(9,749)**
Transfer to retained earnings on disposal of assets	-	(3,105)	3,105	-
Public dividend capital received	1,098	-	-	**1,098**
Taxpayers' equity at 31 March 2018	**335,986**	**43,026**	**(145,695)**	**233,317**

Statement of Changes in Equity for the year ending 31 March 2017

	Public Dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**332,848**	**77,258**	**(77,209)**	**332,897**
(Deficit) for the year	-	-	(36,796)	**(36,796)**
Impairments	-	(21,378)	-	**(21,378)**
Public dividend capital received	2,040	-	-	**2,040**
Taxpayers' equity at 31 March 2017	**334,888**	**55,880**	**(114,005)**	**276,763**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £000	2016-17 £000
Cash Flows from Operating Activities			
Operating (deficit)		(14,335)	(27,335)
Non-cash income and expense:			
Depreciation and amortisation	5	17,694	25,979
Net impairments	6	55,417	34,267
Income recognised in respect of capital donations	4	(2,595)	(1,031)
(Increase) in receivables and other assets		(13,189)	(13,076)
(Increase) / decrease in inventories		(705)	517
Increase in payables and other liabilties		8,288	21,657
(Decrease) / increase in provisions		(232)	586
Net cash generated from operating activities		**50,343**	**41,564**
Cash Flows from Investing Activities			
Interest received		90	68
Purchase of intangible assets		(527)	(1,064)
Purchase of property, plant, equipment and investment property		(21,341)	(28,803)
Sales of property, plant, equipment and investment property		154	110
Receipt of cash donations to purchase capital assets		2,138	1,031
Net cash (used in) investing activities		**(19,486)**	**(28,658)**
Cash Flows from Financing Activities			
Public dividend capital received		1,098	2,040
Movement on loans from the Department of Health and Social Care		(11,249)	20,278
Capital element of finance lease rental payments		(38)	(36)
Capital element of PFI and other service concession payments		(6,473)	(9,761)
Interest paid on finance lease liabilities		(8)	(8)
Interest paid on PFI and other service concession obligations		(12,401)	373
Other interest paid		(2,154)	(2,017)
PDC dividend paid		(4,570)	(7,170)
Net cash (used in) / generated from financing activities		**(35,795)**	**3,699**
(Decrease) / increase in cash and cash equivalents		**(4,938)**	**16,605**
Cash and Cash Equivalents at 1 April 2017		**19,967**	**3,362**
Cash and Cash Equivalents at 31 March 2018	20.1	**15,029**	**19,967**

Notes to the Accounts

1. Accounting policies and other information

1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1.2 Going Concern

These accounts have been prepared on a going concern basis. (see note 36)

The cash position, combined with the fact that the Trust delivered a surplus (£18.9 million) and has a plan to achieve a larger surplus in 2018/19 (£28.9 million) which in turn is underpinned by the certainty of agreed Aligned Incentive Contracts with principal commissioners has given the directors full confidence that the Trust is a going concern. In the NHS, going concern status derives from the certainty that services will continue to be provided in the foreseeable future. There are national mechanisms in place to ensure that this will always be the case and directors are reassured by the fact that the Trust is able to prepare its annual accounts as a going concern in its own right and with a strong financial position to support that decision.

1.2 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Bexley Wing and Wharfedale Hospital, constructed under the Private Finance Initiative (PFI), meet the criteria for inclusion in the financial statements as Finance Leases as the Trust bears the risks and rewards of ownership. See paragraphs 1.13 Leases and 1.7.5 PFI transactions.

1.2.1 Sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Valuation of Plant, Property and Equipment - Para.1.7.2 and Note 14.1
- Provision for Impairment of Receivables - Note 18.2
- Provisions - Para 1.14 and Note 25.1

1.3 Interests in other entities

The Trust has no interests in other entities.

1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme which is designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The Trust provides certain employees, who are not enrolled into the NHS Pensions Scheme, with cover from the defined contributions scheme which is managed by the National Employment Savings Trust (NEST). The cost to the Trust is taken as equal to the contributions payable to the scheme for the accounting period.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250,

where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on the basis that reprovision would be on a single site basis located at St James's Hospital.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income

in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the

plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

1.7.6 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	88
Dwellings	2	88
Plant & machinery	5	18
Transport equipment	5	10
Information technology	5	12
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business

or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.development

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	10
Software licences	5	10

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables"

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using

the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

Fair value is determined by reference to quoted market prices where possible, or failing that by reference to similar arms-length transactions between knowledgeable and willing parties.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision. Amounts charged to the bad debt provision are written off against the carrying value of the financial asset when the financial asset is no longer judged to be realisable or independent advice is received to that effect.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.13.1 The trust as lessee

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.13.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 25.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation tax

The Trust has no interests in any associate or subsidiary which has a corporation tax liability and as an NHS Trust is not liable for corporation tax.

1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts (note 20.2) in accordance with the requirements of HM Treasury's FReM.

1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that

ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

These standards are still subject to HM Treasury FReM adoption with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

All of these would require further consideration although it is not anticipated that the impact of these standards would have a material impact on the 2017/18 accounts of the Trust.

2. Operating segments

The Trust has determined that the Chief Operating Decision Maker (as defined by IFRS 8) is the Board of Directors on the basis that all strategic decisions are made by the Board.

The Trust engages in its activity as a single operating segment i.e. the provision of healthcare. Financial results are reported to the Board under the single segment of healthcare. Whilst internally the Trust operates via 18 clinical service units, they each provide essentially the same service (patient care), have the same customers (commissioners), use similar processes and services and face fundamentally the same risks. Therefore the Trust believes that there is only one segment and has reported under IFRS 8 on this basis.

3. Operating income from patient care activities

3.1 Income from patient care activities (by nature)

	2017-18 £000s	2016-17 £000s
Acute services		
Elective income	156,614	164,205
Non elective income	219,671	191,970
First outpatient income	49,082	48,412
Follow up outpatient income	75,643	80,717
A & E income	27,329	26,184
High cost drugs income from commissioners (excluding pass-through costs)	162,240	160,157
Other NHS clinical income	331,698	292,608
Private patient income	5,857	5,593
Other clinical income	6,088	5,702
Total income from activities	**1,034,222**	**975,548**

3.2 Income from patient care activities (by source)

	2017-18 £000s	2016-17 £000s
NHS England	498,293	476,132
Clinical commissioning groups	522,806	486,784
Other NHS providers	101	119
NHS other	1,077	1,218
Non-NHS: private patients	5,857	5,593
Non-NHS: overseas patients (chargeable to patient)	276	559
NHS injury scheme	4,712	4,420
Non NHS: other	1,100	723
Total income from activities	**1,034,222**	**975,548**
Of which: Related to continuing operations	1,034,222	975,548

3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017-18 £000s	2016-17 £000s
Income recognised this year	276	559
Cash payments received in-year	180	350
Amounts added to provision for impairment of receivables	123	330
Amounts written off in-year	385	415

4. Other operating revenue

	2017-18 £000s	2016-17 £000s
Research and development	20,471	20,795
Education and training	69,079	72,123
Receipt of capital grants and donations	2,595	1,031
Charitable and other contributions to expenditure	12,066	2,142
Non-patient care services to other bodies	39,031	44,417
Sustainability and transformation fund income	29,922	24,665
Rental revenue from operating leases	1,540	1,686
Income in respect of staff costs where accounted on gross basis	11,153	11,498
Other income	18,188	19,022
Total other operating revenue	**204,045**	**197,379**
Of which: Related to continuing operations	204,045	197,379

Sustainability and Transformation income was paid to the Trust by NHS England as part of a national programme to support improvements in service accessibility and help trusts to deliver agreed financial control totals. Payment under the scheme is quarterly and dependent on NHS trusts meeting milestone targets.

Other revenue incorporates income received for goods and services which are incidental to the Trust's core activity of healthcare, for example, car parking, creche fees, access to health records income and catering.

5. Operating expenses

	2017-18 £000s	2016-17 £000s
Purchase of healthcare from NHS and DHSC bodies	-	472
Purchase of healthcare from non-NHS and non-DHSC bodies	8,444	11,005
Staff and executive directors costs	687,814	663,895
Remuneration of non-executive directors	88	93
Supplies and services - clinical (excluding drugs costs)	155,889	152,001
Supplies and services - general	8,366	8,318
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	178,445	173,284
Consultancy costs	596	1,001
Establishment	5,820	6,405
Premises	42,348	38,975
Transport (including patient travel)	4,815	4,963
Depreciation on property, plant and equipment	16,734	24,529
Amortisation on intangible assets	960	1,450
Net impairments	55,417	34,267
Increase in provision for impairment of receivables	769	313
Increase in other provisions	239	736
Change in provisions discount rate(s)	40	306
Audit fees payable to the external auditor:		
audit services- statutory audit	96	120
other auditor remuneration (external auditor only)	10	10
Internal audit costs	317	393
Clinical negligence scheme for trusts - contribution	36,190	32,900
Legal fees	571	468
Insurance	701	796
Research and development	14,766	15,233
Education and training	4,936	4,207
Rentals under operating leases	6,987	5,623
Early retirements	-	135
Redundancy	100	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI) on IFRS basis	9,451	8,251
Car parking & security	279	304
Hospitality	167	155
Losses, ex gratia & special payments	87	60
Other services, eg external payroll	1,590	1,129
Other	9,570	8,465
Total	**1,252,602**	**1,200,262**
Of which: Related to continuing operations	1,252,602	1,200,262

Other expenses incorporates the costs for goods and services which are incidental to the Trust's core activity, for example, hosted services or childcare vouchers and lease cars (both recovered through income).

5.1 Other auditor remuneration

Other auditor remuneration paid to the external auditor	2017-18 £000s	2016-17 £000s
All assurance services (Quality Accounts)	10	10
Total	**10**	**10**

5.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

6. Impairment of assets

Net impairments charged to operating deficit resulting from:	2017-18 £000s	2016-17 £000s
Changes in market price	55,417	34,267
Total net impairments charged to operating deficit	**55,417**	**34,267**
Impairments charged to the revaluation reserve	9,749	21,378
Total net impairments	**65,166**	**55,645**

The Trust's land and buildings have been revalued by an independent qualified valuer in both 2017/18 and 2016/17 which has resulted in impairment charges in both years. Further details can be found in note 16.

7. Employee benefits

	2017-18 £000s	2016-17 £000s
Salaries and wages	552,118	529,729
Social security costs	50,702	48,390
Apprenticeship levy	2,689	-
Employer's contributions to NHS pensions	65,960	63,072
Pension cost - other	-	135
Termination benefits	100	-
Temporary staff (including agency)	32,684	39,135
Total staff costs	**704,253**	**680,461**
Of which: Costs capitalised as part of assets	1,295	909
Total staff costs excluding capitalised costs	**702,958**	**679,552**

7.1 Retirements due to ill-health

During 2017/18 there were 12 early retirements from the trust agreed on the grounds of ill-health (25 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £616k (£1,227k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme.

NEST is a defined contribution scheme managed by a third party organisation. It carries no possibility of actuarial gain or loss to the Trust and there are no financial liabilities other than payment of the 1% employers contribution of qualifying earnings. This contribution will increase from 1% to 2% in April 2018 and will increase to 3% in April 2019. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. At 31st March there were 228 employees enrolled in the scheme (376 at 31 March 2017). Further details of the scheme can be found at www.nestpensions.org.uk.

9. Operating leases

9.1 Leeds Teaching Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Leeds Teaching Hospitals NHS Trust is the lessor.

The Generating Station Complex at Leeds General Infirmary is licenced to Engie Ltd who supply the Trust and University of Leeds with electricity. Other leases relate to various retail facilities provided across the Trust's sites.

Operating lease revenue	2017-18 £000	2016-17 £000
Minimum lease receipts	1,540	1,686
Total	**1,540**	**1,686**

Future minimum lease receipts due:	31 March 2018 £000	31 March 2017 £000
- not later than one year;	1,571	1,701
- later than one year and not later than five years;	1,978	1,869
- later than five years.	2,410	2,046
Total	**5,959**	**5,616**

9.2 Leeds Teaching Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Leeds Teaching Hospitals NHS Trust is the lessee.

The Trust has operating leases for items of medical and non-medical equipment, vehicles and short-term property lets. None of these are individually significant. The amounts recognised in these accounts are:

	Buildings £000s	Other £000	2017-18 Total £000s	2016-17 Total £000s
Operating lease expense				
Minimum lease payments	1,474	5,513	**6,987**	5,623
Total	**1,474**	**5,513**	**6,987**	5,623

			31 March 2018 £000s	31 March 2017 £000s
Future minimum lease payments due:				
- not later than one year;	1,413	4,836	6,249	5,460
- later than one year and not later than five years;	2,333	3,325	5,658	8,005
- later than five years.	2,851	-	2,851	3,294
Total	**6,597**	**8,161**	**14,758**	**16,759**

10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017-18 £000s	2016-17 £000s
Interest on bank accounts	90	68
Total	**90**	**68**

11 Finance expenses

11.1 Finance expenses

Finance expenditure represents interest and other charges involved in the borrowing of money.

Interest expense	2017-18 £000s	2016-17 £000s
Loans from the Department of Health and Social Care	2,154	2,036
Finance leases	8	8
Main finance costs on PFI and LIFT schemes obligations	6,053	(6,027)
Contingent finance costs on PFI and LIFT scheme obligations	6,348	5,654
Total interest expense	**14,563**	**1,671**
Unwinding of discount on provisions	6	28
Total finance costs	**14,569**	**1,699**

During the course of 2016-17 the Trust completed a re-financing arrangement for its Bexley Wing private financing initiative (PFI) agreement which secured a reduced rate of interest. The revised arrangement delivers an overall benefit of £50 million over the life of the contract. Of this sum, £10 million was brought into account in 2016/17 as a cash lump sum and the balance will be spread across the remaining 20 years of the contract via a reduction in the unitary charge. The £10 million brought into account in 2016/17 was taken as a reduction to existing PFI main finance costs from £3,973k (Bexley Wing PFI £3,309k, Wharfedale PFI £664k) to a closing credit balance of £6,027k.

11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The Trust has not made any payments under the terms of this legislation in either the current or preceding financial year.

12 Other (losses) / gains

Interest expense	2017-18 £000s	2016-17 £000s
Gains on disposal of assets	154	96
Losses on disposal of assets	(303)	-
Total (losses) / gains on disposal of assets	**(149)**	**96**

13 Intangible assets

13.1 Intangible assets - 2017/18

	Software licences £000s	Internally generated information technology £000s	Total £000s
Valuation / gross cost at 1 April 2017 - brought forward	1,907	8,556	10,463
Additions	-	527	527
Transfers to assets held for sale	-	(36)	(36)
Gross cost at 31 March 2018	1,907	9,047	10,954
Amortisation at 1 April 2017 - brought forward	714	3,231	3,945
Provided during the year	125	835	960
Transfers to assets held for sale	-	(36)	(36)
Amortisation at 31 March 2018	839	4,030	4,869
Net book value at 31 March 2018	1,068	5,017	6,085
Net book value at 1 April 2017	1,193	5,325	6,518

13.2 Intangible assets - 2016/17

	Software licences £000s	Internally generated information technology £000s	Total £000s
Valuation / gross cost at 1 April 2016 - brought forward	1,136	5,014	6,150
Transfers by absorption	-	-	-
Additions	771	293	1,064
Reclassifications	-	4,069	4,069
Transfers to assets held for sale	-	(820)	(820)
Valuation / gross cost at 31 March 2017	1,907	8,556	10,463
Amortisation at 1 April 2016 - brought forward	482	2,833	3,315
Provided during the year	232	1,218	1,450
Transfers to assets held for sale	-	(820)	(820)
Amortisation at 31 March 2017	714	3,231	3,945
Net book value at 31 March 2017	1,193	5,325	6,518
Net book value at 1 April 2016	654	2,181	2,835

14. Property Plant and Equipment

14.1 Property, Plant and Equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Valuation/gross cost at 1 April 2017 - brought forward	21,114	523,012	1,657	10,088	186,178	532	45,368	1,387	789,336
Additions	-	6,246	-	6,438	7,287	-	2,632	-	22,603
Impairments	(11,735)	(62,351)	682	-	-	-	-	-	(73,404)
Revaluations	-	(48,514)	(437)	-	-	-	-	-	(48,951)
Reclassifications	-	5,304	-	(5,304)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(8,036)	-	(1,914)	-	(9,950)
Valuation/gross cost at 31 March 2018	9,379	423,697	1,902	11,222	185,429	532	46,086	1,387	679,634
Accumulated depreciation at 1 April 2017 - brought forward	-	48,568	463	-	144,532	516	28,016	1,385	223,480
Provided during the year	-	8,117	41	-	5,583	7	2,984	2	16,734
Impairments	-	(8,171)	(67)	-	-	-	-	-	(8,238)
Revaluations	-	(48,514)	(437)	-	-	-	-	-	(48,951)
Disposals / derecognition	-	-	-	-	(7,733)	-	(1,914)	-	(9,647)
Accumulated depreciation at 31 March 2018	-	-	-	-	142,382	523	29,086	1,387	173,378
Net book value at 31 March 2018	9,379	423,697	1,902	11,222	43,047	9	17,000	-	506,256
Net book value at 1 April 2017	21,114	474,444	1,194	10,088	41,646	16	17,352	2	565,856

14.2 Property, Plant and Equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Valuation / gross cost at 1 April 2016 - brought forward	20,475	590,522	2,352	10,135	200,338	884	62,388	1,387	888,481
Additions	-	9,558	-	8,555	8,699	-	4,809	-	31,621
Impairments	639	(81,601)	(695)	-	-	-	-	-	(81,657)
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	4,533	-	(8,602)	-	-	-	-	(4,069)
Transfers to assets held for sale	-	-	-	-	(22,859)	(352)	(21,829)	-	(45,040)
Valuation/gross cost at 31 March 2017	21,114	523,012	1,657	10,088	186,178	532	45,368	1,387	789,336
Accumulated depreciation at 1 April 2016 - brought forward	(639)	66,357	509	-	158,175	855	43,350	1,382	269,989
Provided during the year	-	8,764	52	-	9,203	13	6,494	3	24,529
Impairments	639	(26,553)	(98)	-	-	-	-	-	(26,012)
Transfers to assets held for sale	-	-	-	-	(22,846)	(352)	(21,828)	-	(45,026)
Accumulated depreciation at 31 March 2017	-	48,568	463	-	144,532	516	28,016	1,385	223,480
Net book value at 31 March 2017	21,114	474,444	1,194	10,088	41,646	16	17,352	2	565,856
Net book value at 1 April 2016	21,114	524,165	1,843	10,135	42,163	29	19,038	5	618,492

14.3 Property, Plant and Equipment Financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Net book value at 31 March 2018									
Owned - purchased	9,379	302,930	1,902	9,414	28,821	9	16,793	-	369,248
Finance leased	-	583	-	-	-	-	-	-	583
On-SoFP PFI contracts and other service concession arrangements	-	111,134	-	-	9,621	-	-	-	120,755
Owned - donated	-	9,050	-	1,808	4,605	-	207	-	15,670
NBV total at 31 March 2018	**9,379**	**423,697**	**1,902**	**11,222**	**43,047**	**9**	**17,000**	**-**	**506,256**

14.4 Property, Plant and Equipment Financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Net book value at 31 March 2017									
Owned - purchased	21,114	325,265	1,194	9,260	28,385	16	17,104	2	402,340
Finance leased	-	613	-	-	-	-	-	-	613
On-SoFP PFI contracts and other service concession arrangements	-	137,579	-	346	8,548	-	-	-	146,473
Owned - donated	-	10,987	-	482	4,713	-	248	-	16,430
NBV total at 31 March 2017	**21,114**	**474,444**	**1,194**	**10,088**	**41,646**	**16**	**17,352**	**2**	**565,856**

15 Donations of property, plant and equipment

During the year the Trust received grants and donations to fund capital assets from the following:

	2017-18 £000s	2016-17 £000s
Leeds Hospital Charitable Foundation	2,120	863
Take Heart	310	-
Yorkshire Air Ambulance	108	-
Medical Research Council	-	109
Others	57	59
Total	**2,595**	**1,031**

16 Revaluations of property, plant and equipment

All land and building assets were revalued as at 1st April 2017 by an independent, qualified valuer at depreciated replacement cost using the Modern Equivalent Asset (MEA) approach (Note 1.7). In assessing values, regard was given to various factors, including physical and functional obsolence of buildings, site location and where active markets exist, e.g. land and residences, sales comparison. To assess fair value at the balance sheet date of 31 March 2018 a further exercise was undertaken by the valuer to assess movement in building cost indices since 1st April 2017 and the impact of capital expenditure during the year. The results of this exercise indicated valuation falls of £65 million which have been reflected in the carrying values of fixed assets at 31 March 2018 (see note 6).

During the year the Trust completed a major exercise to review its plant and equipment and information technology assets. This indicated that there are a significant volume of assets that remain in use beyond their allocated estimated useful economic lives. As a result the Trust has revised the estimated useful economic lives of plant and equipment and information technology assets and this has resulted in a reduction in depreciation of £6,857k in 2017/18.

17 Inventories

	31 March 2018 £000s	31 March 2017 £000s
Drugs	6,504	5,889
Work In progress	-	-
Consumables	10,021	9,928
Energy	202	205
Other	-	-
Total inventories	**16,727**	**16,022**

Inventories recognised in expenses for the year were £276,332k (2016/17: £271,787k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

18 Trade receivables and other receivables

18.1 Trade receivables and other receivables

	31 March 2018 £000s	31 March 2017 £000s
Current		
Trade receivables	40,660	34,475
Capital receivables (including accrued capital related income)	897	441
Accrued income	17,938	12,732
Provision for impaired receivables	(2,513)	(2,221)
Prepayments (non-PFI)	6,118	5,166
PFI lifecycle prepayments	3,000	7,300
VAT receivable	1,522	1,722
Other receivables	7,444	6,231
Total current trade and other receivables	**75,066**	**65,846**
Non-current		
Provision for impaired receivables	(1,151)	(1,120)
PFI lifecycle prepayments	9,052	6,733
Other receivables	5,038	4,882
Total non-current trade and other receivables	**12,939**	**10,495**
Of which receivables from NHS and DHSC group bodies:		
Current	47,018	36,253
Non-current	-	-

The great majority of trade is with NHS England and Clinical Commissioning Groups. As NHS bodies are funded by Government to buy NHS patient care services, credit scoring of them is not considered necessary.

18.2 Provision for impairment of receivables

	2017/18 £000s	2016/17 £000s
At 1 April	**3,341**	**3,700**
Increase in provision	769	313
Amounts utilised	(446)	(672)
At 31 March	**3,664**	**3,341**

Receivables are impaired when there is evidence to indicate that the Trust may not recover sums due. This can be on the basis of legal advice, insolvency of debtors or other economic factors. Impaired receivables are only written off when all possible means of recovery have been attempted. The nature of the Trust's business generally means that no collateral is held against outstanding receivables.

18.3 Credit quality of financial asset

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
Over 180 days	633	-	849	-
Total	633	-	849	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,152	-	753	-
30-60 Days	369	-	620	-
60-90 days	163	-	276	-
90- 180 days	708	-	608	-
Over 180 days	-	-	71	-
Total	2,392	-	2,328	-

All receivables are reviewed regularly throughout the year to assess their credit risk. Those which are neither past due nor subject to impairment are deemed to represent a low risk of default.

19 Non-current assets held for sale and assets in disposal groups

	2017/18 £000s	2016/17 £000s
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	-
Assets classified as available for sale in the year	-	14
Assets sold in year	-	(14)
Transfer to FT upon authorisation	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	-

20 Cash and cash equivalents movements

20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18 £000s	2016/17 £000s
At 1 April	**19,967**	**3,362**
Net change in year	(4,938)	16,605
At 31 March	**15,029**	**19,967**
Broken down into:		
Cash at commercial banks and in hand	32	60
Cash with the Government Banking Service	14,997	19,907
Total cash and cash equivalents as in SoFP and SoCF	**15,029**	**19,967**

20.2 Third party assets held by the trust

The Trust held cash and cash equivalents which relate to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018 £000s	31 March 2017 £000s
Bank balances	41	1
Total third party assets	**41**	**1**

21 Trade and other payables

21.1 Trade and other payables

	31 March 2018 £000s	31 March 2017 £000s
Current		
Trade payables	49,182	48,270
Capital payables	5,294	6,013
Accruals	26,084	20,612
Social security costs	7,660	7,588
Other taxes payable	6,697	6,073
PDC dividend payable	1,428	166
Accrued interest on loans	126	127
Other payables	9,930	9,353
Total current trade and other payments	**106,401**	**98,202**
Of which payables from NHS and DHSC group bodies:		
Current	7,203	4,022

21.2 Early retirements in payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000s	31 March 2017 £000s
Outstanding pension contributions (March 18)	**9,359**	**8,941**

22 Other liabilities

	2018 £000s	2017 £000s
Current		
Deferred income	7,804	7,084
Total other current liabilities	**7,804**	**7,084**
Non-current		
Deferred income	170	259
Total other non-current liabilities	**170**	**259**

23 Borrowings

	2018 £000s	2017 £000s
Current		
Loans from the Department of Health and Social Care	42,975	5,646
Obligations under finance leases	39	38
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	8,265	6,303
Total current borrowings	**51,279**	**11,987**
Non-current		
Loans from the Department of Health and Social Care	53,308	101,886
Obligations under finance leases	334	373
Obligations under PFI, LIFT or other service concession contracts	173,123	181,558
Total non-current borrowings	**226,765**	**283,817**

24 Financial leases

24.1 Leeds Teaching Hospitals NHS Trust as a lessee

Obligations under finance leases where Leeds Teaching Hospitals NHS Trust is the lessee.

Finance lease obligations relate to the Catering Receipt and Distribution Unit (RADU) at Seacroft Hospital. The unit was constructed in 2002 by a private partner and will revert to Trust ownership upon expiry of the lease in 2027. The arrangement has been determined as a finance lease on the grounds that the Trust has the substantive risks and rewards associated with control of the facility. Accounting treatment is in line with the policy described in note 1.13.

	31 March 2018 £000s	31 March 2017 £000s
Gross lease liabilities	**403**	**448**
of which liabilities are due:		
- not later than one year;	45	45
- later than one year and not later than five years;	179	179
- later than five years.	179	224
Finance charges allocated to future periods	(30)	(37)
Net lease liabilities	**373**	**411**
of which payable:		
- not later than one year;	39	38
- later than one year and not later than five years;	161	159
- later than five years.	173	214
	373	**411**

25.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2017	**6,108**	**370**	**114**	**6,592**
Change in the discount rate	40	-	-	40
Arising during the year	60	212	43	315
Utilised during the year	(375)	(136)	-	(511)
Reversed unused	(60)	-	(16)	(76)
Unwinding of discount	6	-	-	6
At 31 March 2018	**5,779**	**446**	**141**	**6,366**
Expected timing of cash flows:				
- not later than one year;	380	446	141	967
- later than one year and not later than five years;	1,520	-	-	1,520
- later than five years.	3,879	-	-	3,879
Total	**5,779**	**446**	**141**	**6,366**

Early departure costs represent amounts payable to the NHS Business Services Authority - Pensions Division to meet the costs of early retirements and industrial injury benefits. Amounts are determined by the NHS Business Services Authority - Pensions Division based on actuarial estimates of life expectancy and there is therefore, a degree of uncertainty regarding the value of future payments.

Legal claims relate to personal injury and other claims where the Trust has received advice that settlement is probable. The final amounts and timings of payments remain subject to negotiation or legal judgement. Included are claims with a value of £323k (£178k in 2016/17) which are being handled on behalf of the Trust by NHS Resolution (formerly the NHS Litigation Authority) who have advised on their status. The value represents amounts which the Trust may bear as its share of any settlement. The balance of claims are being dealt with directly by the Trust as they represent settlement values likely to fall below NHS Resolution's excess level.

Other provisions include those for employment related claims where the Trust disputes liability but recognises some probability of payment.

26 Contingent assets and liabilities

	31 March 2018 £000s	31 March 2017 £000s
Value of contingent liabilities		
NHS Resolution legal claims	(143)	(91)
Other	(366)	(513)
Gross value of contingent liabilities	**(509)**	**(604)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(509)**	**(604)**

NHS Resolution contingent liabilities consist entirely of claims for personal injury where the probability of settlement is very low. The NHS Resolution have advised on their status. In all

cases, quantum has been assessed on a "worst case scenario" and represents the maximum of any payment which may be made. "Other" contingencies relate to personal injury claims which are being managed internally by the Trust. In all cases, the potential payment values have been assessed on a "worst case scenario" basis by reference to independent advice. Settlement of these claims is considered highly improbable but the values quoted represent the Trust's maximum exposure to loss.

27 Contractual capital commitments

	31 March 2018 £000s	31 March 2017 £000s
Property, plant and equipment	19,340	13,429
Intangible assets	191	81
Total	**19,531**	**13,510**

28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has two PFI schemes which have been assessed as on-SoFP

Institute of Oncology at St James's Hospital - Bexley Wing

This is a 30 year contract which expires in 2037. It provides for the construction, maintenance and partial equipping of Bexley Wing by the PFI partner in return for an annual charge to the Trust. The Trust has full use of the facilities to provide healthcare services and will take ownership of the building and equipment at the end of the contract period. The PFI partner is responsible for providing a managed maintenance service for the length of the contract after which the responsibilities revert to the Trust. The contract contains payment mechanisms providing for deductions from the annual charge for any poor performance or unavailability. Future charges to the Trust will be determined by reference to the Retail Price index. In 2022 the annual charge will reduce significantly to reflect the fact that the contractual commitment to meet equipment costs will be complete although the contractor is obliged to continue to provide equipment that is fit for purpose. The contract was subject of a refinancing agreement during 2016/17 as detailed further in note 11.1.

Wharfedale Hospital

This is a 30 year contract which expires in 2034. It provides for the construction and maintenance of Wharfedale Hospital by the PFI partner in return for an annual unitary charge to theTrust. The Trust has full use of the Wharfedale Hospital to provide healthcare services and will take ownership of the building at the end of the contract period. The PFI partner is responsible for providing a managed maintenance service for the length of the contract after which the responsibilities revert to the Trust. The contract contains payment mechanisms providing for deductions from the annual charge for any poor performance or unavailability. The unitary charge is subject for an annual uplift for future price increases determined by reference to the Retail Price index.

28.1 Imputed finance lease obligations

Leeds Teaching Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	31 March 2018 £000s	31 March 2017 £000s
Gross PFI liabilities	**270,489**	**285,529**
Of which liabilities are due		
- not later than one year;	16,094	14,438
- later than one year and not later than five years;	63,583	64,540
- later than five years.	190,812	206,551
Finance charges allocated to future periods	(89,101)	(97,668)
Net PFI obligation	**181,388**	**187,861**
of which payable:		
- not later than one year;	8,265	6,303
- later than one year and not later than five years;	35,291	34,835
- later than five years.	137,832	146,723
	181,388	**187,861**

28.2 Total on-SoFP PFI arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000s	31 March 2017 £000s
Total future payments committed in respect of the PFI arrangements	**600,734**	**627,214**
Of which liabilities are due:		
- not later than one year;	33,208	32,135
- later than one year and not later than five years;	134,498	134,295
- later than five years.	433,028	460,784
	600,734	**627,214**

28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's payments in 2017/18:

	2017/18 £000s	2016/17 £000s
Unitary payment payable to service concession operator	**31,188**	**21,059**
Consisting of:		
- Interest charge	6,053	(6,027)
- Repayment of finance lease liability	6,473	9,785
- Service element and other charges to operating expenditure	9,451	8,251
- Capital lifecycle maintenance	2,863	3,396
- Contingent rent	6,348	5,654
Total amount paid to service concession operator	**31,188**	**21,059**

During the course of 2016-17 the Trust completed a re-financing arrangement for its Bexley Wing private financing initiative (PFI) agreement which secured a reduced rate of interest. The revised arrangement delivers an overall benefit of £50 million over the life of the contract. Of this sum, £10 million was brought into account in 2016/17 as a cash lump sum and the balance will be spread across the remaining 20 years of the contract via a reduction in the unitary charge. The £10 million brought into account in 2016/17 was taken as a reduction to existing PFI main finance costs from £3,973k (Bexley Wing PFI £3,309k, Wharfedale PFI £664k) to a closing credit balance of £6,027k.

29 Financial instruments

29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust treasury activity is subject to review by its internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust borrows from government for capital expenditure, subject to approval by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets. Interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

Since the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2018 are in receivables from customers, as disclosed in the trade and other receivables note (Note 18).

Liquidity Risk

The Trust's operating costs are incurred under contracts with NHS commissioning organisations, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

29.2 Carrying values of financial assets

	Loans and receivables £000s	Total book value £000s
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	59,438	59,438
Cash and cash equivalents at bank and in hand	15,029	15,029
Total at 31 March 2018	**74,467**	**74,467**
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	47,052	47,052
Cash and cash equivalents at bank and in hand	19,967	19,967
Total at 31 March 2017	**67,019**	**67,019**

29.3 Carrying value of financial liabilities

	Other financial liabilities £000s	Total book value £000s
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	96,283	**96,283**
Obligations under finance leases	373	**373**
Obligations under PFI, LIFT and other service concession contracts	181,388	**181,388**
Trade and other payables excluding non financial liabilities	90,492	**90,492**
Total at 31 March 2018	**368,536**	**368,536**
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	107,532	**107,532**
Obligations under finance leases	411	**411**
Obligations under PFI, LIFT and other service concession contracts	187,861	**187,861**
Trade and other payables excluding non financial liabilities	83,989	**83,989**
Total at 31 March 2017	**379,793**	**379,793**

29.4 Fair values of financial assets and liabilities

Due to the nature of the Trust's financial assets and finacial liabilities book value (carrying value) is considered a reasonable approximation of fair value.

29.5 Maturity of financial liabilities

	31 March 2018 £000s	31 March 2017 £000s
In one year or less	141,771	95,976
In more than one year but not more than two years	14,417	51,273
In more than two years but not more than five years	48,544	58,397
In more than five years	163,804	174,147
Total	**368,536**	**379,793**

30 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	2	-	3	-
Bad debts and claims abandoned	259	481	844	636
Stores losses and damage to property	5	34	5	9
Total losses	**266**	**515**	**852**	**646**
Special payments				
Ex-gratia payments	167	175	192	195
Total special payments	**167**	**175**	**192**	**195**
Total losses and special payments	**433**	**690**	**1,044**	**840**
Compensation payments received		-		-

Losses and Special payments relate to cases not specifically funded and which, ideally should not arise. They cover bad debts written off, losses from theft or accidental damage and claims for personal loss or injury which are not reimbursed from insurance arrangements.

31 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Leeds Teaching Hospitals NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Leeds Teaching Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

The Trust has also received revenue and capital payments from a number of charitable funds, including the Leeds Hospital Charitable Foundation. The Trust's Chair, Dr Linda Pollard, is a Trustee of the Leeds Hospital Charitable Foundation. The Chairman of Trustees, Edward Ziff, is also Chairman and Chief Executive of Town Centre Securities Plc Group. During the year the Trust paid £93k to Town Centre Securities Plc Group for provision of car parking. The financial statements of the Charitable Foundation are published separately and can be obtained from: **www.leedshospitalsfundraising.org.uk/index.php**

Professor Paul Stewart, Non Executive Director, is Dean of the School of Medicine, University of Leeds. Caroline Johnstone (Non Executive Director and Chair of the Trust's Audit Committee to 31 January 2018) is a Member of the Council of the University of Leeds and its audit committee. Alison Page, (Non Executive Director to 31 January) is Managing Partner of DLA Piper. During the year the Trust paid DLA Piper £151k for legal services. Mark Chamberlain, Non Executive Director and Chair of the Quality Committee is an Associate of Capsticks LLP. The Trust paid Capsticks LLP £83k in 2017/18 for legal services. Carl Chambers, Non Executive Director and current Chair of the Trust's Audit Committee is a council member of the University of Bradford. Mark Ellerby, Non Executive Director and Chair of the Trust's Finance and Performance Committee is also a Non Executive Director of NHS Business Services Authority.

	Expenditure with related party £000s	Income from related party £000s	Amounts owed to related party £000s	Amounts due from related party £000s
NHS Airedale, Wharfedale and Craven CCG	0	6,554	44	14
NHS Bradford Districts CCG	0	10,477	187	22
NHS Calderdale CCG	0	5,718	141	13
NHS Greater Huddersfield CCG	0	7,015	12	27
NHS Harrogate And Rural District CCG	0	6,282	18	159
NHS Leeds North CCG	0	98,347	566	636
NHS Leeds South And East CCG	0	155,344	1,841	838
NHS Leeds West CCG	0	177,166	923	3,213
NHS North Kirklees CCG	0	9,183	44	74
NHS Vale Of York CCG	0	8,384	29	25
NHS Wakefield CCG	0	20,341	54	44
NHS England	4	537,620	0	31,014
Department of Health	0	9,006	0	924
Leeds Community Healthcare NHS Trust	786	5,757	237	456
Mid Yorkshire Hospitals NHS Trust	1,841	3,782	814	807
Bradford Teaching Hospitals NHS Foundation Trust	693	3,543	152	1,018
Leeds And York Partnership NHS Foundation Trust	323	3,493	22	496
Sheffield Teaching Hospitals NHS Foundation Trust	168	6,972	207	156
Leeds Hospital Charitable Foundation	25	13,460	0	5,226
University of Leeds	16,739	5,703	908	693
NHS Health Education England	1	67,132	1	1,355
NHS Resolution	36,754	2	0	0
NHS Blood and Transplant	8,195	1,381	133	123

32 Better Payment Practice code

	2017/18 Number	2017/18 £000s	2016/17 Number	2016/17 £000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	237,001	500,478	205,555	487,533
Total non-NHS trade invoices paid within target	182,510	360,014	192,370	453,124
Percentage of non-NHS trade invoices paid within target	**77%**	**72%**	**94%**	**93%**
NHS payables				
Total NHS trade invoices paid in the year	9,300	85,934	7,428	84,070
Total NHS trade invoices paid within target	5,828	75,680	5,897	76,848
Percentage of NHS trade invoices paid within target	**63%**	**88%**	79%	91%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

33 External financing limit

The Trust is given an External Financing Limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	(11,724)	(4,084)
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	**(11,724)**	**(4,084)**
External Financing Limit (EFL)	(7,164)	(3,814)
Underspend against EFL	**4,560**	**270**

34 Capital resource limit

The Trust is given a Capital Resource Limit which it is not permitted to exceed:

	2017/18 £000	2016/17 £000
Gross capital expenditure	23,130	32,686
Less: Disposals	(303)	(14)
Less: Donated and granted capital additions	(2,595)	(1,031)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	**20,232**	**31,641**
Capital Resource Limit	20,877	31,705
Underspend against CRL	**645**	**64**

35 Breakeven duty financial performance

The Trust is given a Capital Resource Limit which it is not permitted to exceed:

	2017/18 £000
Adjusted financial performance surplus (control total basis)	18,880
Breakeven duty financial performance surplus	**18,880**

36 Breakeven duty rolling assessment

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance		963	2,051	4,207	3,089	1,615	(24,386)	(30,194)	(1,901)	18,880
Breakeven duty cumulative position	3,868	4,831	6,882	11,089	14,178	15,793	(8,593)	(38,787)	(40,688)	(21,808)
Operating income		910,556	934,527	970,709	1,002,444	1,044,916	1,086,638	1,115,720	1,172,927	1,238,267
Cumulative breakeven position as a percentage of operating income		0.53%	0.74%	1.14%	1.41%	1.51%	(0.79%)	(3.48%)	(3.47%)	(1.76%)

Going concern

The Trust has delivered a significant surplus in 2017-18 inclusive of Sustainability and Transformation funding and has plans in place to continue to deliver surpluses in future years in line with agreed control totals and includive of Provider Sustainability Funding (formerly STF). There is no indication that the services provided by the Trust are unlikely to continue for the foreseeable future and that the Trust has a a reasonable expectation of access to adequate cash support mechanisms should they be required. In the light of this, the directors consider it appropriate that the Trust remains a going concern and the accounts have been prepared on that basis.

Tell us about your care

Feedback from patients, families and carers is very important to us.

Around our hospitals you will find that many wards and departments ask your opinion or have comment cards that you can use to make your views known. In particular, some departments have started to use the NHS Friends and Family Test, with encouraging results.

If there is a problem, we'd like to know about it so we can put it right and make improvements to our service. Equally, staff value compliments if you have received quality care.

For queries or to make a general comment, please visit our website at www.leedsth.nhs.uk

Summaries of this document can be made available, by arrangement, in large print, Braille and community languages, from:

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