The Leeds Teaching Hospitals NHS
NHS Trust

Annual Report and Summary Accounts 2013/14

Incorporating the Annual Quality Account

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Chair's statement

This has been a year of transition for the NHS as a whole and it has been no different for Leeds Teaching Hospitals NHS Trust.

We have seen significant organisational change across the Trust over the last 12 months, which has proved challenging, but I have been impressed with the commitment from staff at all levels of the organisation to ensure that patients remain our focus at all times.

Strong leadership will be the key to our success and I am convinced that we now have in place an experienced and committed Board of Directors to guide us through some of the exciting but demanding times ahead.

During the year, there were a number of significant changes to the Trust Board, including the arrival of our new Chief Executive, Julian Hartley. Maggie Boyle left her post as Chief Executive in June 2013 after six years with the Trust. I would like to take this opportunity to thank Maggie for her commitment over this time and her contributions to the Trust.

This was a critical time for the Trust and we worked closely with the NHS Trust Development Authority (NHS TDA) to appoint Chris Reed as interim Chief Executive and Karen Straughair as Recovery Director to ensure we had appropriate leadership in place to develop robust plans setting out how we would improve key areas of our performance, service delivery and financial sustainability.

In May 2013, we also welcomed Dr Yvette Oade as Chief Medical Officer, Suzanne Hinchliffe as Chief Nurse and Dr Mark Smith as Chief Operating Officer. Tony Whitfield joined as Director of Finance in January 2014 and in May 2014, Simon Neville as Director of Strategy and Planning. Our new non-executive board members include Professor Paul Stewart, Alison Page and from May 2014, Dr Bill Kirkup. More information about our Trust Board members can be found in Members of the Trust Board 2013-14, on page 44.

In October 2013, I was delighted to welcome Julian Hartley into the substantive post as Chief Executive. Julian has an impressive track record in healthcare leadership and has very quickly made a positive impact on the culture and direction of the Trust.

Providing patients with the highest standards of care is the cornerstone of our work at the Trust. In common with the rest of the NHS, we took very seriously the findings of Robert Francis QC's report about the failings of care within the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report describes an organisation where the fundamentals of care were missing and we are committed to learning from its findings.

Some of this work has started already. For example, the Trust Board has agreed to invest an additional £6 million in nurse staffing over the coming months to ensure we always provide patients with care that is safe and of the highest standards. We have also undertaken a comprehensive review of our complaints procedure, which has led to a new policy, to enable us to respond quickly and with compassion when patients do not feel our service met their expectations. Of course, learning from complaints to improve our care is an integral part of our revised processes.

Another area of national concern where lessons must be learned centres around the revelations about the activities of the late Jimmy Savile. An independent investigation team was set up in Leeds to look into the full picture of Savile's involvement with our hospitals, which dates back to the 1960s. The findings of the investigation were published at the end of June 2014, and are available on the Trust's website at www.leedsth.nhs.uk.

In March 2014, we welcomed inspectors from the Care Quality Commission (CQC) to carry out a rigorous review of our services and care across the Trust, as part their new, comprehensive inspection programme. The CQC's report was published in July 2014, and its findings are available on their website, at www.cqc.org.uk/provider/RR8. They will also be reported more fully in the Trust Annual Report and Quality Account for 2014-15.

This year sees us focusing on the many specialist services we provide in Leeds and our work to ensure we are in the best possible position to respond to NHS England's plans to develop centres of excellence around the country. We are already one of the largest providers of specialist services in the country, covering almost 100 specialties in facilities like our state-of-the-art cancer centre. In areas like major trauma, cancer and liver transplantation we offer some of the most cutting edge services in the UK. We are well placed to become the one of the highest rated specialist centres in the region.

This work is backed by world class research and innovation. Our strong reputation is evidenced in the numerous examples of leading edge research programmes, international innovation partnerships, UK-first operations, the use of cutting edge technology and our status as a leading teaching hospital. Strong links with our funding partners, like the National Institute for Health Research, make it possible for us to lead the way in researching new treatments for cancer, renal and liver diseases, among others, and our alliance with Leeds University goes from strength to strength. To this end, I was delighted to welcome the university's Dean of Medicine, Professor Paul Stewart, to the Trust Board in October 2013, and he is now chairing our new Research, Education and Training Committee.

I have been keen to champion the development of our international partnerships this year. Our expertise in cancer treatment has attracted interest from the King Hussein Cancer Centre in Amman, Jordan. A delegation visited the Bexley Wing, St James's University Hospital, in July 2013 and in October we signed a formal Memorandum of Understanding during the World Islamic Forum in London. Together with our emerging ties with clinicians in Egypt and Malta this not only promotes our world class expertise and facilities, but also brings significant economic benefit to the Trust, leading to opportunities for partnerships with other global organisations such as the IT company, CISCO.

Each year, we are very grateful for the work of our Charitable Foundation, which raises thousands of pounds to fund research, purchase equipment and improve the hospital environment for our patients. In particular, I would like to thank Councillor Bernard Atha CBE, who left his role as Chair of the Foundation in March 2014, for all his contributions. Thank you to the Deputy Chair, Roger Cannon, who stepped in to cover this role until July 2014 when local businessman Edward Ziff, the Chair designate, takes up his post.

In January 2014, the Foundation launched an appeal to raise £2 million by 2015 towards a final total of £6 million to create a world class Yorkshire brain research centre here at the Trust. The centre will offer state-of-the-art facilities for further research into conditions like Parkinson's disease, Epilepsy, Multiple Sclerosis and Dementia, including Alzheimers. The Patron is Yorkshire philanthropist Sir Robert Ogden CBE, who has generously started the appeal with a personal donation. You can read more about the work of the Charitable Foundation on page 79.

During the year, we welcomed to the Trust HRH The Countess of Wessex, the Royal Patron of Leeds Children's Hospital. Her support is invaluable, helping us to publicise and generate interest in our work. She met families and patients and opened our impressive new £1.75 million children's intensive care facility, one of the largest in the country.

I believe the key to achieving the best outcomes and experience for our patients lies in developing more partnerships. In his report on page 7, Julian Hartley sets out our vision to become the best hospital trust for specialist and integrated care. It's an ambitious plan, and one

that will call for close and enduring associations with the new national commissioner, NHS England, with our local clinical commissioning groups and a range of other partners in health, social care, research and academia.

This has been a key area of work for us over the last 12 months, particularly in light of all the structural change that has taken place in the NHS. I am pleased to say that we have strong relationships with our clinical commissioning groups in Leeds, and I would like to thank them for their commitment and support during what has been a challenging year. I am confident we will build on these partnerships during the next year to continue to improve services for patients across the city.

Finally, on behalf of the Board, I would like to thank the partners we see every day across the Trust – the staff and volunteers who work tirelessly to offer patients, their relatives and carers compassionate, high quality care 365 days a year. We move into 2014-15 with strong foundations in place on which to build and with a clear ambition and a common aim – to set our sights even higher and deliver outstanding treatment, care and clinical outcomes for patients in Leeds and beyond.

Dr Linda Pollard CBE JP DL

Chair

Chief Executive's report

Every time I visit our wards and clinical departments here at Leeds Teaching Hospitals NHS Trust I meet staff who are dedicated to providing the highest quality compassionate care for our patients.

This is how it should be. Every patient in our Trust deserves the highest standards of treatment and care we can offer, provided in a timely and efficient way.

These are the principles that guide our work at the Trust. They are set out in the NHS Constitution, and are the foundations for developing our services in the future.

Our vision and strategy

Our vision at Leeds is to be the best hospital trust for specialist and integrated care.

To achieve this we need to build strong partnerships with a wide range of partners including the national commissioner NHS England, local clinical commissioning groups, our local authority, other NHS providers, local universities and the voluntary sector. This will mean we can offer patients the very best health and social care in the setting that best meets their needs – whether that is at home, in the community or if necessary, in hospital.

By doing this we will be able to further develop our outstanding specialist services - for example, our world renowned cancer services - and build on our strength as a centre of excellence for state-of-the-art treatments backed up by a strong reputation in research, education and innovation.

Achieving this vision will not always be easy. Like many hospital trusts, we faced a number of tough challenges during 2013-14. These included being put into Escalation Score 4, Material Issues by our regulator, the NHS Trust Development Authority, for not submitting an annual plan that was robust enough to deliver high quality services and a strong financial balance. In addition, there were a number of changes to our Board during the year.

As we move into 2014-15, I am pleased to say that we now have a fully established board of directors and strong and credible plans for delivering the highest quality services to patients while achieving a sustainable financial position.

In 2013, we began working on a five-year strategy to help us fulfil our ambition. If we are to be successful in realising our vision, we must be brave and innovative and think differently about how we deliver high quality care for our patients. This involves listening to those who are closest to the services – our staff, patients and stakeholders.

In December, we asked our staff to define the values and goals that will shape The Leeds Way – that is who we are, what we believe and how we will work to deliver the best for our patients in the coming years.

Thousands of colleagues used our web-based platform, WayFinder, to share their views and comments. It was the largest staff engagement exercise the Trust has ever undertaken and one I firmly believe has set the tone for The Leeds Way of working. Staff engagement is extremely important to me: this shared involvement in our identity and aspirations will ultimately make a real impact on quality of care and outcomes for our patients.

The draft strategy that resulted from this exercise was open to consultation with staff, stakeholders and our members. In 2014-15, we will finalise our plan for the next five years and ensure our values and goals are firmly embedded in our working practices and partnerships with patients, and across health and social care, academia and beyond.

Quality of care

High quality, safe care is a priority for the Trust and last year, we achieved some notable successes in this area.

Once again, the annual independent Dr Foster Hospital Guide to patient care revealed that our Trust has one of the lowest mortality rates in the country, a fantastic indicator of the safe and effective treatment and care we provide for patients.

We've exceeded our targets for patient care in A&E over the year and we're making real progress in reducing the number of people who wait longer than 18 weeks to begin consultant-led treatment. We know we have more to do but we are fully committed to making sure we deliver timely services for our patients.

We've also made good progress in our commitment to reducing the number of falls in our hospitals, and in protecting patients from pressure ulcers. In 2014-15, we'll continue our focus on these areas and others to benefit patients.

The quality and effectiveness of our care was put under close scrutiny when in March 2014 we were one of the first hospital trusts in the country to be inspected under the Chief Inspector of Hospitals new and rigorous Care Quality Commission (CQC) inspection regime. Around 60 inspectors spent a week visiting a wide range of wards and departments across the Trust, day and night, followed by a further unannounced visit a number of days later.

The results of the CQC inspection were published in July 2014, and we welcome them as an opportunity to inform and guide our care over the coming months.

Listening and learning

Last year was particularly challenging for our children's heart surgery unit in the Leeds Children's Hospital at Leeds General Infirmary. Surgery was halted in March 2013 following concerns over mortality data.

Surgery resumed after detailed work by an independent team led by NHS England found no evidence of significant safety concerns, and that there were a number of very positive aspects of practice within the unit. Two further reports were published in March 2014, one of which confirmed the unit was operating safely, while the other looked into concerns raised by 16 families which highlighted a number of cases where our care and practice fell short of what they deserved to expect.

This was of course unacceptable and we apologised unreservedly to those families. We are determined to learn from what happened, but we are pleased that the unit's overall standards were judged to be safe. We continue to play a major part in the work NHS England is leading to develop a new model for congenital heart disease nationally.

Our staff

Our staff are at the heart of our vision for Leeds Teaching Hospitals NHS Trust over the next five years. Everyone plays their role in the delivery of our ambitious plans and my NHS Change Day pledge for this year is to continue to spend time with staff who deliver our services for patients so I can truly understand the issues they face and how my role can support them in providing our patients with the best possible care.

I am constantly amazed by the success and achievements of our staff and the range of awards they receive. It reinforces my belief that they are our greatest asset.

I would like to take the opportunity to offer my thanks to all the staff at the Trust for their hard work during what has been a year of great change. I look forward to working alongside them in 2014-15 to make Leeds Teaching Hospitals the best hospital trust for specialist and integrated care.

Julian Hartley

Chief Executive

About us

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

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

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

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

Our services

We are the district general hospital for the people of Leeds, providing services including A&E, outpatients, inpatients, maternity care and older people's services.

In addition, we are one of the largest providers of specialised hospital services in the country, covering nearly 100 specialties, many of which are delivered across the region.

Working closely with commissioners, both locally and nationally, we have built a national and international reputation for excellence in a range of specialisms, including cancer care, heart and brain surgery and organ transplantation.

The Leeds Cancer Centre in Bexley Wing, St James's University Hospital, houses some of our flagship specialist services. The £220 million centre contains 10 floors dedicated to some of the best treatment for cancer patients available anywhere in the world. Researchers and practitioners provide high quality cancer care by developing and maximising leading edge science, research and technology within this state-of-the-art building.

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

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

Our liver and kidney transplantation teams continue to provide complex, specialist and tertiary renal services for the population of the Yorkshire and Humber region. We are the largest solid organ transplant centre in the UK, performing over 140 transplants in 2013-14. We are the third largest liver transplant centre and the largest liver cancer surgery unit. Our teams also provide comprehensive urological cancer services.

Leeds Children's Hospital is one of the largest facilities for children under 16 years old in the UK, bringing together expertise and services to treat more than 10,000 sick children a year from across the Yorkshire and Humber region. Our many specialties include neonatal services, children's medicine and surgery, cardiac services, cystic fibrosis, oncology and haematology.

We serve a diverse and growing population, and continue to add new services to our specialisms. In 2013-14, major service developments included designating Leeds General Infirmary (LGI) as the Major Trauma Centre for West Yorkshire to provide the highest quality care for patients with complex

Leeds Children's Hospital is located within Leeds General Infirmary

injuries. This has doubled the number of major trauma cases brought to the LGI, rather than district general hospitals.

We also transferred complex vascular surgery from Mid Yorkshire Hospitals NHS Trust to our Trust and we carried out 40% more liver transplants and reduced waiting times. This comes following changes to the national catchment areas from which donors are allocated to transplant centres.

From 1 April 2013, the new, national commissioner NHS England took direct responsibility for commissioning specialised services, to bring a more consistent approach to the quality and funding of these services across the country.

It has established specifications that will inform the future commissioning and configuring of specialised services nationally. The aim is to concentrate expertise in fewer centres of excellence and only commission services from providers who can best meet the standards required.

We believe that 80% of our specialised services already meet the new national requirements, ensuring that we are well placed to be one of the highest rated specialist centres for the region.

Our vision and values

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

Our vision is to be the best for specialist and integrated care – not only for patients in Leeds, but also for those from the Yorkshire and Humber region and beyond.

To achieve this vision, we are developing a new strategy for the Trust for the next five years. In December 2013, we began this work by asking our staff to define the values they believed should form the foundations of our culture, our ethos and how we will work for the benefit of patients for years to come. This is known as **The Leeds Way**.

The Leeds Way – our values

We are patient-centred

We consistently deliver high quality, safe care

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

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

We are fair

We treat patients how we would wish to be treated

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

We are collaborative

We are all one team with a common purpose

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

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

We are accountable

We act with integrity and are always true to our word

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

We disclose results and accept responsibility for our actions

We are empowered

We empower colleagues and patients to make decisions

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

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

Highlights of the year

Below are details of just some of the hundreds of developments and improvements that have taken place at our hospitals over the past year. For more information, visit the news section of our website **www.leedsth.nhs.uk** or look out for *Bulletin*, our staff magazine, which is also available on our website.

To mark International Clinical Trials day in May 2013, a new clinical research facility was opened in the Bexley Wing at St James's University Hospital. The opening was part of a number of events across the Trust to raise the profile of clinical research.

The centre will support the delivery of experimental medicine and complex clinical trials that cannot be delivered in a standard setting. Bexley Wing's atrium hosted a number of interactive displays for staff, patients and members of the public to celebrate the important research taking place in hospitals across Leeds.

The Leeds Centre for Sexual Health played a starring role on BBC3's Unsafe Sex in the City documentary series, which was filmed at the hospital in Summer 2013. The unit decided to take part to raise awareness of sexually transmitted diseases.

Filming also took place for the BBC1 series *Helicopter Heroes*, which follows the work of our partners at the Yorkshire Air Ambulance. Many patients arrive at Leeds General Infirmary Major Trauma Centre from across the region.

A new, robotic workstation was delivered to the Transplant Immunology Laboratory in May to speed up tissue type matching and antibody screening for renal transplant patients.

Jointly funded by the St James's Renal Transplant Trust Fund, the Leeds Teaching Hospitals Trust Charitable Foundation and the British Kidney Patients' Association, the workstation automates parts of the screening tests. It is helping the laboratory manage an increased workload and raise standards of patient safety.

An independent audit by NHS Blood and Transplant revealed that patients on the waiting list for a kidney transplant in Leeds are among the most likely to receive one, thanks to the hard work of the Trust's kidney transplant team.

The world's most advanced radiotherapy came to Leeds Cancer Centre in Autumn. Two Versa HD Radiotherapy systems were installed in Bexley Wing, St James's University Hospital.

Developed by our commercial partners, Elekta, the machines use cutting edge technology to provide faster and more accurate radiotherapy treatment for patients.

The Trust is the first centre in the UK and only the second in the world to begin using this equipment, pioneering new treatment and care for our patients.

The eye clinics at St James's and Seacroft Hospitals in Leeds won a national award in 2013 after outstanding praise from patients receiving care for macular degeneration.

The honour of 'Clinical service of the year' was part of the Macular Society's Awards for Excellence. The nomination recognises exceptionally good practice in the care of people with macular degeneration.

The team was among dozens nominated from across the country, but won the award after judges recognised their exemplary patient care, passion to improve services and efforts made to secure funding for the new eye clinic.

Our Major Trauma Centre, which serves the regional population and beyond, moved to a £1.2 million, purpose built facility in November.

The centre, which was launched in April, provides specialist treatment and care to people who have suffered major injuries or trauma.

Our partners, the Yorkshire Air Ambulance, are a vital part of our service, enabling us to see and treat casualties quickly, significantly improving outcomes for patients in the Yorkshire and Humber region.

We welcomed a team from the King Hussein Cancer Centre in Jordan in Summer. At a two-day workshop, oncology experts, healthcare specialists and delegates from the Leeds Cancer Centre shared information on our research and pioneering new treatments.

We hope to build a productive international relationship between our two specialist centres, sharing our world-class expertise and benefiting patients.

In February 2014, Leeds Children's Hospital became the first hospital in the UK to use a new miniaturised heart monitor with child patients.

Leeds Teaching Hospitals consultant paediatric cardiologist Dr Mike Blackburn inserted a monitor - around the size of two matchsticks - into the chest of two young brothers, Ethan and Kyle Roper, aged 8 and 7, in a short procedure undertaken at Leeds Children's Hospital, one of the UK's leading paediatric cardiac centres.

New to the UK, the monitor is the smallest implantable cardiac monitoring device available. So far, it has only been used on a handful of adult patients.

The technology will allow Dr Blackburn and his colleagues to continuously and wirelessly monitor irregularities in the youngsters' heart rhythm and help identify if further action is needed.

Take Heart, our adult cardiac charity, celebrated an amazing achievement in 2013, passing the £3 million milestone in supporting our wards and departments in the Yorkshire Heart Centre.

They are one of the many charities that do such a huge amount to support our services, improving the environment and experience of being in hospital for our patients.

The Paediatric Intensive Care Unit (PICU) at Leeds Children's Hospital moved to a new, state-of-the-art facility in 2013.

One of the largest and best equipped facilities anywhere in the UK, the unit will care for around 900 patients from all over the region every year. Bright and light, and decorated with colourful artwork, the unit will be a much improved environment for staff, families and patients.

Her Royal Highness, The Countess of Wessex, GCVO, the Royal Patron of the Leeds Children's Hospital officially opened the PICU in September, and met staff and families.

We celebrated the work of 15 of our longest serving volunteers in 2013. The volunteers, part of the Royal Voluntary Service at Wharfedale Hospital were thanked at a special awards ceremony and lunch to mark their long service.

One of the volunteers, Betty Cuthbertson, has been a volunteer for more than 32 years.

Summer saw the opening of a magnificent outdoor play pavilion outside the children's oncology ward at Leeds Children's Hospital, funded through our dedicated children's cancer charity, Candlelighters.

The modern, airy timber building is one of the most unusual constructed on the hospital estate in recent years and is a spectacular place to play, relax and get some fresh air away from the hospital environment.

A play area for the neighbouring children's respiratory unit was also opened in the summer, giving children with respiratory conditions access to a safe and stimulating space that will enhance the treatment they receive.

Links between the Specialist Rehabilitation Centre at Seacroft Hospital and the armed forces were strengthened during the year as part of the partnership between Leeds Teaching Hospital NHS Trust and Catterick, Europe's largest military garrison.

The Seacroft facility was also named as Disablement Service Centre 2013 in the Limbless Association Prosthetic and Orthotic awards for its innovative service to patients.

Section 1

Operating and financial review

Operating and financial review

In 2013-14, Leeds Teaching Hospitals NHS Trust saw and treated 957,922 outpatients, 30,126 inpatients, 100,038 day case patients and 220,888 patients attending our accident and emergency departments.

In addition, we delivered or subcontracted NHS services for a population of around 780,000 and provided specialist services for more than five million people.

1.1 Achieving quality, efficiency and financial sustainability

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

As part of our commitment to securing the best possible quality, outcomes and experience for our patients, we are working closely with the recently formed NHS Trust Development Authority (NHS TDA).

This body provides leadership, monitoring and support for non-Foundation NHS trusts to help them improve their services and ensure they are safe and sustainable. Our Trust must meet the performance and financial standards set by the NHS TDA if we are to progress to Foundation Trust status.

In April 2013, we were required to submit an annual operating plan for 2013-14 to the NHS TDA. Disappointingly, this showed that we were not meeting some of the national standards for quality and service delivery and that we needed a more robust plan for financial sustainability.

As a result, the NHS TDA asked us to draw up a Recovery Plan detailing agreed actions and timescales for improvement. The plan set out five key areas to focus on, which were as follows:

- quality and governance
- strategies to achieve financial balance and sustainability
- improving our performance against local and national targets for patient care
- engaging with and listening to staff
- developing a clear strategy and vision, and shared values.

We established a Recovery Committee, chaired by Trust Chair, Dr Linda Pollard CBE JP DL to oversee the actions arising from the Recovery Plan. Every month, the Trust reported on its delivery against the plan to the NHS TDA.

Later in the year, we commissioned a separate, independent review into our financial position by consultancy firm KPMG, which revealed the extent of our financial challenge and gave us valuable information against which to plan further.

We made substantial progress in the delivery of our Recovery Plan and as a result, in January 2014 we closed the Recovery Committee, embedding any remaining actions from the Recovery Plan into our day to day operations and Trust monitoring arrangements. Close working with the NHS TDA remains particularly important, however, as the organisation is a key partner for us and we expect to plan deficit budgets for the next two years.

The NHS TDA has agreed to support us with working capital, while we fulfil an agreed plan for cost and efficiency improvements that will enable us to provide patients with the highest quality care while achieving a sustainable financial position.

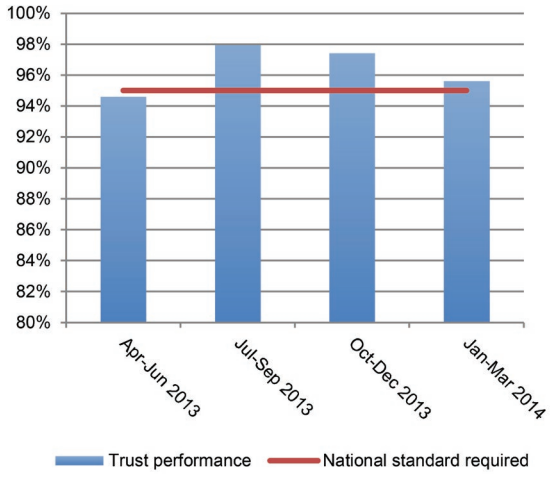
1.2 Our performance in 2013-14

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

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

Emergency care

Percentage of patients treated within four hours in A&E

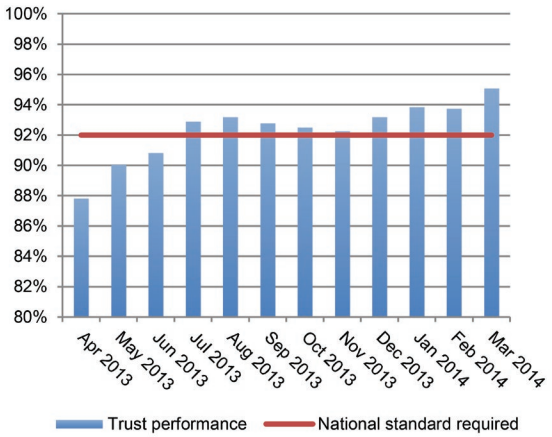


In 2013-14, our performance in Accident and Emergency (A&E) was a major achievement. Overall, our emergency departments saw, treated, discharged or admitted 96.38% of patients within four hours, surpassing the Department of Health target of 95%.

This is testament to the hard work and dedication of our A&E and other hospital teams, and to our improved systems and procedures. We will continue to refine these in 2014-15 to build on our progress.

Harm-free care

Percentage of patients experiencing harm free care

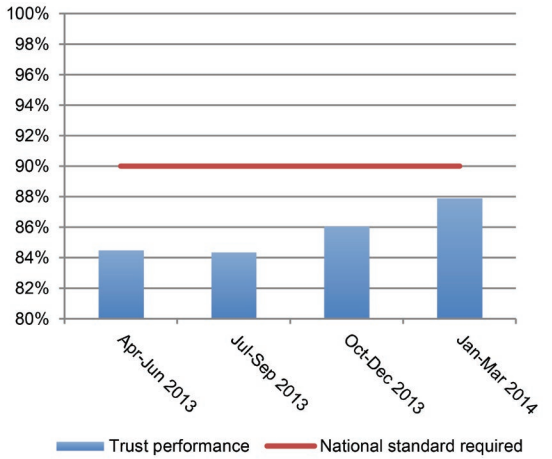


The percentage of patients receiving harm-free care has risen from that recorded 12 months ago, from 84.61% in January 2013 to 93.84% in January this year. Sustaining and improving on this progress remains a priority for us during 2014-15.

18 week waiting times from referral to treatment (RTT)

Admitted

Percentage of patients starting admitted treatment within 18 weeks of referral

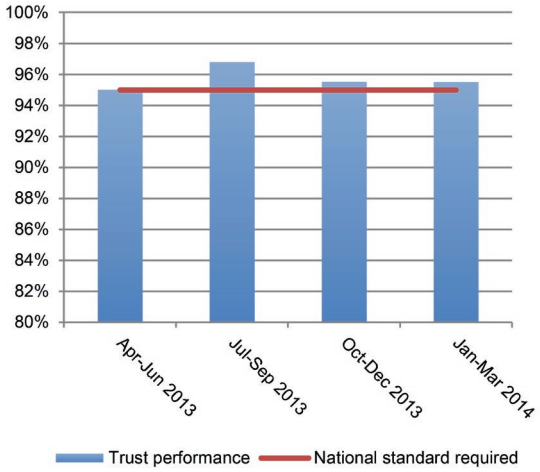


We have made real progress in reducing the number of patients who wait longer than 18 weeks for elective treatment. In April 2013, there were 1888 patients still waiting for

treatment after 18 weeks: in March 2014, this number was 654. Although there is still room for us to improve further, this has shown significant progress in the last 12 months and we continue to make strong progress in reducing this figure further.

Non-admitted

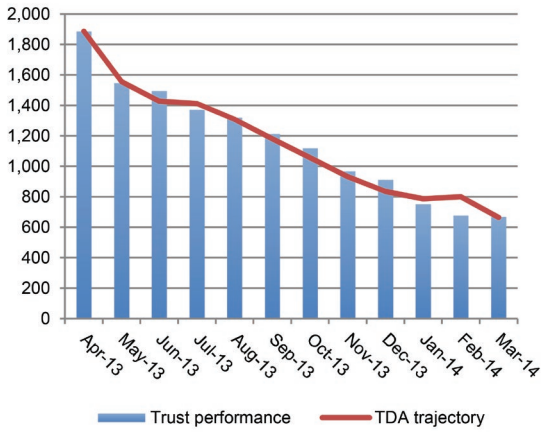
Percentage of patients starting non-admitted treatment within 18 weeks of referral



Trusts are monitored quarterly on this indicator of quality. In the last quarter of 2013-14 we achieved the standard required of at least 95% of non-admitted patients to be treated within 18 weeks.

Incomplete referral pathways

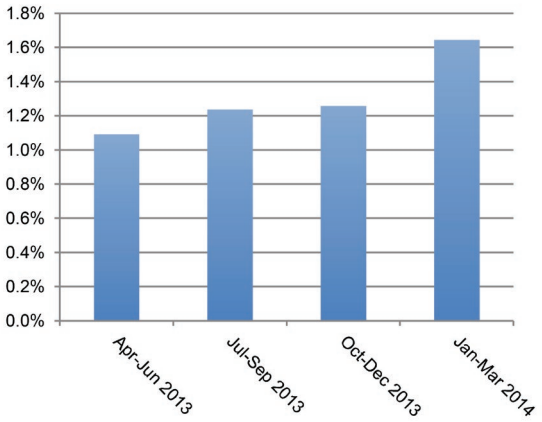
Number of patients on incomplete admitted pathways waiting over 18 weeks



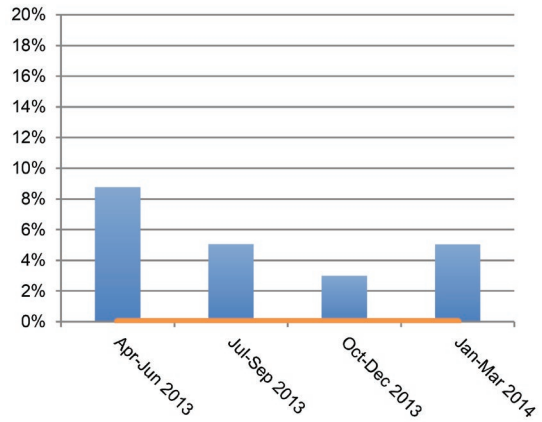
We comfortably achieved the target for incomplete referral to treatment pathways throughout the year. This was achieved in part by reducing the number of patients waiting for admitted treatment. The graph above shows how the numbers waiting over 18 weeks for admitted treatment (referenced above) fell during the year, from 1888 to 654. As well as reducing this number, the total number of patients waiting for treatment also fell throughout 2013-14, from 49,654 in March 2013 to 45,874 in March 2014.

Cancelled operations

Percentage of operations cancelled on the day



Percentage of patients not treated within 28 days of cancellation

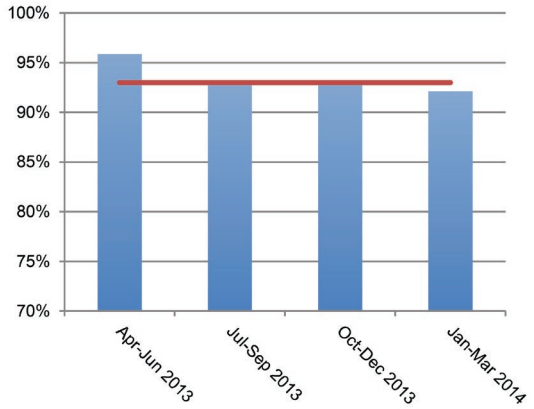


We recognise that last-minute cancelled operations are a distressing experience for patients and we have been working to reduce the number of these during 2013-14.

Whilst our performance has become more consistent, it has not yet reduced to the level that we would want for our patients and we are focused on achieving better results in 2014-15.

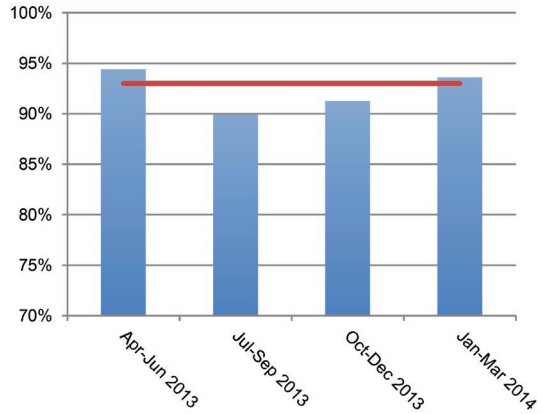
Cancer waiting times

Cancer access target: urgent GP referrals seen within 2 weeks



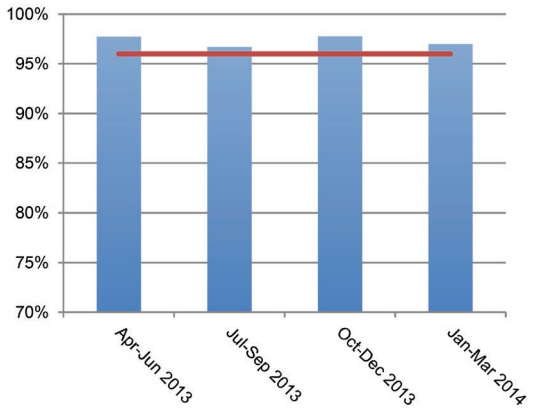
Until the last quarter of 2013-14, we met or exceeded the national target of seeing urgent GP referrals for patients with suspected cancer within two weeks. We have developed plans to ensure we meet this target in 2014-15, which are detailed in the section, **Factors likely to affect performance in 2014-15**.

Cancer access target: breast symptomatic referrals seen within 2 weeks



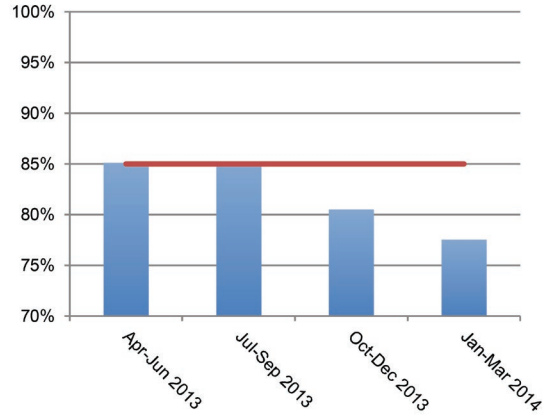
The two week wait standard for patients referred with breast symptoms was hit particularly hard by large peaks in referrals, which lead to issues for the Trust in achieving the target for 2013-14. One peak in late summer last year was exacerbated by staffing shortages in our team and there was another large rise in March and April 2014. As above, we have a strategy to improve our capacity and resources to enable us to meet the target sustainably in 2014-15.

Cancer access target: first treatment within 31 days



During 2013-14, we consistently achieved the target to treat patients within 31 days of a decision to treat. This was the case not only for first treatments, but also for subsequent surgery, drug or radiotherapy treatments.

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



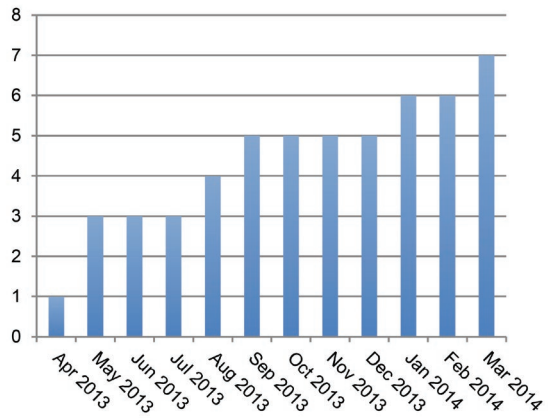
Meeting the target for patients receiving their first definitive treatment for cancer within 62 days of an urgent referral for suspected

cancer is often a shared responsibility with other hospitals that refer their patients on to us, which can make managing the standard more challenging. During 2013-14, we also experienced some resource issues in certain specialties.

Our work to resolve both our resourcing, and external referral issues should have a positive impact on our performance against this target in 2014-15.

Hospital acquired infections

Number of MRSA cases attributed to the Trust (cumulative)

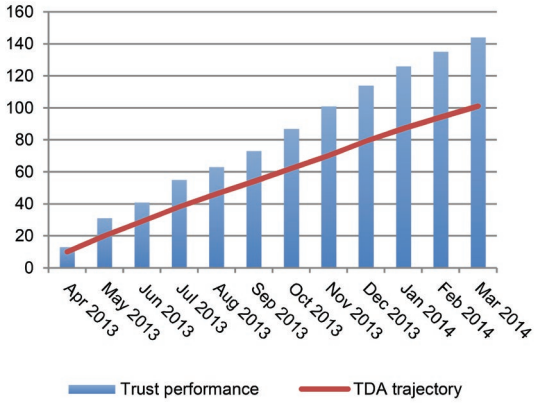


We are committed to reducing the levels of hospital acquired infections. Reducing the rate of Methicillin Resistant Staphylococcus Aureus (MRSA) infections is a key national target and indicates the degree to which hospitals prevent the risk of infection by ensuring the cleanliness of their facilities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

During 2013-14 we had seven cases of MRSA bacteraemia recorded against a target of no cases. We need to improve in this area and during 2014-15 we will focus again on keeping these infections to a minimum.

Clostridium Difficile (C difficile)

Number of CDI cases attributed to the Trust (cumulative)



Our commissioners had set us a target of no more than 101 cases of Clostridium Difficile (C difficile), another hospital acquired infection, but in 2013-14 we had 144 cases.

This was disappointing as we had continued to focus on the enhanced deep cleaning programme on our wards, careful use of antibiotics, a rigorous approach to hand hygiene and the vigorous root cause analysis review of all cases. We were encouraged to see the rate of infection beginning to slow in the last quarter of the year.

We are determined to make further progress and will continue to engage our staff, patients and visitors in maintaining good hand hygiene. For 2014-15, we have been set a target of 127 cases of C difficile. This is still a challenge for us, but is in line with our desire to reduce harm for our patients.

Factors likely to affect performance in 2014-15

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

Referral to treatment

We want to maintain our progress in reducing the numbers of patients who have waited more than 18 weeks for their procedure, and ensure that 90% of our patients receive their treatment in less than 18 weeks from June 2014. To achieve this, we are working with other providers and our commissioners to make sure our pathways of care both inside our hospitals and across the local health care system are as efficient as possible. An example of this is our work to make sure we use our theatre capacity effectively.

Cancer waiting times

Seeing patients with suspected cancer within the waiting times set by the NHS is of fundamental importance to us. A rise in the number of patients being referred for suspected cancer (two week wait referrals) means we have faced challenges in creating enough capacity within the Trust to meet demand, particularly for breast services.

In 2014-15, we will continue to act on our plans to increase and sustain our capacity to deliver two week waiting times for urgent appointments, recruiting more staff in some cases, or using our resources more efficiently.

Achieving the target that a patient with suspected cancer should be treated within 62 days of an urgent GP referral remains a challenge. We have plans in place to make sure we can meet the demand for this service. Many of our referrals are made by surrounding hospitals and we are working closely with them to make sure these patients arrive at our hospitals in time to gain the most benefit from our care.

Delivering the four hour target for patients in A&E (the emergency care standard) during the year was a huge achievement for the Trust. To sustain our performance in 2014-15, we are planning further arrangements to ensure patients receive care in the right place at the right time and are discharged from the Trust in a timely way.

1.3 Improving quality

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

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

In 2013-14, we had much to be proud of in our quality achievements. Some of the highlights are described below;

- The annual Dr Foster Hospital Guide, the independent guide to outcomes for patient care, revealed that for the third year running our mortality rates are either significantly lower, or lower than expected depending on the severity of a patient's condition. This places Leeds Teaching Hospitals NHS Trust among the best performing trusts in England.
- We reduced the number of patients who developed MRSA by 46%, thanks to our focus on stringent ward cleaning and hand hygiene.
- We made real improvements in the way we respond to complaints, including acknowledging complaints within three days and using clearer, more empathetic language.
- We met our local commissioner target to reduce the number of category 4 pressure ulcers (the grading refers to the level of severity, 4 being the most severe) by 50%.
- Following patient feedback, we've improved patients' experience of being discharged from our hospitals, including our communication about their medication, what to do if they have any concerns, and delays in their discharge.

Although these results are encouraging, maintaining and raising quality standards is a continuous process. We have robust improvement plans in place for the coming year, both to sustain our progress in those areas

where we have made advances in quality and to address issues in those where we recognise we are falling short of the standards of care patients should expect.

We have worked with our clinicians, managers and local partners at Leeds West Clinical Commissioning Group and Healthwatch Leeds to identify the following priorities, among others, for 2014-15.

Patient safety

We aim to reduce the incidence of falls and harm sustained to patients following a fall.

Clinical effectiveness

We aim to improve the care of patients when their condition deteriorates on the ward.

Patient experience

We will continue to improve the way we handle complaints and the timeliness of our responses. You can read more about our work in this area in **Patient Care and Experience**, on page 73.

In 2014-15, we will be working with a number of partner organisations, including the Yorkshire and Humber Improvement Academy (YHIA), Haelo, the nationally recognised experts in quality improvement, and the Leeds Institute for Quality Healthcare (LIQH) to deliver our quality goals and develop our strategy for providing healthcare that will improve patient safety, experience and outcomes.

Nurse staffing levels will be a particular focus. We know that having the right number of nurses on our wards is extremely important to patients, relatives and carers.

We are committed to ensuring we have enough staff with the skills to provide high quality care. To this end, last year the Trust Board approved an additional £6 million investment in nursing and midwifery staffing for 2014-15.

Over the next two years, our plans will include increasing nurse staffing levels to a minimum level of one nurse to eight patients on inpatient wards, contributing to a more positive hospital experience for our patients and better clinical outcomes.

Further information on key improvements in our quality of care and patient safety, the Trust's performance against national targets in 2013-14, goals agreed with commissioners and our plans for 2014-15 can be found in our **Quality Account**, published on page 83.

1.4 The NHS Constitution

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

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

Our Trust is almost fully compliant with the requirements of the NHS Constitution, but disappointingly is not yet achieving the target that 90% of admitted patients, and 95% of non-admitted patients should be seen within 18 weeks of the date their GP refers them for a hospital consultation. We aim to meet this target by end June 2014 and will report on it by the end of July 2014.

1.5 Financial review

Despite a very difficult year with the backdrop of a challenging economic climate, the Trust delivered a small surplus of £0.5 million in 2013-14, which is slightly better than the break even position planned for at the start of the financial year. This and other indicators of financial performance are summarised in the table opposite.

	31 March 2014 £M	31 March 2013 £M	Statutory Duty
Retained Surplus	0.5	1.5	Breakeven
Cash	23.2	24.3	External Financing Limit (EFL)
Capital Expenditure	29.0	35.3	Capital Resource Limit (CRL)
% Invoices paid in 30 days	67%	80%	95%

In achieving this position, the Trust has continued to maintain high quality services and in doing so has increased expenditure significantly when compared to last year. This has only been possible with the continued support of commissioners with whom we have worked very closely throughout the year. This close collaboration has ensured that income has similarly increased in order to pay for all of the goods and services required to provide patient care at the high standard expected.

Expenditure increased between the two financial years by £43.9 million (growth in percentage terms of 4.5%); £15.3 million of which was on pay costs (2.6%) and £28.6 million on non pay costs (7.3%).

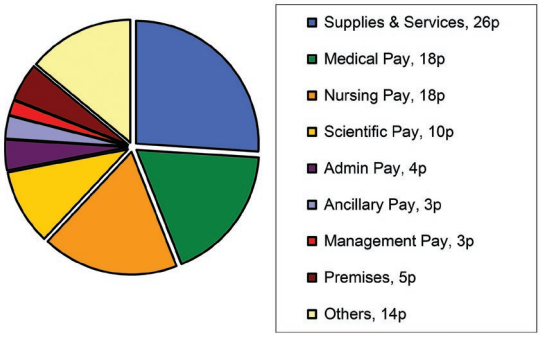
Of the increase in pay costs the majority of the increase relates to pay awards and incremental costs (2.1%), with the remainder being the result of a growth in staff numbers of 88 when compared to last year. This increase has predominantly been in staff groups with a direct link to patient care - nursing and medical staff numbers increased by 167 across the year, with a corresponding decrease in administrative and estates workers of 62 and smaller numbers elsewhere.

The largest growth area in non pay this year was in clinical supplies and services which increased by £23.7 million compared to last year, and of that figure the main increases were in drugs (£14 million). There was also a slight increase in costs associated with the use of the independent sector in 2013-14, driven by the Trust's commitment to ensure waiting lists are kept as low as possible.

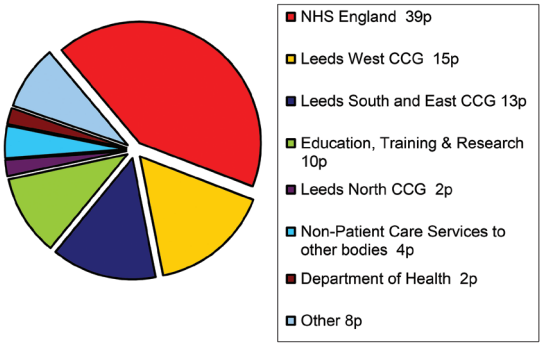
There was a significant change in the commissioning landscape in 2013-14. With the abolition of primary care trusts and strategic health authorities at the start of the financial year. The creation of NHS England and clinical commissioning groups meant the principal source of income to the Trust changed, and this is reflected in the summary accounts published on page 145.

This change highlighted the importance of the Trust's need to work closely with its new commissioning partners, and to build successful working relationships between the two. In doing so, we have ensured that the additional expenditure incurred in this year to deliver high quality patient care has been fully supported by our commissioners. The charts below show where our income came from and how it was spent.

How each £1 was spent



Where each £1 came from



Balance Sheet, Cash Flow and Going Concern

Net assets employed have increased by £8.7 million to £345.8 million compared to the previous year and there has been a reduction of £2.8 million in net current liabilities. Property, plant and equipment assets have reduced in value slightly as illustrated below:

	£ million
1 April 2013 Property, Plant, Equipment and Intangible assets	602.6
Capital Investment	29.0
Depreciation and Amortisation	(31.8)
Equipment disposals	(0.5)
31 March 2014 Property, Plant, Equipment and Intangible assets	599.3

The sale of land at Seacroft did not affect the carrying value of property. Following the introduction of a modern equivalent asset based valuation in 2010 the land in question carried no value for the purpose of providing healthcare services. Once declared surplus it was independently assessed for market value and the transactions taken through the Statement of Changes in Taxpayers' Equity (see page 148).

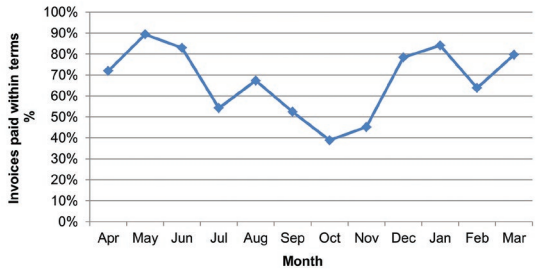
Total loans and borrowing liabilities on the Balance Sheet amount to £249 million, a reduction of £7.5 million in the year with no additional loans taken in 2013-14. Of the outstanding balance at 31 March, £207 million relates to the Bexley Wing and Wharfedale Hospital Private Finance Initiative (PFI) schemes while £42 million is owed to the Department of Health for capital investment loans taken in previous years.

The cash balance at 31 March of £23.2 million is £1.1 million less than the opening position. There was an expectation that 2013-14 would present some cash challenges and the planned end of year balance was £18 million. The increase was made possible by the receipt from our land sale. In fact, the year proved to be even more challenging from a cash point of view than anticipated.

April 2013 saw major changes in the way the NHS is structured and managed. New national and local bodies were established with responsibility for purchasing healthcare on behalf of patients from provider organisations such as Leeds Teaching Hospitals NHS Trust. The Trust established excellent working relationships with these new commissioners and was able to agree robust contractual arrangements. During the year, however, we experienced some delays in payment which added to cash shortfalls when coupled with our own challenging income and expenditure situation. These did mean that we experienced some difficulties in meeting all of our commitments to pay our suppliers within agreed timescales.

Under the terms of the Better Payment Practice Code we are required to pay suppliers within 30 days. Across the year our performance with non NHS suppliers fell to an average of just 67%. We need to improve this position. The chart below illustrates performance across each month of the year and it will be seen that there was improvement in the later period. A number of measures were put in place to improve cash flow and many of these are projects that will continue into 2014-15. The Trust is extremely grateful to our commissioning partners and our suppliers for their continuing support.

Better Payment Code - Non NHS Suppliers



In light of the cash challenges in 2013-14 and more significantly the fact that the Trust is planning a deficit budget of £50 million in the next financial year it is important to reflect on why the annual accounts have been prepared on the "going concern" basis.

Looking forward to the foreseeable future it is evident that the Trust is facing very difficult

financial pressures. To deal with these, and the efficiency savings that will have to be delivered as a result, the Trust has developed a plan to ensure its underlying financial sustainability after two years of deficit budgets.

The NHS Trust Development Authority has agreed the plan and also to provide the necessary financial support during that period. The Trust therefore has access to cash which will ensure that it can meet all of its financial obligations and maintain its liquidity. In those circumstances it is quite right that the accounts continue to be presented on the basis of going concern.

Capital Investment

Capital expenditure in 2013-14 was £29 million and is analysed in the table opposite. Alongside schemes to maintain our existing infrastructure, replace equipment or ensure safety, there was considerable investment in service development. For example we opened our new Major Trauma Centre at Leeds General Infirmary early in the year and replaced two ageing linear accelerators in Bexley Wing with state-of-the-art models which will deliver additional benefits to our patients.

Capital Expenditure Summary 2013/14

Description	Amount £000
Equipment	
2 Linear Accelerators	2,563
Gamma Camera	641
Vascular Theatre Room 2	635
Catheter Lab 2 - Upgrade	461
6 Ultrasound Machines	355
Renal Dialysis Machines	255
HDR Brachytherapy Equipment	200
Other	2,748
Sub Total	**7,858**
Building and Engineering Schemes	
St James's Electrical Infrastructure	4,581
Multi Specialty Trauma Ward	1,075
Critical Care	956
Legionella/Pseudomona works - Trustwide	387
PICU Wards L47/L48 Clarendon Wing	293
Paediatric Cardiology Ward L51 Clarendon Wing	279
Asbestos Management	273
Seacroft Boiler	230
ENT Clinic - LGI	212
Occupational Health - LGI	205
Other minor works	4,611
Sub Total	**13,102**
Informatics	
Data Storage Management	1,885
Windows 7 Migration	1,764
Dental Clinical System	761
Clinical Documentation	544
Electronic Patient Records	458
Clinical Portal	398
Order Communications	341
IT Infrastructure	305
Other	1,634
Sub Total	**8,090**
Grand Total - Gross Capital Spend	**29,050**

Conclusion

There is no doubt that 2013-14 was difficult financially and that the Trust was required to manage a challenging cash position. To achieve its planned breakeven position and be able to invest £29 million in capital projects does therefore represent a satisfactory achievement. The quality of patient care was and will continue to remain paramount in the more economically problematic years that lie ahead.

For the first time in its history the Trust is in the position of planning deficit budgets in 2014-15 and 2015-16. The entire NHS is facing increasing financial constraints and is required to make on-going efficiency savings of approximately 4%.

Leeds Teaching Hospitals NHS Trust has plans in place to deliver its financial targets in the coming years and return to a position of underlying financial sustainability. Cost improvements will be necessary as will the continued support of our commissioners and the NHS Trust Development Authority who have agreed to provide working capital during our return to breakeven. Directors are grateful for this support and committed to delivering the best healthcare services from a secure financial base.

Countering Fraud and Corruption

The Trust has comprehensive arrangements for countering fraud and corruption with three fully trained and accredited Local Counter Fraud Specialists (LCFSs) who have the full support of the Trust Board, Audit Committee and Director of Finance. The Trust has an effective working relationship with NHS Protect, the organisation that leads on tackling crime across the service.

The Trust has an approved Counter Fraud Policy in place with all staff duty bound to report any suspicions. The policy is cross referenced to other policies such as Whistleblowing and Standards of Business Conduct to ensure its message is embedded in the culture and governance of the organisation.

The Trust has an approved, risk based, plan of counter fraud work which is in line with the standards for providers. This plan:

- informs and involves those who work for or use the NHS about fraud and how to tackle it
- prevents and deters fraud in the NHS, taking away the opportunity for fraud to re-occur and discouraging those individuals who may be tempted to commit fraud
- holds to account those who have committed fraud against the NHS by detecting and prosecuting offenders and seeking redress where viable.

Progress against the plan is monitored and reported upon regularly.

The Trust's current arrangements for both Internal Audit and Counter Fraud work have been established for a number of years, with a protocol in place to formalise those arrangements to encourage continued cooperation, coordination and information sharing.

1.6 Future direction

In October 2013, we began work on a five year strategy to help us create the quality of services and sound financial platform we need to achieve our ambition to become the leading hospital trust for specialist services and integrated health care.

From the beginning, staff involvement has been at the heart of developing our strategy. Using the web-based system, WayFinder, we pioneered the use of crowdsourcing to seek staff ideas and views on the vision, values and goals that will define who we are and how we will work for the next five years – an identity and approach known as 'The Leeds Way'.

Thousands of staff took part in this process, helping to shape a draft strategy that was the subject of a six-week consultation with staff, stakeholders and our members. This ended in March 2014.

This was the first time we had consulted so widely on our strategy, and the response was extremely supportive. We received nearly

40,000 contributions to our engagement exercise. From these, common themes emerged to form our core values (described in more detail on page 10) and five goals that will drive our strategic direction.

Our goals are:

- to be the best for patient safety, quality and experience
- to be the best place to work
- to be a centre of excellence for research, education and innovation
- to offer seamless integrated care across organisational boundaries
- to be financially sustainable

Those responding to the consultation were generally supportive of the direction of travel we described but were keen for us to provide more detail on how we would achieve our ambitions. Our new Director of Strategy and Planning, appointed at the beginning of 2014-15, will lead this work in the coming 12 months to translate these goals into tangible, measurable actions across all areas of the Trust that will make a real impact on patient treatment, care and experience.

Work has already begun to realise our ambition to become the best for specialist and integrated health care.

We have begun a series of initiatives to become the best place to work by starting to embed The Leeds Way into our employment and staff engagement practices. These include updating our recruitment processes to ensure our values are an integral part of working life at the Trust from day one. We are shaping our appraisal system around our values to reflect the behaviours we expect staff to display.

During 2013, we spent more than £7 million to improve infrastructure across the Trust – for example replacing water tanks and drainage – to ensure our care takes place in the safest environment. We also completed schemes to open a new children's cardiac ward in Clarendon Wing, provide better clinical accommodation for areas like Ear Nose and Throat outpatients and bereavement services at the LGI and install measures to prevent the spread of infection, among others.

During 2014-15, our estates strategy will build on the improvements we are already making to offer care for patients in an environment that is safe and comfortable, improving their experience of our hospitals.

Our new clinically led Clinical Service Units will focus on delivering the highest standards of quality, safety and financial performance for their services. During 2014-15, we will agree a clinical strategy setting specific targets for mortality, health care infection, harm free care, avoidable harm and patient experience.

Partnerships for better care

Our future strategy sets out our clear vision to become the best for integrated care and one of NHS England's centres of excellence for specialist services.

To achieve this, we will need to work closely with local and national partners to deliver health and social care that is centred around patients' needs, whether this is for care in hospital, in a community setting or at home.

There are a number of key partners working with us to shape the direction of health and social care in Leeds and the region. NHS England, the national body that commissions specialist care and three local Clinical Commissioning Groups (CCGs) are crucially important to our aspirations.

CCGs are formed by groups of GP practices to ensure the health needs of the local population are met by local providers, so we work together very closely to develop high quality services. The CCGs are actively involved in our future ambitions. They collaborated with us to inform our draft five year strategy and responded enthusiastically to our consultation on this draft, helping us to move towards a clear and coherent strategic plan.

In 2013, we took a major step forward in realising our ambition to be the best for specialist and integrated care when Leeds was awarded 'Integrated Care Pioneer' status by NHS England, one of 14 across the country.

This enables us to work with our partners in health and social care to realise better integrated services for people in Leeds more quickly. The aim is to work together to provide better support at home and earlier treatment in the community to prevent unnecessary hospital admissions, or stays in care homes. As the partnership progresses, we will offer high quality, seamless care for adults and children in Leeds, sharing learning with local and national partners.

A major part of this care will involve older people. We are already working together to ensure rehabilitative care is available, reducing the need for hospital admissions and lengthy hospital stays while promoting independence.

The health and social care needs of an increasingly elderly population are a major focus for the Health and Social Care Transformation Board in Leeds, of which the Trust is a member. The Leeds Health and Social Care Transformation Programme (LHSCT) brings together a range of organisations to plan and take action on the most appropriate health and social care solutions for the local population.

The partnership will continue to focus on improving productivity, increasing efficiency and raising the quality of services while promoting measures to prevent ill health.

Equally vital is our work with academia. Our partnership with Leeds University will play a significant role in the transformation not only of health services but also the local and regional economy in the months and years to come. You can read more about this work in detail in **Research and Innovation**, on page 59.

1.7 Managing risk

In 2013, the Trust established a wide-ranging improvement programme for managing risk. The programme places an equal and proactive emphasis on quality, safety, performance and financial risk and raises the profile of risk management within the Trust's overarching governance arrangements.

A description of the principal risks and uncertainties facing the Trust is set out in the **Annual Governance Statement** on page 45.

1.8 Regulatory ratings

During 2013-14, the NHS Trust Development Authority placed Leeds Teaching Hospitals NHS Trust in Escalation Score 4, Material Issues. This means we are not meeting some of the national performance targets for quality, service delivery and financial sustainability. We have been required to make improvements, as detailed in our Recovery Plan described earlier in this section.

Further details of our compliance against national and commissioner performance targets and of inspections made by the independent regulator of health and social care services in England, the Care Quality Commission, can be found in our **Quality Account**, on page 83.

1.9 Sustainability report

Environmental Impact Performance Indicators 2013-14

Area		Non-financial Metric	Non-financial Metric		Financial data (£,000)	Financial data (£,000)
		2013/14	2012/13		2013/14	2012/13
Waste minimisation and management	Clinical HTI	2,335 Tonnes	2,231 Tonnes	Total Waste Cost	£1,610	£1,625
	Clinical – Alternative	2,330 Tonnes	2,159 Tonnes			
	Landfill disposal	1,181 Tonnes	1,184 Tonnes			
	Recycling / Recovery	1,294 Tonnes	1,218 Tonnes			
Finite resources	Water / sewerage	*717,744 m³*	692,837 m³	Water / Sewerage	£1,300	£1,195
	Electricity	17.19 GWh	15.97 GWh	Energy	£12,321	£12,811
	Gas	297.68 GWh	319.86 GWh			
	Heat and Power	5.72 GWh	7.63 GWh			
	Oil	0.10 GWh	0.10 GWh			

Those in italics are where invoices have not been received and number estimated.

Energy saving

A scheme undertaken to shut the old steam raising boiler house and replace with a modular low pressure hot water system at Seacroft hospital has realised a 25% reduction in gas consumption, achieving significant carbon emission savings. This has demonstrated that reduction in steam usage can save significant energy.

Work is underway to renew energy contracts at both Leeds General Infirmary and St James's University Hospital in 2015 which aim to deliver significant energy savings and reduce the Trust's carbon emissions. Strategic outline cases have been approved by the Board.

Carbon reduction

We continue to make progress to reduce our carbon footprint. Since the base year of 2007, we have saved over 1,160 tonnes per annum. This is measured against energy savings but it excludes reductions from the transport fleet and waste.

Waste segregation

We have continued to run education campaigns to improve the management and disposal of waste. The introduction of double bins has enabled staff to segregate easily, ensuring that waste is treated in the most efficient and environmentally friendly manner.

Recycling

During 2013, we awarded a new municipal waste contract, which began in early in 2014. The new contract will ensure that non clinical waste is sent to a sorting facility where it will be separated with all possible items being sent for recycling and the remainder sent for energy recovery, significantly reducing the Trust's waste sent to landfill.

Lighting

We have been running LED lighting scheme trials on two levels of Gledhow and Chancellor Wing circulation areas. The trials will determine the most suitable colour for the right environment, which can then be expanded to other areas and future schemes.

Wellbeing

The Trust's Health and Wellbeing team has been working with Sustran to obtain loan bikes to enable Trust staff to trial cycling. A cycle to work campaign has been widely publicised, offering staff the opportunity to enjoy the health benefits of moving out of the car and onto a bike for the commute into work. This improves the health of staff and the local environment.

The team continues to promote travel via public transport, encouraging staff take up of the Metro Card travel scheme which saves money and reduces the impact of travel to work on the environment.

Future plans

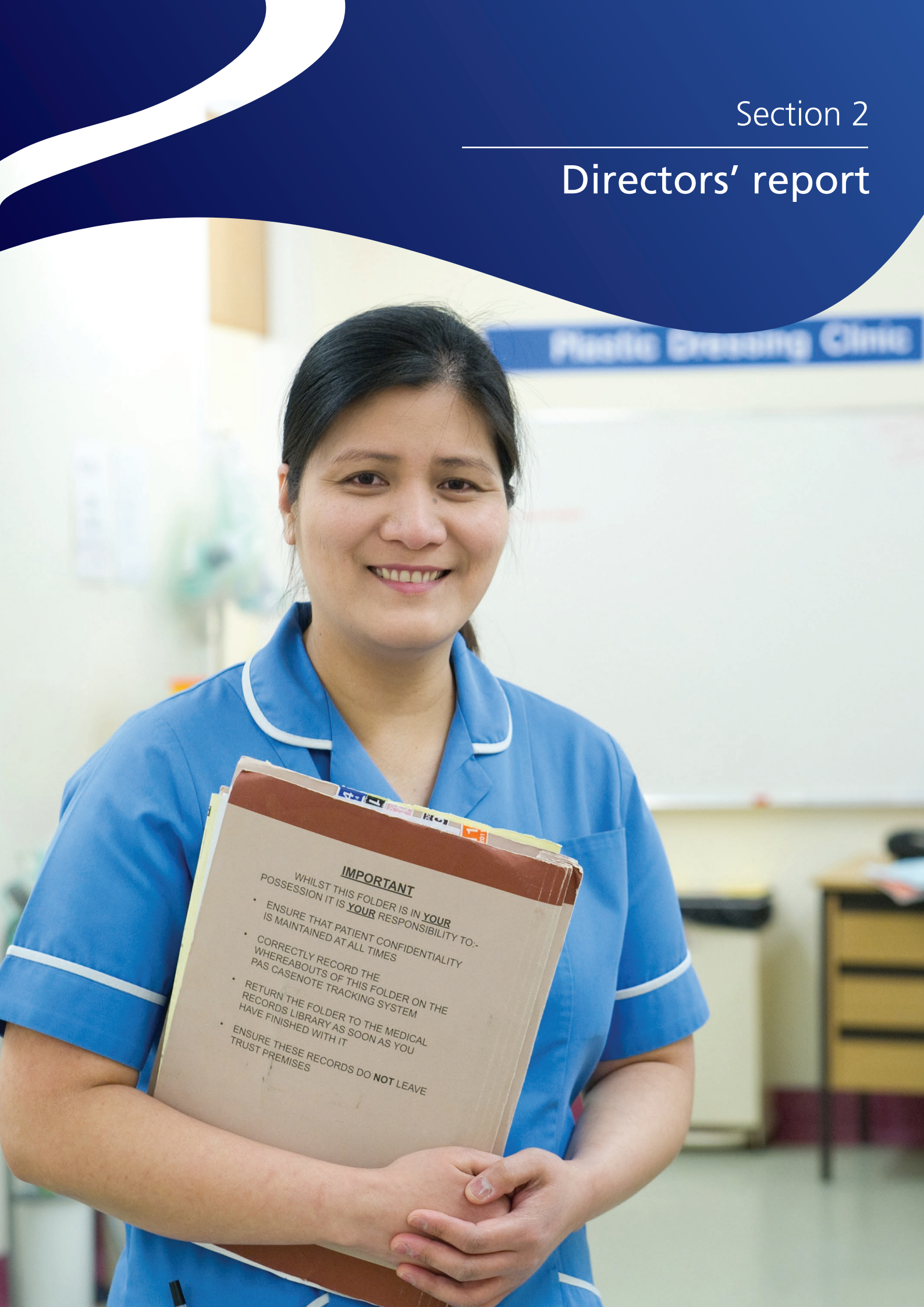
Renegotiation of the two largest energy centre contracts in 2015 will be a major step in reducing our carbon footprint, reducing the energy we consume in our daily operations and saving money on our overheads which can than be better used for patient care.

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

- expansion of LED lighting in circulation areas
- better control of non clinical buildings and their heating systems
- better use of technology in forthcoming refurbishments
- investigation into reconfiguration of energy provision at Leeds General Infirmary and St James's University Hospital

Section 2

Directors' report



Directors' report

2.1 Members of the Trust Board in 2013-14

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

During 2013-14, the Board met on the last Thursday of every month (excluding August), in public at St James's University Hospital until September 2013, when it began to meet bi-monthly, with an informal workshop between meetings. A staff council member is also present and takes part in discussions. The media attend and report on proceedings in the local press. Any member of the public is welcome to attend the formal meetings. These are advertised in the local media and on the Trust's website (see address below).

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

Membership of the Trust Board

During 2013-14, the Trust Board experienced a number of changes in both executive and non-executive membership.

At all times during the year, however, the Trust Board has been compliant with the statutory composition of executive officers of the Board. Following the departure of a non-executive director in September 2013, we have been keen to fill this role and have finally recruited a high calibre individual to support the quality ambition of the Trust. Working closely with the NHS Trust Development Authority (NHS TDA), we have now appointed Dr Bill Kirkup, who will be joining the Trust from 19 May 2014.

The composition of the Trust Board is five voting executive directors with five voting non-executive directors in addition to the Chair. We have an incoming new appointment and a longer term vacancy being held.

Observers at the Trust Board during 2013-14 were the Director of Human Resources, the Director of Estates and Facilities, the Director of Informatics, the Director of Communications and External Affairs and the Head of Corporate Affairs/Trust Board Secretary.

Appointment of non-executive directors

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

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

Measuring the performance of the Board members

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

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

The Chief Executive has appraised executive colleagues during the year.

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

During 2014-15, as a stable team, the Trust Board will begin an externally led Board development programme. Discussions are underway to develop this.

Register of interests

The register of interests for Trust Board members was reported to the public Board meeting in March 2014. This is available by contacting the Head of Corporate Affairs/Trust Board Secretary at the Trust.

Non-executive directors of the Board during 2013-14

Dr Linda Pollard CBE JP DL
Chair

From 1 February 2013

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

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

Linda is also Chair of An Inspirational Journey, an organisation that supports women to reach the top of their professions and seeks to increase their participation at Board level.

Linda is Regional Chairman of Coutts Bank plc, and was until July 2013 Pro Chancellor/ Chairman of the University of Leeds where she was awarded an Honorary Doctorate.

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

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

Mark Abrahams
Vice-Chairman and Chair of the Finance and Investment Committee

From 1 Feb 2009
Second term of office from
1 February 2012 – 31 January 2015

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

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

Mark Chamberlain
Non-executive director and Chair of the Workforce Committee

From 4 January 2010

Mark is currently Director of Human Resources Programmes at BT Retail, where he has worked since 1986, holding a variety of roles in HR, marketing, operations, strategy and business development. He is a member of the BT Yorkshire and the Humber Regional Board, and was a non-executive director of the Learning and Skills Council Regional Board until 2010.

Lynn Haggar
Non-executive director and Chair of Quality Committee

4 January 2012 – 30 September 2013 (Dr Bill Kirkup to commence in post 19 May 2014)

A Lecturer in Medical Law and Ethics at the University of Sheffield, Lynn also undertakes periodic training for members of the Research Ethics Committee in Leeds on behalf of the Department of Health's National Patient Safety Agency. She was Chair of the Sheffield Children's Hospital Trust Board (1998 – 2008) and is a former Non-executive Director at the Northern General Hospital, Sheffield.

Clare Morrow
Non-executive director

4 January 2012 – 31 December 2013

Clare has been Chair of Welcome to Yorkshire (previously the Yorkshire Tourist Board) since April 2008. She is also a Non-executive Director of the Rugby Football League and Network Manager of the Broadcasting and Creative Industries Disability Network.

Clare trained as a journalist and is a former Assistant News Editor at BBC Look North in Leeds and was later Controller of Programmes at ITV Yorkshire.

Professor David Cottrell
Non-executive director

1 October 2012 – 30 September 2013

The University of Leeds representative on the Trust Board, David is Professor of Child and Adolescent Psychiatry and the University's Dean of Medicine. After graduating in medicine from Oxford in 1976, and London in 1979, he trained as a lecturer at St George's Hospital Medical School and then worked as a Senior Lecturer at the London Hospital Medical College before he was appointed to the Foundation Chair in Child and Adolescent Psychiatry in Leeds in 1994.

Caroline Johnstone
Non-executive director and Chair of the Audit Committee

From 1 January 2013

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

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

Professor Paul Stewart
Non-executive director and Chair of the Education, Research and Training Committee

From 1 October 2013

Paul is an Endocrinologist who became the new Dean of Medicine at the University of Leeds in August 2013, having moved to Leeds from the University of Birmingham.

Trained in medicine at the University of Edinburgh, Paul held a number of positions in Edinburgh before joining the University of Birmingham in 1989. His career has been supported at the highest level by personal career awards from the Medical Research Council (MRC), Wellcome Trust Programme grants and, most recently, by a European Research Council Advanced Research Fellowship.

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

Allison Page
Non-executive director

From 1 January 2014

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

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

Dr Bill Kirkup CBE
Non-executive director

From 19 May 2014

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

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

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

Executive Directors of the Board

Maggie Boyle
Chief Executive

1 May 2007 - 16 June 2013

Maggie has a background in nursing and Human Resources management and has led transformational change in various health service organisations. She has worked at chief executive level since 1991. Before joining Leeds Teaching Hospitals NHS Trust, she headed large NHS trusts in Liverpool and Glasgow.

Maggie left the Trust in June 2013 and her role was undertaken by Chris Reed, Interim Chief Executive.

Chris Reed
Interim Chief Executive

17 June 2013 – 13 October 2013

Chris joined the Trust as Interim Chief Executive in June 2013. He had previously been Chief Executive of the PCT cluster for Newcastle, North Tyneside and Northumberland. Chris carried out his role until October 2013, when a permanent Chief Executive, Julian Hartley, joined the Trust.

Julian Hartley
Chief Executive

From 14 October 2013

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

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

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

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

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

Neil Chapman
Director of Finance

31 May 1983 - 30 September 2013

Neil was Director of Finance since the Trust was formed in April 1998. He joined the NHS in 1983 after qualifying as a chartered accountant and spending three years in industry.

Neil left the Trust in September 2013 and his role was undertaken by an Interim Director of Finance.

Kim Gay
Interim Director of Finance

1 October 2013 – 27 October 2013

Kim joined the Trust as acting Director of Finance until Kevin Howells was appointed Interim Director of Finance in October 2013.

Kevin Howells
Interim Director of Finance

28 October 2013 – 19 January 2014

Kevin has a wealth of NHS leadership experience in Leeds, most recently as Director of Finance at the former Leeds Primary Care Trust. He brought his skills to the Trust to cover management of our finances until Tony Whitfield joined as permanent Director of Finance in January 2014.

Tony Whitfield
Director of Finance

From 20 January 2014

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

Tony has been a Finance Director in the NHS for more than 20 years. He is a fellow

of the Chartered Institute of Management Accountants, and holds an MA in financial management.

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

Clive Walsh
Interim Chief Operating Officer

21 May 2012 – 26 April 2013

Clive has worked at a number of large trusts including Hammersmith Hospitals in London, City Hospital Birmingham and Worcestershire Acute Hospitals where he was Chief Operating Officer (COO) for two years. More recently Clive completed interim assignments as a COO at Royal Berkshire and Whipps Cross University Hospital London and Peterborough and Stamford NHS Foundation Trust.

Dr Mark Smith
Chief Operating Officer

From 20 May 2013

Mark joined us from City Hospitals Sunderland NHS Foundation Trust, where he was Chief Operating Officer since 2010, having originally joined the Board in 2008 as Executive Director of Strategy and Service Development.

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

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

Dr David Berridge
Dr Bryan Gill
Dr Phil Ayres
Joint Interim Medical Director

1 April 2013 – 31 May 2013

Dr David Berridge, Medical Director, Operations and Dr Bryan Gill, Medical Director, Quality and Governance fulfilled the role of Joint Interim Medical Director, and Dr Phil Ayres, Associate Medical Director, deputised until Dr Yvette Oade joined as Chief Medical Officer in June 2013.

Dr David Berridge

Dr Berridge began his career at Leeds Teaching Hospitals NHS Trust in 1995 as a Consultant Vascular Surgeon at St James's University Hospital. He progressed to become Clinical Director of Surgical Services at the Leeds General Infirmary, then Clinical Centre Director. He has also held roles as Divisional Medical Manager, Oncology and Surgery, Joint Interim Medical Director for the Trust and is now Medical Director (Operations).

Dr Berridge is the current President of the Venous Forum of the Royal Society of Medicine.

Dr Bryan Gill

Dr Gill joined the Trust in 1994 as a Consultant in Neonatal Medicine. He spent 19 years as Medical Manager and held the role of Deputy Medical Director from 2009-2013, before taking up the role of interim Medical Director from April - May 2013.

Dr Phil Ayres

Dr Ayres has been at the Trust since it was formed in 1998, having joined St James's University Hospital in 1996 as a consultant in Public Health. He was a divisional Medical Director and associate Medical Director to

the Trust for its first five years, transferring to the role of Deputy Medical Director in 2003. He was appointed to the post of Associate Medical Director (Professional Standards) and Responsible Officer in 2013.

Dr Yvette Oade
Chief Medical Officer

From 1 June 2013

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

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

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

Clare Linley
Acting Chief Nurse

17 January 2013 – 19 May 2013

Deputy Chief Nurse Clare Linley carried out the role of Acting Chief Nurse until the appointment of Suzanne HInchliffe as Chief Nurse in May 2013.

Professor Suzanne Hinchliffe
Chief Nurse

From 20 May 2013

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

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

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

Non-voting executive directors in attendance at the Board

Jackie Green
Executive Director of Human Resources

From 16 March 2009

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

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

Alison Dailly
Director of Informatics

From 1 January 2009

Alison has over 25 years' experience in NHS management, of which 14 have been spent in the specialist area of Informatics.

Before joining the Trust she served for four years as Director of Information at Royal Liverpool and Broadgreen University Hospitals.

Darryn Kerr
Director of Estates and Facilities

From 1 March 2006, returned to post 1 October 2012 following an internal secondment

Before joining the Trust, Darryn worked at the Department of Health, where he was Chief Engineer and Acting Director of Estates and Facilities. Before that, Darryn, a chartered engineer, worked at NHS Estates and a number of health authorities and acute trusts in the North East of England.

Karl Milner
Director of Communications and External Affairs

From 1 December 2011

Before joining the Trust Board in 2011, Karl was Director of Communications and Corporate Affairs for Yorkshire and Humber Strategic Health Authority. Before this, he was a partner at global financial public relations group, Finsbury. Karl is a fellow of the Chartered Institute of Public Relations and a visiting lecturer at Leeds Business School.

Karl started a 12 month secondment on 1 April to the Northern Health Science Alliance.

Karen Straughair
Recovery Director

17 June 2013 – 13 October 2013

Karen has a background as a Chief Executive in the acute sector and commissioning stretching back 13 years. She was latterly Chief Executive of the PCT Cluster for Gateshead, South Tyneside and Sunderland.

Malcolm Poad
Recovery Director

14 October 2013 – 30 November 2013

Malcolm has over 35 years' experience working in the NHS, much of this as an executive director in acute hospitals in Grimsby and Bradford and for the NHS North of Tyne Commissioning Consortium. In 2012-13 he worked to set up the new Cumberland, Northumberland, Tyne and Wear Local Area Team. He has an MPhil in Marketing awarded for his research into the NHS internal market established in the 1990s.

2.2 Trust Board attendance at public Board meetings

Name/Date	23 Apr 2013	30 May 2013	27 Jun 2013	25 Jul 2013	26 Sep 2013	28 Nov 2013	30 Jan 2014	27 Mar 2013
Members:								
Linda Pollard (Chair)	✓	✓	✓	✓	✓	✓	✓	✓
Maggie Boyle	✓	✓						
Chris Reed				✓	✓			
Julian Hartley						✓	✓	✓
Mark Abrahams	✓	✓	✓	✓	✓	✓	✓	✓
Mark Chamberlain	✓	✓	✓	✓		✓	✓	✓
Caroline Johnstone	✓	✓	✓	✓	✓	✓	✓	✓
Clare Morrow	✓	✓	✓	✓	✓	✓		
Lynn Haggar	✓	✓	✓	✓	✓			
David Cottrell		✓		✓	✓			
Neil Chapman	✓	✓	✓	✓	✓			
Kevin Howells						✓		
Allison Page							✓	✓
Paul Stewart						✓	✓	✓
Suzanne Hinchliffe		✓	✓	✓	✓	✓	✓	✓
Yvette Oade			✓	✓	✓	✓	✓	✓
Mark Smith		✓	✓	✓	✓	✓	✓	✓
Tony Whitfield							✓	✓
In Attendance:								
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓
Alison Dailly	✓		✓	✓	✓	✓	✓	✓
Michelle Davies	✓	✓	✓					
Joy Murphy				✓				
Jackie Green		✓	✓	✓	✓	✓	✓	✓
Karen Straughair				✓	✓			
Tracy Gill					✓	✓	✓	✓
Darryn Kerr	✓	✓	✓	✓	✓	✓	✓	✓
Clive Walsh	✓							
Clare Linley	✓							
Phil Ayres	✓							
Karl Milner	✓	✓	✓	✓	✓	✓	✓	
Dave Berridge		✓						
Craig Brigg								✓
Bryan Gill		✓						
Paul Moore							✓	

Attendance at committee meetings: Audit Committee

Name/Date	9 May 2013	29 May 2013	12 Sep 2013	5 Dec 2013	13 Mar 2014	Special Risk Review Meeting 26 Feb 2014
Members:						See note below
Caroline Johnstone (Chair)	✓	✓	✓	✓	✓	✓
Mark Abrahams	✓	✓	✓	✓	✓	✓
David Cottrell	✓	✓	✓			
Allison Page					✓	✓
Neil Chapman	✓	✓	✓			
Tony Whitfield					✓	✓
Attendees:						
Maggie Boyle	✓					
Jo Bray	✓	✓	✓	✓	✓	✓
Michelle Davies	✓	✓				
David Gregory	✓	✓	✓	✓	✓	✓
David Hay		✓				
Chris Reed			✓			
Craig Brigg			✓	✓	✓	
Karl Milner			✓			
Balbir Bhogal				✓		✓
Alison Dailly				✓	✓	✓
Tracy Gill				✓	✓	✓
Kevin Howells				✓	✓	
Phil Knight				✓		
Paul Moore				✓	✓	✓
Observers from External Auditors:						
Perminder Sethi	✓	✓	✓	✓	✓	✓
Phil Jones	✓	✓	✓	✓	✓	✓

Special Risk Review Meeting - A number of other attendees were requested to attend the special meeting to provide a one item report

Finance and Investment Committee

Name/Date	9 May 2013	11 Jul 2013	14 Nov 2013	9 Jan 2014	13 Mar 2014
Members:					
Mark Abrahams (Chair)	✓	✓	✓	✓	✓
Maggie Boyle	✓				
Chris Reed		✓			
Julian Hartley			✓	✓	✓
Mark Chamberlain	✓	✓	✓		
Neil Chapman	✓	✓			
Kevin Howells			✓	✓	✓
Tony Whitfield					✓
Linda Pollard	✓		✓	✓	✓
Caroline Johnstone		✓		✓	✓
Mark Smith		✓	✓	✓	✓
Jackie Green			✓		
Kim Gay		✓		✓	✓
David Hay	✓	✓	✓	✓	✓
Dave Berridge				✓	
Jo Bray	✓	✓	✓	✓	✓
Attendees:					
Yvette Oade				✓	
Suzanne Hinchliffe				✓	
Sylvia Craven	✓				
Michelle Davies	✓	✓			
Bryan Gill	✓				
Darren Kerr	✓		✓	✓	✓
Peter Kirk	✓				
Mick Taylor	✓				
Tracy Gill			✓	✓	✓
Paul Stewart					✓
Malcolm Poad			✓		

Quality Committee

Name/Date	11 Apr 2013	13 Jun 2013	8 Aug 2013	5 Sep 2013	3 Oct 2013	7 Nov 2013	5 Dec 2013	6 Feb 2014	6 Mar 2014
Members:									
Lynn Hagger (Chair)	✓	✓	✓	✓					
Linda Pollard (acting Chair)	✓		✓		✓	✓	✓		✓
Maggie Boyle	✓								
Helen Christodoulides	✓								
Yvette Oade		✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Hinchliffe		✓	✓		✓	✓	✓		✓
David Cottrell	✓	✓							
Mark Chamberlain						✓		✓	✓
Clare Morrow				✓	✓	✓	✓		
Caroline Johnstone	✓								
Alison Dailly	✓	✓		✓	✓		✓	✓	
Bryan Gill	✓	✓			✓	✓	✓	✓	✓
David Berridge			✓	✓	✓	✓			
Craig Brigg	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Reed			✓						
Julian Hartley									
Attendees:									
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓
Joy Murphy			✓						
Julia Roper	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Hodgson				✓					
Balbir Bhogal					✓	✓			
Tracy Gill					✓	✓	✓	✓	✓
Nicola Wright					✓				
Clare Linley								✓	
Juliette Cosgrove	✓								
Michelle Davies	✓	✓							

Remuneration Committee

Name/Date	9 May 2013	25 July 2013	14 Nov 2013	30 Jan 2014	30 Mar 2013
Members:					
Linda Pollard (Chair)	✓	✓	✓	✓	✓
Mark Abrahams	✓	✓	✓	✓	✓
Mark Chamberlain	✓	✓	✓	✓	
Caroline Johnstone	✓	✓		✓	✓
Lynn Hagger	✓	✓			
Clare Morrow	✓	✓	✓		
David Cottrell	✓	✓			
Paul Stewart					✓
Allison Page				✓	
Attendees:					
Jo Bray	✓	✓	✓	✓	✓
Jackie Green		✓	✓	✓	✓
Maggie Boyle					
Chris Reed		✓			
Julian Hartley			✓	✓	✓

Research, Education & Training Committee

Name/Date	7 Jan 2014
Members:	
Paul Stewart (Chair)	✓
Yvette Oade	✓
Stephen Smye	✓
Suzanne Hinchliffe	✓
Alison Dailly	✓
Greg Reynolds	✓
Adam Glaser	✓
Andrew Lewington	✓
David Jackson	✓
Ian Simmons	✓
Anne Marie Kennan	✓
Jacqueline Andrews	
Julia Ward	✓
Jo Bray	
In attendance for specific issues	
Jackie Green	

Risk Management Committee

Name/Date	27 Feb 2014
Members:	
Julian Hartley (Chair)	✓
Tony Whitfield	✓
Yvette Oade	✓
Suzanne Hinchliffe	✓
Mark Smith	✓
Jackie Green	✓
Alison Dailly	✓
Darryn Kerr	
Attendees:	
Jo Bray	✓
Paul Moore	✓
Tracy Gill	✓
David Gregory	
Craig Brigg	
Philip Knight	✓
Mick Taylor	✓

2.3 Governance

Annual Governance Statement 2013-14

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, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

2. The purpose of the system of internal control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Teaching Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leeds Teaching Hospitals NHS Trust for the year ended 31 March 2014 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 sub-committees that scrutinise and review assurances on internal control; such sub committees include the Audit, Quality, Finance & Investment, Workforce and the Research, Education and Training committees. The Risk Management Committee is a new management committee reporting to the Board of Directors, established in March 2014. Going forward the Risk Management Committee will oversee all risk management activity 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 shall routinely attend each meeting. The Trust has kept under review and updated the Risk Management Policy that clearly describes the process for managing risk and the roles and responsibilities of staff. While the Risk Management Committee reports directly to the Board through me, it also works closely with the Audit Committee and other committees of the Board in order to triangulate material issues in accordance with the Board's appetite for taking risk and ensure a coordinated approach to effective risk treatment.

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

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

3.4 I have ensured that all significant risks of which I have become aware are reported to Board of Directors and also, more recently, to the Risk Management Committee. 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 is developing arrangements to scan the horizon for emergent threats and opportunities and consider the nature and timing of the response required in order to ensure risk is kept under prudent control at all times.

4. The risk and control framework

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

(i) Determine priorities

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

(ii) Risk Identification

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

(iii) Risk Assessment

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

(iv) Risk Response (Risk Treatment)

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

(v) Risk Reporting

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

(vi) Risk Review

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

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

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

Risk Profile

5. Significant Risks Facing the Trust

5.1 As at 31 March 2014, Leeds Teaching Hospitals NHS Trust has identified a range of significant risks, which are currently being mitigated, whose impact could have a direct bearing on compliance, CQC registration or the achievement of corporate objectives in the following areas should the mitigation plans be ineffective:

- Exposure to Healthcare Associated Infections (MRSA and C. difficile)
- Failure to maintain a minimum FRR level 3
- Adequacy of nurse staffing levels
- Quality and completeness of employee appraisal
- Completion of mandatory training
- Supply of medical workforce
- Compliance with 18-Week Referral to Treatment Target
- Compliance with A&E 4-hour Target
- Compliance with 6-week Diagnostic Waiting Time Target
- Compliance with 2-week waiting time target for urgent referrals for breast symptoms where cancer is not initially suspected
- Compliance with 62-day Cancer Target
- Adequacy of data quality and data governance
- Adequacy of IT investment
- Current Terms & Conditions of service and working patterns impede further development of 24/7 patient care

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

6. Care Quality Commission Registration

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

- reporting and keeping under review matters highlighted within the Care Quality Commission's Intelligent Monitoring Report and inspections;
- liaising with the Care Quality Commission Compliance Inspectors and local CSU clinicians and managers in response to specific concerns that are raised with the Care Quality Commission by patients and members of the public;
- engaging with the Care Quality Commission Compliance Inspectors on the inspection process, co-ordinating the Trust's response to inspections and recommendations/actions arising from this;
- analysing trends from incident reporting, complaints, and patient and staff surveys to detect potential non-compliance or concerns in Clinical Service Units;
- reviewing assurances on the effective operation of controls;
- receiving details of assurances provided by Internal Audit, and being notified of any Clinical Audit conclusions which provide only limited assurance on the operation of controls; and

- challenging assurances or gaps in assurance by attending meetings of Risk Management Committee, Quality Committee, Workforce Committee and Audit Committee.

6.2 The Trust is registered with the Care Quality Commission, has no compliance actions in force and is fully compliant with the Essential Standards for Quality and Safety. The Care Quality Commission inspected the Trust on two separate occasions during 2013-14; the first inspection took place in October 2013; the most recent inspection took place during March 2014. This was part of the new comprehensive inspection - wave 2, following publication of the first Intelligent Monitoring Report by the CQC in October 2013. The outcome of the March inspection has yet to be formally reported to the Trust; there were no major concerns brought to our attention during the CQC's verbal feedback to the Trust. There were no major concerns raised by the Care Quality Commission during 2013-14.

7. Pensions

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

8. Carbon Reduction

8.1 The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act 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 organisation has arrangements in place for securing value for money in the use of its resources. To do this I have maintained systems to:

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

9.2 The Trust is required to submit to the NHS Trust Development Authority an Annual Plan incorporating a supporting financial plan approved by the Board of Directors. This informs the detailed operational plans and budgets which are also approved by the Board. The views obtained from stakeholders are taken into account by the Board prior to approval.

9.3 The Board agrees annually a set of corporate objectives which are communicated to colleagues. This provides the basis for performance reviews at Clinical Service Unit level. Operational performance is kept under constant review by the Executive Team and Board of Directors. In order to keep under review the delivery of the corporate objectives, the Board reviews at each formal meeting an Integrated Performance and Quality Report covering patient safety, quality, access and experience metrics in addition

to a finance performance report. Since my appointment as Chief Executive, I have continued to oversee the development of the Trust's Quality Account in readiness for publication.

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

10. Annual Quality Report

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

10.2 The Trust has continued to embed strong clinical leadership for the development of the Annual Quality Account during 2013-14 and this has been provided by the Chief Medical Officer in close collaboration with the Chief Nurse and the Chief Operating Officer. Assurance relating to the outcomes highlighted within the Annual Quality Account are provided to the Quality Committee, a formal committee of the Trust Board, which is chaired by a Non-Executive Director, overseen by the Trust Chairman in 2013-14. The Quality Committee is responsible for overseeing the production of the Annual Quality Account and for overseeing monitoring indicators and data quality. The Trust has engaged with partner organisations, including Leeds Healthwatch and commissioners at NHS West Leeds CCG to agree to priority quality goals for 2014-15, relating to the key quality domains: safety, effectiveness and experience.

A limited scope assurance report is provided by external audit on the content of the quality account and selected key performance indicators.

There are a range of sub-committees and groups established under the leadership of the Quality Committee to take forward and evaluate safety, quality and patient experience, including the Risk and Safety, Clinical Effectiveness and Outcomes, Patient Experience and Information Governance sub-committees.

Each element of the Patient Safety, Quality and Patient Experience programme is supported by a range of policies, procedures and safe systems to promote staff engagement and ensure the implementation of key safety initiatives. Examples of this include hand hygiene audits, safer surgery checklists, pressure ulcer audits and venous thromboembolism risk assessment tools.

During 2013-14, there has been further development of the quality and safety metrics in the Board's Integrated Quality and Performance report. Reports received by the Board contain information in relation to incidents and complaints trends and root cause analysis investigations, including notification of serious incidents.

11. Review of effectiveness

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

12. The Board of Directors

12.1 The Board has set out the governance arrangements including the committee structure within the Standing Financial Instructions. The Chairs of the Board's Committees report to the Board at the first available Board meeting after each committee meeting. Urgent matters are escalated by the committee chair to the Board as deemed appropriate.

13. Internal Audit

13.1 With respect to the internal audits concluded during 2013-14, there were 15 assignments for which Internal Audit reported the level of assurance as limited for the year ended 31 March 2014. These audits provide limited assurance as a result of weaknesses in the design and/or operation of controls. Management action plans are developed and implemented or in the process of being implemented to address identified weaknesses, and progress against these is reviewed by the Audit Committee.

14. External Audit

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

15. Significant In-Year Matters

- The Trust did not meet the national requirement to treat a minimum of 90% of patients within 18-weeks of referral for those patients on the admitted pathway. We closed the year with 89.3% of admitted patients being treated within 18 weeks. The Trust started the year with an admitted backlog of approximately 2000 patients waiting more than 18 weeks; our efforts to address the admitted backlog have resulted in a substantial reduction to approximately 500 patients (on 12/05/14) waiting 18 weeks or more. This is the lowest level of backlog ever achieved by the Trust and an important step towards improving access for patients. Clearing the backlog enables the Trust to sustainably treat patients in chronological order, while reliably delivering the 90% admitted standard.
- The Trust did not meet the national requirement to treat a minimum of 85% of patients referred for suspected cancer within 62 days of referral from a GP. We closed the year with 82% of patients with suspected cancer being treated within 62-days of referral from their GP. Surgical staffing challenges during the year, combined with late referrals adversely affected our ability to meet this standard in full. We are continuing to work closely with neighbouring providers, GPs, commissioners and other relevant stakeholders to improve the timeliness of referrals to the Trust and also working to improve internal systems and processes and build capacity to improve performance for all patients. The Trust is developing plans to increase theatre capacity and utilisation within Urology and Thoracic surgery to improve resilience and performance during the year ahead.
- The Trust did not meet the national requirement for all last minute cancelled operations to be rebooked within 28 days. The Trust endeavours to ensure cancellations are avoided wherever possible, and we recognise the need to reduce the rate of cancelled operations and improve performance re-booking procedures within 28 days. This work is allied to securing improvements across a range of internal pathways and targets including 18-week RTT, cancer targets and urgent care performance. Going forward the Trust is reviewing internal processes to ensure this standard can be met in future.
- The Trust did not meet the national requirement to see a minimum of 93% of patients within 2 weeks of an urgent referral for breast symptoms where

cancer was not initially suspected. The Trust closed the year with 92.5% of patients referred urgently for breast symptoms. Going forward the Trust is reviewing capacity and demand models alongside internal processes to ensure this standard can be met in future.

- While the Trust has improved infection prevention, we did not meet the trajectory to reduce the incidence of Clostridium difficile or MRSA infections resulting in a £2m penalty under the Contract. We have established a detailed infection prevention action plan encompassing a wide range of specific interventions to minimise risk for patients and improve the control of infection throughout the Trust. This remains a high priority in the year ahead.
- There were 56 reported events during the year that crossed the seriousness threshold and were declared a Serious Incident. Each case has been investigated and reported to local commissioners. Detailed action plans are developed in response to specific cases.
- Eight patients were exposed to 'Never Events' during the year. The nature of those events involved nasogastric tube misplacement (n=1), retained swab or foreign body following surgery (n=6), and wrong device implantation during surgery (n=1). The harm caused by these events to individual patients ranged between severe harm (n=1), moderate harm (n=3) and minor harm (n=4).
- There were 69 events during the reporting period that crossed the threshold for reporting to the Health & Safety Executive under the provisions of the *Reporting of Injuries, Diseases or Dangerous Occurrences* (RIDDOR) Regulations. This represents a year-on year reduction, although not an acceptable outturn. We plan to review the Trust's Safety Management System going forward with a view to achieving further reductions in the incidence of RIDDOR reportable events.
- There was one formal *Prevention of Future Death Report* (formerly known as Rule 43) issued by the Coroner. The Trust has addressed the concerns raised by the Coroner and there are no outstanding actions regarding this case.
- There were two breaches of data protection reported to the Information Commissioner's Office on which a judgment by the Information Commissioner is pending.
- There were significant gaps in nurse staffing levels for which it was necessary to agree an investment of £6m for 2014-15 to address shortfalls and work towards increasing nurse staffing levels to a blueprint put in place by the Chief Nurse.
- We reviewed compliance with the Joint Accreditation Group National Endoscopy Programme standards for decontamination of flexible endoscopes during the year and found unacceptable gaps in control, particularly at Wharfedale General Hospital, in respect of endoscope reprocessing. Arrangements were put in place to install a fully compliant reprocessing operation which is near completion. There were no reports of any harm to patients or staff arising from this matter.
- The Trust has not met its obligation to deliver high quality education and training for foundation year doctors in Orthopaedic services at Leeds General Infirmary. There is a detailed action plan to deliver improvements although there is a risk that these posts will be withdrawn. A further assessment of the training will take place in June 2014.
- On joining the Trust the Chief Executive was made aware by the Interim Director of Finance of a significant underlying deficit and insufficient cost improvement plans. We commissioned KPMG to undertake a review of the Trust's financial health. This work confirmed the scale of the Trust's future financial deficit. The Trust has appointed a Financial Turnaround Director.

Following his appointment in January 2014 the Director of Finance considered that the arrangements for financial stewardship and reporting were lacking against best practice. Immediate remedial action has been taken and further actions are planned to improve core financial control and governance. While 2013-14 ended with a small surplus, this was achieved in large part with non-recurring support from local commissioners. Going forward, plans for 2014-15 are set requiring £50m of external support and £54m of Cost Improvement (CIP) Schemes.

16. Concluding Remarks

16.1 As Accounting Officer with responsibility for maintaining a sound system of internal control at Leeds Teaching Hospitals NHS Trust, a responsibility I assumed from 14 October 2013, I have reviewed the system of internal control. At the time of my appointment the Trust was and remains in Stage 4 escalation with the NHS Trust Development Authority. I have focused on assessing the breadth and depth of problems leading to control weakness in order to understand the effectiveness of the system of internal control and I have taken steps to address the issues of which I am aware. My review confirms that Leeds Teaching Hospitals NHS Trust has a system of internal control in operation, but this requires improvement to better support the achievement of the Trust's policies, aims and objectives going forward. Those control issues highlighted in this statement have been or are currently being addressed. I confirm that there are no other significant breaches of internal control that have been brought to my attention in respect of the financial year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Signed

Julian Hartley, Chief Executive
28 May 2014

2.4 Remuneration report

Remuneration

All executive directors are appointed by the Trust through an open, national recruitment process. All have substantive contracts and annual appraisals. The outcome of these appraisals is reported to the Remuneration Committee.

Members of the Remuneration Committee are the Chair and the serving non-executive directors. Their terms of office are stated on page 40, in the section **Attendance tables**.

A non-executive director post is currently vacant. In addition, Dr Bill Kirkup will commence in post from 19 May 2014.

Executive director salaries are determined following comparisons with similar posts in the public sector and are reviewed annually by the Remuneration Committee. In determining the remuneration packages of its directors and managers, the Trust fully complies with guidance from the Chief Executive of the NHS TDA.

Non-executive directors were appointed by the former NHS Appointments Commission, now the NHS TDA, following an open selection procedure. Non-executive director appointments are usually for a fixed period. Remuneration is fixed in accordance with national formula.

Pay Multiples

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

The banded remuneration of the highest paid director of the Trust in the financial year 2013-14 was £230-235k (2012/13, £220-225k). This was 8.48 times (2012/13, 8.03) the median remuneration of the workforce, which was £27,675 (2012/13, £27,484). The highest paid director in 2013-14 was the Medical Director (2012/13 – Chief Executive).

The increase in the remuneration of the highest paid director reflects the changes in the Trust Board personnel that occurred during 2013-14.

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 2014).

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.

Accounting policies for pensions and other retirement benefits are set out in the **Summary Accounts**, published on page 145. Details of senior employees can be found on the following page.

Salary and pension entitlements of senior managers

A) Salaries and allowances 2013-14

Name and Title	2013-14					
	Salary	Expense Payments (taxable)	Long Term Performance Pay and Bonuses	Other	All Pension-related Benefits	TOTAL
	(bands of £5,000) £000	Rounded to nearest £100	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
L. Pollard - Chair	40-45	21	0	0	0	**45-50**
M. Abrahams - Non Executive Director (Vice Chair)	5-10	11	0	0	0	**5-10**
M Chamberlain - Non Executive Director	5-10	2	0	0-5	0	**5-10**
C.A. Johnstone - Non Executive Director	5-10	17	0	0	0	**5-10**
A.J. Page - Non Executive Director (from 01 January 2014)	0-5	0	0	0	0	**0-5**
Prof P.M. Stewart - Non Executive Director (from 01 October 2013)	0-5	0	0	0	0	**0-5**
Prof D Cottrell - Non Executive Director (to 30 September 2013)	0-5	0	0	0	0	**0-5**
L.E. Hagger - Non Executive Director (to 30 September 2013)	0-5	10	0	0	0	**0-5**
C Morrow - Non Executive Director (to 31 December 2013)	0-5	2	0	0	0	**0-5**
M. Boyle - Chief Executive (to 16 June 2013)	45-50	1	0	165-170	0	**215-220**
C.H. Reed - Interim Chief Executive (from 17 June to 13 October 2013)	45-50	19	0	0	15-17.5	**65-70**
J.M. Hartley - Chief Executive (from 14 October 2014)	105-110	0	0	0	20-22.5	**125-130**
D.C. Berridge - Interim Medical Director (to 31 May 2013)	25-30	0	5-10	0	0-2.5	**35-40**
Y.A. Oade - Medical Director (from 01 June 2013)	170-175	0	20-25	0	12.5-15	**210-215**
A.N. Chapman - Director of Finance (to 30 September 2013)	70-75	0	0	105-110	2.5-5	**175-180**

K.M. Gay - Acting Director of Finance (01 October to 27 October 2013)	5-10	0	0	0	0-2.5	**5-10**
K Howells - Interim Director of Finance (28 October 2013 to 19 January 2014)	35-40	0	0	0	0	**35-40**
T A Whitfield - Director of Finance (from 20 January 2014)	35-40	0	0	0	0-2.5	**35-40**
C.E.Linley - Interim Chief Nurse (to 19 May 2013)	10-15	0	0	0	0-2.5	**10-15**
S Hinchliffe - Chief Nurse (from 20 May 2013)	140-145	1	0	0	(10-12.5)	**130-135**
C.Walsh - Interim Chief Operating Officer (to 26 April 2013)	20-25	0	0	0	0	**20-25**
M.A. Smith - Chief Operating Officer (from 20 May 2013)	130-135	0	0	0	32.5-35	**165-170**
A.S. Dailly - Director of Informatics	105-110	0	0	0	2.5-5	**105-110**
R. J. Green - Director of Human Resources	120-125	0	0	0	17.5-20	**140-145**
D.A.Kerr -Director of Estates and Facilities (from 01 October 2012)	100-105	34	0	0-5	(27.5-30)	**75-80**
K.J. Milner - Director of External Affairs and Communications (to 31 March 2014)	115-120	8	0	75-80	0-2.5	**195-200**
K Straughair - Recovery Director (from 17 June to 13 October 2013)	45-50	0	0	0	0	**45-50**

Benefits in kind 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.

Long term performance pay represents amounts paid under the national clinical excellence award scheme.

Other remuneration to the Chief Executive (to 16 June 2013), the Director of Finance (to 30 September 2013) and the Director of External Affairs and Communications represent contractual payments in lieu of notice agreed during the year.

Other remuneration to the Director of Facilities represents pay arrears relating to 2012-13. Other remuneration to the non executive directors is for additional work undertaken.

The Interim Chief Operating Officer was employed via a third party agency. The amount shown represents the full cost payable by the Trust to the agency for his services.

The Director of Estates and Facilities' and the Director of External Affairs and Communications' taxable expenses relate to lease cars. All other taxable expenses relate to taxable business mileage.

B) Salaries and allowances 2012-13 of senior managers who also served in 2013-14

Name and Title	2013-14					
	Salary	Expense Payments (taxable)	Long Term Performance Pay and Bonuses	Other	All Pension-related Benefits	TOTAL
	(bands of £5,000) £000	Rounded to nearest £100	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
L. Pollard - Chair (from 01 February 2013)	5-10	2	0	0	0	**5-10**
M. Abrahams - Non Executive Director (Vice Chairman)	5-10	10	0	0	0	**5-10**
M Chamberlain - Non Executive Director	5-10	4	0	0	0	**5-10**
C.A. Johnstone - Non Executive Director (from 01 January 2013)	0-5	4	0	0	0	**0-5**
Prof D Cottrell - Non Executive Director (to 30 September 2013)	0-5	0	0	0	0	**0-5**
L.E. Hagger - Non Executive Director	5-10	18	0	0	0	**5-10**
C Morrow - Non Executive Director	5-10	2	0	0	0	**5-10**
M. Boyle - Chief Executive	220-225	1	0	0	0	**220-225**
A.N. Chapman - Director of Finance	140-145	0	0	0	(10-12.5)	**130-135**
C.E.Linley - Interim Chief Nurse (from 17 January 2013)	20-25	0	0	0	10-12.5	**30-35**
C.Walsh - Interim Chief Operating Officer (from 21 May 2012)	295-300	0	0	0	0	**295-300**
A.S. Dailly - Director of Informatics	105-110	0	0	0	(7.5-10)	**95-100**
R. J. Green - Director of Human Resources	120- 125	23	0	0	15-20	**140-145**
D.A.Kerr -Director of Estates and Facilities (from 01 October 2012)	50-55	19	0	0	(15-20)	**35-40**
K.J. Milner - Director of External Affairs & Communications	115-120	0	0	5-10	20-25	**145-150**

Benefits in kind 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.

Long term performance pay represents amounts paid under the national clinical excellence award scheme.

Other remuneration to the Director of External Affairs and Communications relates to additional work undertaken for and recharged to the NHS Confederation.

The Director of Human Resources taxable expenses in 2012-13 relate to a lease car. All other taxable expenses are in respect of taxable business mileage.

The Interim Chief Operating Officer was employed via a third party agency. The amount shown represents the full cost payable by the Trust to the agency for his services.

C) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 as at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase in Cash Equivalent Transfer Value £000	Total Pension Entitlement at 31 March 2014 (bands of £5,000) £000
J.M. Hartley - Chief Executive (from 14 October 2014)	0-2.5	5-7.5	45-50	140-145	696	797	40	**45-50**
C.H. Reed - Interim Chief Executive (from 17 June to 13 October 2013)	0-2.5	2.5-5	85-90	265-270	1,811	0	n/a	**85-90**
Y.A. Oade - Medical Director (from 01 June 2013)	0-2.5	2.5-5	75-80	230-235	1,436	1,539	59	**75-80**
D.C. Berridge - Interim Medical Director (to 31 May 2013)	0-2.5	0-2.5	70-75	215-220	1,463	1,558	11	**70-75**
T A Whitfield - Director of Finance (from 20 January 2014)	0-2.5	0-2.5	60-65	190-195	1,281	1,358	10	**60-65**

K.M. Gay - Acting Director of Finance (01 October to 27 October 2013)	0-2.5	0-2.5	35-40	115-120	741	793	3	**35-40**
A.N. Chapman - Director of Finance (to 30 September 2013)	0-2.5	0-2.5	50-55	160-165	1,191	1,268	52	**50-55**
S Hinchliffe - Chief Nurse (from 20 May 2013)	(0-2.5)	(2.5-5)	60-65	180-185	1,135	1,176	14	**60-65**
C.E. Linley - Chief Nurse (to 19 May 2013)	0-2.5	0-2.5	25-30	80-85	431	471	4	**25-30**
M.A. Smith - Chief Operating Officer (from 20 May 2013)	2.5-5	7.5-10	40-45	130-135	718	818	73	**40-45**
A.S. Dailly - Director of Informatics	0-2.5	0-2.5	40-45	120-125	737	781	27	**40-45**
R.J. Green - Director of Human Resources	0-2.5	2.5-5	15-20	40-45	313	365	46	**15-20**
D.A. Kerr - Director of Estates and Facilities	(0-2.5)	(5-7.5)	35-40	110-115	631	624	(21)	**35-40**
K .J. Milner - Director of External Affairs & Communications (to 31 March 2014)	0-2.5	0-2.5	10-15	35-40	198	211	9	**10-15**

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

own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Off-Payroll engagements

As part of the review of the "Tax Arrangements of Public Sector Employees" published by the Chief Secretary to the Treasury on 23 May 2012, reporting bodies are required to publish certain information in relation to the number of "off payroll" engagements, at a cost of £58,200 per annum that were in place at 31 March. This information is presented in the tables below. There were three cases where assurance evidence had been sought from individuals that they were complying with tax and national insurance requirements and the information was awaited at the reporting date. Where such assurance is not forthcoming the Trust will seek to terminate contracts.

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	5
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	5
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	8
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	6
Number for whom assurance has been requested	6
Of which,	
assurance has been received	3
assurance has not been received	3
engagements terminated as a result of assurance not being received	0

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	1
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	28

2.5 Research and innovation

The Trust is renowned for its commitment to the highest quality research and innovation. We know that advancing treatment and care for patients is the key to improving clinical outcomes.

We are one of the best performing trusts in England for projects recognised by the National Institute for Health Research (NIHR). This is the highest standard for research. Last year, we involved 12,241 patients in 464 research studies.

Our Research and Innovation (R&I) strategy is founded on developing ambitious and innovative partnerships. Our collaboration with the University of Leeds brings together one of the largest health care providers in Europe with the second largest university for research in the UK.

Called the Leeds Academic Health Sciences Partnership, this alliance has the potential to drive improvements in patient care, to make an impact on the quality of our service and to benefit the regional and national economy in ways that few other partnerships could match.

The partnership has four goals :

- To increase opportunities for patients to take part in clinical trials across all specialities and conditions and to build on existing research in areas like musculoskeletal disease, cardiovascular sciences and diabetes, genes and development. We will do this by investing in infrastructure and recruiting high quality clinical researchers.
- To ensure the University of Leeds becomes a 'top five' medical school in the UK by developing education programmes for undergraduates and postgraduates and by creating a cohort of clinical academics from all disciplines. This will ensure we can meet the growing demand for skilled health professionals and provide the senior clinical academics of the future.
- To work with our partners, including the Academic Health Sciences Network for Yorkshire and the Humber, local NHS providers and commissioners to improve health and wealth through the adoption of new practice based on high quality research findings.
- To drive the economic and social development of Leeds, the surrounding region and the UK as a whole by securing Leeds as an integrated global centre for health innovation, collaborating with partners like the Leeds Innovation Health Hub and the Academic Health Sciences Network.

We aim for Leeds to be known as a centre of excellence for research and innovation, with a portfolio of world class education and research that is translated quickly into clinical practice, improving outcomes and benefiting patients.

We will build on our status as one of the top performing trusts in the country for the numbers of patients taking part in research, promoting 'research for all' campaigns to encourage more people to participate. Again, this will drive improvement in outcomes for patients.

Our state-of-the-art facilities already attract the highest calibre staff, and as our reputation grows we expect significant investment from health related industries, creating employment and making a real impact on the local and national economy.

Success during 2013-14

Some of the Trust's research highlights of the year are described below:

New ways of treating psoriatic arthritis

A national clinical trial involving more than 200 patients, based at our Chapel Allerton Hospital has shown that people with a type of arthritis affecting the skin and joints respond significantly better to early, aggressive drug treatment compared to standard care.

The £550,000 trial is funded by Arthritis Research UK and involves a number of centres, including the Trust. Dr Philip Helliwell, who is leading the research, presented the findings to the American College of Rheumatology Congress in San Diego, in October 2013.

World class brain research

The Trust's Charitable Foundation launched an appeal in 2013 to raise £2 million by 2015 towards the final total of £6 million to create a centre of excellence for research into conditions of the brain.

The Yorkshire Brain Research Centre, based at the Trust, will be a state of the art facility, conducting clinical trials and research to help scientists and clinicians develop new treatments and drug therapies for Parkinson's disease, epilepsy, multiple sclerosis and dementia, including Alzheimer's.

Leeds Aneurysm Development Study

One of the largest research studies into the risk factors surrounding the development and progression of abdominal aortic aneurysms (AAA) celebrated 10 years of success in 2013.

The Leeds Aneurysm Development Study (LEADS) aims to identify new underlying mechanisms of the disease to help in the development of new treatments.

In the last 10 years, it has become one of the largest repositories of AAA data and tissue samples in the world, with more than 1,300 participants. The study will continue to recruit patients and conduct further research to benefit patients.

Childhood cancer

Leeds General Infirmary is one of two centres in the country taking part in a trial investigating the use of chemotherapy for young adults with recurring or resistant neuroblastoma, the most common childhood cancer that occurs outside the brain.

The BEACON-neuroblastoma trial, funded by Cancer Research UK, will also investigate whether blocking the growth of new blood vessels supplying the tumours can enhance this treatment.

The study is being run by the Cancer Research UK Clinical Trials Unit in Birmingham.

Cancer Research UK Leeds Centre

Funding for the Cancer Research UK Leeds Centre has been successfully renewed for another three years. These centres form a national framework to deliver world leading research, improved patient care and to ensure research is translated into practice as quickly as possible.

Researchers at the Leeds Centre will focus on two interrelated themes, reflecting strategic scientific priorities and existing excellence in cancer research. These are viruses and immunology, and radiation biology and radiotherapy.

Diagnostic research

A new clinical research facility was opened in the Bexley Wing at St James's University Hospital, as part of events to mark International Clinical Trials day on 20 May 2013.

The facility supports the delivery of experimental medicine and complex clinical trials that cannot be carried out in a standard setting.

The Trust has been awarded a share of £4 million funding from the Department of Health to research how to improve the way diseases are diagnosed so patients can access the best treatments available more quickly.

The National Institute for Health Research (NIHR) will share the funding among four NHS organisations in the UK, in Leeds, London, Newcastle and Oxford. These will become national centres of expertise, called NIHR Diagnostic Evidence Cooperatives.

The Leeds project is led by Professor Peter Selby and will focus on liver, musculoskeletal and renal diseases.

You can read more about our Research and Innovation programmes in the Quality Account, on page 83.

2.6 Information Governance

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

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

Assessing the quality of data has been a significant part of the workload of the Trust's Information Governance in the past year. A Data Assurance Programme has been established using the 'Data Diamond Methodology' and a comprehensive assessment of systems and data processes carried out. A project team has been set up to support this work and is overseen by a formal Data Assurance Group reporting into the Information Governance committee structure.

The Trust maintains a high standard of Information Governance and has met the NHS Information Governance Toolkit requirements for 2013-14.

Two serious incidents involving data loss or confidentiality breaches have occurred within the last year. Both have been reported to the Health and Social Care Information Centre (HSCIC) via the Serious Incidents Requiring Investigation (SIRI) tool.

The first incident related to the loss of staff information. All staff members were contacted and notified with supporting information on the next steps.

The second incident involved the release of third-party information contained in another patient record.

The Trust is fully committed to ensuring that personal information is protected and used appropriately. After reviewing the two incidents the Trust has enhanced existing processes to significantly reduce the likelihood of future breaches.

2.7 Our staff

The staff at Leeds Teaching Hospitals NHS Trust are our greatest asset. Their skill and dedication means we can offer patients the highest quality care and experience.

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

Our staff also play a meaningful role in the development of the Trust. With strong encouragement and leadership from our new Chief Executive and senior team, engagement with people working in our hospitals has improved significantly during the past 12 months.

Workforce statistics

At 31 March 2014

Gender	Job Role	Position Title	Number
Female	Medical Director	Medical Director	1
	Non Executive Director	Chairman	1
	Non Executive Director	Non Executive Director	2
	Nurse Manager	Chief Nurse	1
	Senior Manager	Director of Human Resources	1
	Senior Manager	Director of Informatics	1
Female Total			7
Male	Chief Executive	Chief Executive	1
	Non Executive Director	Non Executive Director	3
	Senior Manager	Chief Operating Officer	1
	Senior Manager	Director of External Affairs and Communication	1
	Senior Manager	Director of Facilities	1
	Senior Manager	Director of Finance	1
Male Total			8
Grand Total			15

Gender	Head Count
Female	11,535
Male	3,744
Grand Total	15,279

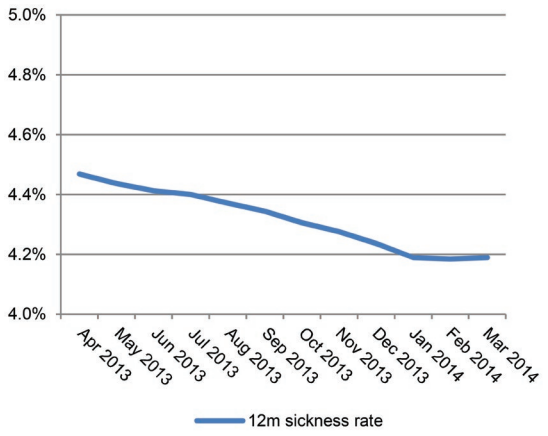
For the purposes of the Annual Report 2013-14, 'senior managers' is defined as the Chair, non-executive and executive directors of the Trust.

The gender division of all other employees is also included.

Sickness absence

The sickness absence rate for Leeds Teaching Hospitals during 2013-14 was as follows:

Sickness absence rate April 13 - March 14



We have been committed to reducing sickness rates across the Trust in 2013-14. In April 2013, we set up an attendance management team to work with managers across the Trust to support staff in managing levels of absence from work through sickness. We will continue this work in 2014-15, helping to ensure we have the numbers of staff we need at work to bring real benefits to patients.

Education and training

Medical and Dental Education

Leeds Teaching Hospitals NHS Trust is one of the largest providers of medical education in the country, delivering quality undergraduate and postgraduate programmes to more than 2,000 trainee doctors and medical students – the future for high quality care in Leeds, the wider region and beyond.

We aim to deliver high quality medical education, combined with opportunities to practise skills that will drive improvements in patient safety and compassionate clinical care.

Undergraduate Medical Education

We work in partnership with the University of Leeds to provide 1,600 clinical placements for around 1,300 medical and dental students. In term-time, there will be more than 370 students on placement in the Trust at any one time. Learning in a major teaching hospital and specialist referral centre, medical students come into contact with a wide mix of patients and clinical staff. In addition, we deliver an array of quality teaching to students, both in classrooms and at the bedside.

Postgraduate Medical Education

Our postgraduate medical training programme is the biggest in Yorkshire and the Humber and one of the largest in the country. We have 885 medical and 62 dental trainees undertaking around 1,445 clinical placements with us each year, across all medical and dental training grades: foundation, core and higher.

Simulation and Technology Enhanced Learning

We have a number of clinical skills and simulation centres. The Children's Hospital at Leeds General Infirmary manages its own facility delivering multi-professional paediatric training.

Medical Education Leeds operates three centres at the St James's site and one at Leeds General Infirmary. The Clinical Practice Centre at St James's is a multi-professional simulation hub on three floors. Each room is set up to emulate clinical areas and there are two simulation wards. It also includes a dedicated trauma simulation area as well as multi-use teaching rooms and lecture facilities.

The Leeds Institute for Minimally Invasive Therapy is a highly technical facility providing specialist surgical simulation. It has a simulation theatre, wet lab and an array of surgical simulators. We have a dedicated training ward, enabling skills teaching in a clinical environment, and space for Objective structured clinical examination assessments.

Technology Enhanced Learning is an emerging field for the Trust. We are creating a new generation of mobile learning applications using the latest web technologies and delivering online courses and training programmes on our purpose-built Virtual Learning Environment. The Department has been actively developing social media to engage trainers, trainees and students.

Working with Health Education Yorkshire and the Humber

Health Education Yorkshire and the Humber (HEYH), previously known as the Yorkshire Deanery, is one of our key education partners.

Each year, HEYH runs a Quality Management visit to the Trust. Whilst the visit in March 2014 identified areas of excellent postgraduate teaching and support, along with a number of examples of improved practice, it highlighted issues with the support and supervision of foundation year doctors (particularly in surgical specialties).

The Trust's medical directorate and Medical Education Leeds developed a detailed action plan, which was shared with HEYH and demonstrate improvement in key areas.

Specific emphasis was placed on improving educational supervision and day-to-day support in trauma and orthopaedics, handover, e-induction and access of foundation doctors to the surgical acute unit at St James's University Hospital and formal teaching.

In addition to the HEYH visits, there was also an academic programme review for HEYH to visit academic clinical fellows, academic foundation doctors and their trainers.

NHS Staff Libraries

Our libraries are changing as we build a more responsive service, moving away from a traditional model to one that is embedded in clinical areas and more accessible to staff. We continue to operate library facilities in three of our hospitals; Leeds General Infirmary (LGI), St James's University Hospital (run in partnership with the University of Leeds) and at Wharfedale Hospital.

In 2013, we relocated our LGI library into larger and better facilities, providing greater space for personal study. The range and depth of evidence searches undertaken by the library team has increased markedly during the year. Searches have been requested to support research bids, underpin training programmes, feed into audits and to explore new ways to deliver patient care.

Nursing and Midwifery Education

Nursing and Midwifery education is linked closely to our plans for workforce modernisation. Our aim is to have every patient receiving the right care at the right time from the right person with the right training.

We offer high quality clinical placements in a wide range of settings for nursing and Allied Health Practitioner (AHP) students from most of the universities in the Yorkshire and Humber region, with support for learning from over 1,500 mentors and practice supervisors.

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

In 2013-14, the Trust supported 570 applications in Nursing and Midwifery for higher education programmes ranging from single modules to doctoral study. By working with the Local Education and Training Board (LETB) and local and national education providers we have delivered new roles in advanced nursing and midwifery practice, in pre-operative patient assessment and in surgical skills development for nurses.

Our successful healthcare apprenticeship programme in association with Learn Direct offers placements, support and learning for 200 candidates a year. Continuing development is offered through programmes and units linked to national occupational standards.

Our Trainee Assistant Practitioner programme offers the opportunity to develop skills, knowledge and behaviours to work alongside registered practitioners in planning, delivering and evaluating care, leading to a Certificate in Healthcare and Foundation Degree achievement. Our people can also take the next step to professional training through seconded study with the Open University and secondments to full-time training. We offer funded secondments to local universities for nursing and AHP training.

All of this is delivered against a backdrop of developing the leadership potential of our Nursing and Midwifery staff though programmes from the Leadership Academy and local university providers and from in-house developments. We aim to improve the leadership and management of patient care provided by our staff.

Non clinical education, training and development

Our induction programme has been refreshed and our joining processes streamlined so that 98% of new starters complete corporate induction. Our Chief Executive, Julian Hartley, now welcomes all new starters to the organisation as part of corporate induction. Feedback shows that this is valued and provides valuable context on the organisation.

During 2013-14, we delivered more than 75,000 mandatory training sessions and saw a 10% improvement in staff taking mandatory training, reflecting its importance within the Trust. Our training interface allows staff to see at a glance what mandatory training they need to do whilst also providing access to training materials, including films and e-learning.

Currently, we have 178 apprentices working in Leeds Teaching Hospitals across a wide range of areas including:

- Pharmacy
- Clinical simulation
- Healthcare science
- Apprentice Clinical Support Workers
- Estates and Facilities
- Nursing support staff

Positive About Disabled People

The Trust was re-assessed for its eligibility to use the Two Ticks symbol in October 2011 and was re-accredited as being "Positive About Disabled People" in its employment activities. One of the requirements of this commitment is that disabled applicants meeting the essential criteria for a role are automatically guaranteed an interview. The similarity in the applications and shortlisted figures for disabled applicants indicate that the Trust's interview guarantee scheme is working effectively.

Mindful Employer Charter

In addition to the Positive About Disabled People accreditation, the Trust has also signed up to the Mindful Employer Charter, which is a voluntary commitment to work towards removing barriers to the recruitment and retention of staff with mental health problems.

We are providing training for managers to assist them in implementing a range of interventions to minimise the risk of workplace stress from occurring in their teams.

Access to training

Since 2012, there has been a small decrease in difference in reported access to training both from the Electronic Staff Record and staff survey results between those employees declared as disabled and those who are not.

This shows that the improvements we have made to improve access to training – including the on-line provision of training films and written materials – appear to be reaching the employee group declared as disabled.

Sector-based Work Academy

In partnership with Leeds City Council and Jobcentre Plus, we operate a Sector Based Work Academy which aims to bring the unemployed back into the work place by offering them a place as an Apprentice Clinical Support Worker (CSW). In 2013, 31 unemployed individuals commenced on and successfully completed the programme. In addition, as a result of the programme, two people on application were offered substantive employment as CSWs as they held the appropriate National Vocational Qualifications (NVQ).

Recognising success

The expertise and dedication of our staff won praise, recognition and accolades throughout 2013-14. Below is just a small sample of their achievements:

The Informatics Education, Training and Development team were awarded the status of 'Gold Accredited Learning Provider' by the Learning and Performance Institute after an assessment of their work over summer 2013. The award recognised their high quality learning, development and training services and means they can now offer training to other organisations in Leeds and further afield.

In May 2013, **Jon Craven, Maintenance Manager in Estates and Facilities** picked up the prestigious Estates Manager of the Year award at the Health Estates and Facilities Management Association conference in recognition of his leadership, and commitment to ensuring patients are treated in a safe environment.

June 2013 saw the **Paediatric Neuromuscular Disease Unit,** based at the Leeds Children's Hospital in Leeds General Infirmary, recognised by the Muscular Dystrophy Campaign as one of only five centres of excellence in the UK for its work with children and young adults with rare and complex conditions affecting muscle function. The team was acknowledged for its high standard of care, comprehensive diagnostic services and participation in both national audits and research.

A number of staff were nominated for awards in the Yorkshire Evening Post Health Awards in October 2013. **Dr Keith Brownlee and Dr Tracey Glanville** were shortlisted for Doctor of the Year. **Jane Nicholson and Nicci Isaac** were named in the Nurse of the Year category. The Trust's **Head and Neck team** picked up the Team of the Year award, while **wards L12 and L40** were also nominated. **Specialist nurse Georgina Speak** was runner-up for the Unsung Hero award, which went to Karen Stead, a former patient who is now a fundraiser for the Yorkshire Cancer Centre.

In November 2013, **Professor Simon Kay**, pioneer of the UK's first hand transplant, which he carried out at the LGI, was named as the Health Service Journal's Clinical Leader of the Year. This is a prestigious award that demonstrates Professor Kay's commitment to innovation and patient care.

Our **Infection Prevention and Control team** won three awards in the UK Public Sector Communications Awards in November 2013 for a campaign they ran in partnership with Leeds City Council and Diva Creative on infection prevention across the Trust to protect patients from harm.

Our **Teenage and Young Adult Cancer Service** won the Cancer Team of the Year award in the oncology section of the national Quality in Care awards in December 2013. Judges commented on the 'real team working' and 'amazing set of supporting materials' used by our staff. The service has also been shortlisted in the Cancer Care Team category at the British Medical Journal's awards in May 2014.

Professor Peter Selby was asked on behalf of the Trust and the University of Leeds to join the Steering Group for the European Cancer Concord and to help draft the European Cancer Patient's Bill of Rights, which was launched at the European Parliament in February 2014.

In March 2014, staff from **Medicines Management and Pharmacy Services (MMPS) and the Quality Improvement team** passed their Lean Six Sigma Green Belt Certification, an internationally recognised qualification for service improvement. They used techniques learned on the course to refine procedures in MMPS to deliver a faster, more efficient service for patients.

During the year, the **Yorkshire Regional Genetics Laboratories** was awarded accreditation by the College of American Pathologists. This is the only NHS Genetics Laboratory in the UK to have achieved this recognition, putting it in a unique position to develop business opportunities for the Trust.

And finally, thanks to **Ken Davidson**, who retired in October 2013 after working on the switchboard at Leeds General Infirmary for 50 years without taking a single day off sick.

Many individuals and teams across the Trust are thanked for their dedication and service by patients, their families and carers in letters sent to the local media. You can read some of these letters on our Facebook page, at **www.facebook.com/LeedsTHTrust**.

Health and wellbeing

The Trust has a range of services to support and promote health and wellbeing for staff. These include:

- staff gyms and exercise classes
- fitness testing for staff
- touch rugby games
- walking packs
- Cycle to Work scheme

During 2013-14, we carried out a detailed review of our current health and wellbeing arrangements, benchmarked against best practice from the NHS and beyond and taking into account feedback from staff about health and wellbeing issues that are important to them.

We have established a new Health and Wellbeing Group in the Trust to take this work forward and have identified a number of priorities including managing stress in the workplace and promoting healthy lifestyles.

We have policies in place that advise staff on the support available to assist with smoking cessation and alcohol or drug dependency and the management of stress.

Support for staff in balancing home and work life is provided through the provision of childcare facilities. We have three staff nurseries and detailed advice on accessing externally provided care and financial support that may be available through tax credits and childcare vouchers.

Occupational Health Service

The Occupational Health Service for Leeds Teaching Hospitals is accredited to the national accreditation scheme for Occupational Health providers SEQOHS (Safe Effective Quality Occupational Health Service - **www.seqohs.org**)

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

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

Health and Safety

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

In January 2014 the Trust Board approved a revised Health and Safety Policy, which explicitly details roles, responsibilities, arrangement and integration with the Trust corporate governance processes.

Minimum performance standards have been created for all health and safety risks: wards and departments are audited annually to ensure they comply.

An annual Health and Safety Report contains the results of the auditing process. In 2013-14, we conducted an audit of the previous year's performance in which 434 wards and departments - over 98% of the total number across the Trust - took part.

Reactive monitoring of health and safety data, in particular RIDDOR reports, following serious incidents shows a declining number of serious health and safety incidents occurring / reported to the Health and Safety Executive (HSE) in 2013-14.

RIDDOR (staff) - significant work related injuries and diseases

Year	2010	2011	2012	2013
RIDDOR's	127	103	90	69
All reported incidents	20674	21411	24203	25080

In 2013-14 the HSE did not issue 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 continue to increase within the NHS. At Leeds Teaching Hospitals NHS Trust, the rate of increase is less than that for the whole of the NHS, which suggests less harm is occurring in our hospitals and there is suitable control of health and safety risks.

Injuries from used disposable medical devices, especially hollow bore needles, that may be contaminated with blood and body fluids is a major infection risk to healthcare employees. New statutory regulations became effective in May 2013 requiring employers to introduce devices to reduce the risk. The Trust has made good progress in complying with the new duty.

Staff Survey report

NHS National Staff Survey is an annual indicator of how staff in NHS settings feel about their working life and environment. In 2013, a random selection of 822 Trust staff were invited to take part in the survey. Of these, 478 responded, a rate of 58% which places the Trust among the highest 20% of acute trusts in England.

A summary of the survey's findings shows an improvement in 24 out of 28 key areas for the Trust from our scores in 2012 – some by as much as 11%.

Areas where we performed well included:

- effective team working
- fewer numbers of staff having to work extra hours
- a reduction in staff experiencing physical violence from patients, relatives or the public in the last 12 months
- the number of staff who had taken part in equality and diversity training in the last 12 months
- a reduction in staff experiencing harassment, bullying or abuse from other staff in the last 12 months

However, there are a number of areas where we recognise the need to improve. These include staff motivation, the number of staff who are able to contribute to improvements at work and reducing the numbers who feel under pressure to attend work when they are ill.

Details of our top and bottom ranking scores can be found in the tables on page 70.

	2013		2012		Improvement / Deterioration
	Trust	England Average	Trust	England Average	
Response Rate	58%	49%	47%	49%	Increase of 11%

	2013		2012		Improvement / Deterioration
Top 4 Ranking Scores	Trust	England Average	Trust	England Average	
KF16 % Staff experiencing physical violence from patients/ relatives/public	12%	15%	14%	15%	Improvement: 2% fewer experiencing violence
KF5 % staff working extra hours	67%	70%	69%	70%	Improvement: 2% fewer working extra
KF4 Effective Team Working	3.77	3.74	3.57	3.72	Improvement: 0.20
KF26 % staff having E& D training	64%	60%	58%	55%	Improvement: Increase of 6% receiving training
Bottom 4 Ranking Scores	Trust	England Average	Trust	England Average	
KF25 Staff Motivation	3.76	3.86	3.67	3.84	Improvement: 0.9
KF22 % staff able to contribute to improvements at work	63%	68%	60%	68%	Improvement: 3% more able to contribute
KF20 % staff feeling pressure in last 3 months to attend work when feeling unwell	33%	28%	40%	29%	Improvement: 7% fewer feeling pressure
KF7 % of staff appraised in the last 12 months	78%	84%	74%	84%	Improvement: Increase of 4% having an appraisal

Results and next steps

The Trust's survey results were reviewed by the Board of Directors, published on our intranet site and shared with all staff. Although the results are encouraging, we will continue to roll out the improvements we have already begun in staff engagement, appraisal, leadership, health and wellbeing and support to raise concerns.

We identified and have begun work on five priorities for action:

- **Ensure our vision and values – The Leeds Way – are an integral part of every employee's working life at the Trust**

  This will include their recruitment, induction and later, recognition and appraisal.

  The Leeds Way also focuses strongly on open, honest communication with all staff. Every week, the Chief Executive's personal Start the Week email is sent to all staff to update them on issues ranging from the economic factors affecting the Trust to awards and successes. Staff are also sent a fortnightly bulletin containing clinically focussed information to improve quality and safety.

In addition, the Chief Executive visits wards and departments regularly to meet staff, share their experiences and listen to their views on how we can improve our services and care for patients.

Towards the end of 2013, we began a system of Team Brief for all staff. Within five days of the Chief Executive briefing senior staff on key Trust matters, everyone should have the chance to respond to the same information at a face to face meeting.

More than 1,300 staff responded to an online survey in March 2014 seeking their feedback after the first team briefing. Of those who completed the survey, 78% had received a Team Brief, 96% said they had had the opportunity to ask questions and share their views and 77% felt the briefing had helped them to feel more engaged and involved with the Trust.

This is extremely encouraging and we will build on their feedback and suggestions for improvement to ensure Team Brief meets staff needs during 2014-15.

Staff engagement will continue to be a priority for the Trust in 2014-15.

- **Develop the staff appraisal process**

  Everyone at the Trust has the right to an appraisal. They provide an opportunity for staff to discuss their performance, objectives, the way they do their job and their development needs. They are the foundation for the best possible patient care.

  During 2013-14, staff worked hard to increase the number of appraisals we carried out, so that 60% of our staff have had a yearly appraisal. This equates to 9,500 appraisals during 2013-14. Managers were given training, support and the right materials to enable them to deliver high quality appraisals.

  Under the new system, all staff should receive their appraisal within the first quarter of 2014-15. We will continue to offer training, monitor the completion of appraisals and carry out a validation exercise to ensure the quality of the appraisal process.

- **Continue to develop good leadership and management skills throughout the Trust**

  A number of programmes designed to build leadership capability at all levels of the Trust will begin in summer 2014. These will focus on solving real and live challenges and building clinical leadership.

- **Update and relaunch the staff Health and Wellbeing strategy**

  A healthy, motivated workforce is essential if we are to provide good patient care. At the Trust, we believe in protecting and promoting the health and wellbeing of our staff. Our strategy will include specific programmes on managing stress in the workplace and promoting healthy lifestyles

- **Ensure staff feel confident and secure in raising concerns**

  During 2013-14 the Trust undertook a comprehensive exercise to review and re-launch our whistleblowing arrangements. This work was undertaken in conjunction with Public Concern at Work (the leading independent whistleblowing charity) to ensure our arrangements were in line with best practice.

  The review involved extensive engagement with staff to understand their views on our existing processes, any barriers to reporting and suggested improvements to support a cultural shift in whistleblowing.

  The result of this work was the launch of a new Whistleblowing Policy in March 2014, supported by an extensive communications campaign called, "If in doubt, speak out".

  We have identified a number of designated Whistleblowing Leads for the Trust who can support staff in raising concerns. They are receiving ongoing training to assist them in this role.

  The new policy is supported by robust monitoring and reporting to the Trust Board, Workforce Committee, Executive Team and Trust Consultation and Negotiating Committee, to ensure it meets the needs of all staff.

We believe that improvements in these key areas will make bring real benefits to employees at the Trust, supporting them to feel engaged and motivated and to deliver the highest quality patient care.

We have agreed plans and timescales for each of the five areas. Progress against key milestones for each will be monitored by the Workforce Committee.

Section 3

Patient care and experience

Patient care and experience

The needs of patients and their carers are at the heart of everything we do at the Trust. During 2013-14, the Trust made a number of improvements to ensure we offer the best possible care and experience to those who use our services.

3.1 Involving patients and the public

The Trust has developed a Patient and Public Involvement (PPI) Strategy in the last year, which sets out the vision, strategy and priorities for their involvement with Leeds Teaching Hospitals NHS Trust.

This followed consultation with patients, representatives of patient panels, user groups, local interest groups, members of the public and stakeholders. Trust staff were also involved in the process.

Our strategy aims to involve patients and the public in the way we design, deliver and continuously improve the quality of our services to ensure we provide safe, effective and individual care to every patient, every time.

Our strategy has been informed by:

- direct feedback from patients, the public, representatives of patient panels and user groups, staff, local interest groups and stakeholders
- current feedback from patient experience activities including the Friends and Family Test and patient survey activity
- feedback, national reviews, and policy development in relation to complaints, patient advice liaison, and volunteering
- wider strategies in relation to quality, communications, equality and diversity, and foundation trust membership

We have now developed an action plan to build on the six priorities set out in the strategy. These are as follows:

- develop a clear model for consultation, involvement and patient feedback in the Trust
- improve communication and information to patients and the public
- support staff and patients involved in PPI activities
- develop feedback and involvement activity with specific groups
- embed equality in our involvement approaches
- provide structures and opportunities for volunteers in the Trust

The strategy will be reviewed annually by the Patient Experience sub-Committee and will last for two years. It has already enabled us to make significant changes to volunteering, for example, and its contribution to improving the quality of patient experience.

3.2 Improving patient experience

Friends and Family Test

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

The test has now been successfully rolled out across all Trust inpatient wards, emergency departments and maternity services. In 2013-14, we gathered 49,033 views and comments from patients about our services.

Overall, 94% of these patients are positive about the care they received, and our overall net promoter score (a rating based on the number of people who promote our service) is 64, which is higher than the national average.

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

Work is now underway to introduce the FFT to our day case areas, outpatient and children's services, the latter using a child focused electronic application. By April 2015, we will have introduced the test to all areas of the Trust, offering all patients the opportunity to shape our services and care.

Improvements to our services for patients following feedback from the FFT include:

- introducing more comfortable waiting areas
- staging admission times in same day surgical units to improve the experience of attending hospital
- improving processes to release drugs more quickly when a patient is discharged

"My care has been second to none. The nursing staff are all extremely helpful and reassuring and nothing is too much trouble."

"Nothing could be improved on. The nursing staff are exemplary and do a brilliant job. Everyone from consultants to tea ladies make you feel as if you are their chief concern."

National Patient surveys

In addition to the Friends and Family Test and ongoing patient feedback we receive every day, the Trust participates in a number of National Patient Survey programmes.

National Inpatient Survey 2013

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

Patients reported positively in areas such as the provision of information when their admission was planned, cleanliness and feeling safe. They felt we needed to improve our discharge process, however, reducing delays and explaining the reasons for delays when they occurred.

As a result of feedback from the inpatient survey, we employed a full-time Matron in December 2013 to review our discharge process - including our communication with patients and carers - and to drive improvements in this area during 2014-15.

Maternity survey 2013

Conducted every three years, the maternity survey seeks the views of women using maternity services on the quality of their care.

The majority of women involved in the survey were satisfied with their care and had a positive experience.

Key findings included:

- 81% of maternity patients felt they were involved enough in decisions about their ante-natal care
- 87% of women reported being treated with respect and dignity during birth and labour: 60% reported the same in hospital after birth

Some women reported being left alone by midwives or doctors at a time when it worried them, highlighting the need for good communication.

We are working to ensure we share information, and with staff to make sure they provide consistently compassionate advice and support to women using the maternity service.

Patient stories

We are gathering the experiences of patients, carers and relatives of our care in a series of films.

The stories have ranged from teenagers' experience of cancer to issues around religious needs. Some are positive about our care while others show how we need to improve.

The films are available to all staff on the Trust's intranet site and one is shown at the beginning of every meeting of the Trust Board. They are a powerful reminder of why providing the highest quality patient care must always be the Trust's greatest priority.

We have made a number of service improvements following individual patient stories.

Care Quality Commission

The Care Quality Commission (CQC) made two unannounced compliance inspection visits in 2013-14, and a planned inspection under the new comprehensive inspection programme in March 2014.

The results of the inspection were published in July 2014. They are available on the CQC's website at **www.cqc.org.uk/provider/RR8** and will be reported more fully in the Trust Annual Report and Quality Account 2014-15.

For details of Care Quality Commission inspections of the Trust's services during 2013-14, please refer to the Quality Account on page 83.

3.3 Improving information for patients and carers

Providing good quality information for patients and carers is a fundamental part of the high standards of care we expect at the Trust. In 2013-14, we revised our process for producing patient information to ensure we are meeting their needs for information that is relevant, useful and accessible.

As a priority, staff and patients identified a need for information relating to discharge from hospital that provided advice, contacts and answered concerns.

As a result of their feedback, the Deputy Chief Nurse and Heads of Nursing across the organisation led a review that resulted in a redesign of the information available for patients.

We also worked with local partner Leeds Directory and other external agencies like Carers Leeds to ensure patients and carers have information about the services and support available to them after discharge.

We now provide information from these agencies, together with our new discharge booklet and information card in a dedicated discharge folder for all patients.

3.4 Resolving complaints

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

Offering patients the opportunity to comment on the quality of their care, using methods like the Friends and Family Test, is part of our everyday commitment to their wellbeing. So too is ensuring patients have the chance to let us know when they are unhappy with any aspect of their hospital experience.

In 2013, the National Inpatient Survey reported that we had made a significant improvement in seeking patient feedback and in making sure patients received information on how to complain if they wish to.

Whilst this is positive news for the Trust, we are continually seeking to improve our procedures relating to complaints and in 2013, the Chief Nurse led an in depth, comprehensive review of our process for handling complaints across the Trust.

The review had three aims:

- to ensure we provide the highest quality, honest, compassionate and complete responses to all complainants
- to achieve a balance between the time required to investigate concerns thoroughly and the complainant's needs for swift resolution
- to ensure the Trust staff learn, change and improve services as a result of complaints

As part of the review, we have developed a set of values that will inform the way we respond to complaints and treat complainants. These include empowering staff to resolve minor comments and problems immediately and making sure we treat those who make a complaint with empathy and respect.

As a result of the review, we now have a clear and consistent process for investigating complaints and a commitment to resolving all formal complaints in less than 40 working days.

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

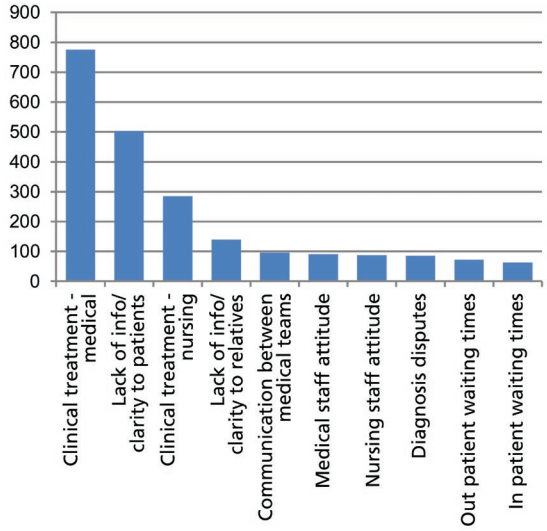
You can read more about our complaints review, and our policy in the Quality Account on page 83.

Service changes in response to complaints

Last year, we received 1,066 complaints, 17% less than the number received during 2012-13. There were 40% fewer reopened complaints and a 50% reduction in the complaints referred to the Parliamentary and Health Services Ombudsman.

A single complaint may cover more than one issue. The main themes raised in complaints during 2013-14 are shown in the following graph.

Main themes of complaints



Complaints are an extremely useful indicator of where we need to adapt, change or improve our services for patients. We have made a number of improvements to our discharge process, for example, following complaints of poor communication on this issue.

We now discuss with patients and their relatives their discharge plan, including medication, so they understand what will happen when they leave hospital.

We are also making a further investment in our Patient Advice and Liaison (PALS) team to improve the availability and impartiality of this support to give advice and resolve problems as quickly as possible for patients, relatives and carers.

3.5 Working with partners

We have continued to develop relationships with patients and stakeholders. We have been working closely with advocacy and involvement groups Healthwatch Leeds and Leeds Involving People (LIP) throughout the year.

We have supported Healthwatch Leeds to make regular visits to all our hospitals and covering a number of our clinical specialties. During these visits, the Healthwatch team and their volunteers independently survey patients, families, carers, and the public about their experiences of our services. These results are then reported to the Trust and any actions required are put into place.

The Healthwatch team visits areas either on a rotational basis, or in response to their own interactions with the public. Last year, as a result of these conversations, they visited the Emergency departments and the Dental Hospital.

Healthwatch Leeds has helped us to identify and approach volunteers to become involved in helping us shape patient experience across the Trust.

Leeds Involving People is working with the Trust to organise a series of events throughout 2014-15. The first of these will seek carers' views on how we can improve their experience of our services, and that of the people they care for. We will be acting on their feedback to make positive changes across the Trust.

Carers

Carers make a huge contribution in supporting the people they care for and as a Trust we are committed to improving the carers' experience of our services. We have been working with the Carers' Strategy Implementation Partnership (CSIP) and are currently developing the Carers' Strategy for Leeds City 2014 – 2016.

Our vision is that carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.

Since last year, the Trust has worked with Carers Leeds and now has an onsite Dementia Carer Support Worker. This service has proved to be a valuable support to the carers of patients with dementia.

Volunteers

We are very grateful to the hundreds of volunteers who give their time, commitment and skills to make a hospital stay a better experience for patients.

In 2013, our Patient Experience team reviewed the process for recruiting volunteers. Supported by Human Resources, our new programme has streamlined volunteer recruitment, reducing delays. We have also developed a new volunteer database: we can use the information to target recruitment campaigns to build a diverse team.

We have also introduced a volunteering opportunities booklet, available on the Trust's website for those thinking of becoming a volunteer.

Recognisable by their new uniforms, volunteers are a vital source of help and support wherever they work. This year, they have begun working in the Accident and Emergency departments and at the self-check in kiosks in Outpatients. They have also made a real difference on the wards by assisting patients at mealtimes.

We will continue to develop volunteering opportunities to benefit patients at the Trust throughout 2014-15.

Involving our members

Over the last year, the Trust continued to grow its membership, which now stands at 22,308 members compared with 20,448 a year ago. The mix of gender, ethnicity and age is monitored to ensure our membership continues to be representative of the wider Leeds population, in addition to Yorkshire and Humber and the rest of England.

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

In addition to circulating our newsletter in Spring 2013 to almost 20,000 members the Trust has held a number of *Medicine for Members* engagement events, which have been well attended by many members. These sessions were held across the Trust sites and at different times of day to enable members to attend at a time suitable for them. Topics have included cardiology, dental services, medical oncology and older people's medicine. The total number of attendances was 265.

The Trust is keen to keep members informed of its activity and progress on statutory requirements and recommendations arising from key national enquiries. To this end, two sessions were held in summer of 2013 on how the Trust was performing in implementing recommendations from The Francis Enquiry.

In addition, in March 2014, the Trust was subject to a Care Quality Commission (CQC) inspection, which involved some 60 inspectors. As part of its preparations, the Trust held sessions in January 2014 to inform members. The total number of attendances was 222.

Whilst many of our members are happy to receive our newsletter, some 2,282 have indicated that they would like to be more actively involved with the work of the Trust. A small number of members have formed part of assessment panels in the recruitment process for senior members of staff and the Trust is hoping to develop this aspect of membership activity further in the coming year.

Members were also invited to contribute feedback on our draft five year strategy, helping us to shape our plans for the future.

Chaplaincy

The Trust's chaplaincy service actively engages with our local communities, to ensure we can meet the spiritual needs of a diverse patient and staff population.

In 2013-14, this has included work with honorary chaplains from the Buddhist, Sikh and Jewish faiths as well as the involvement of more than 60 volunteers in chaplaincy from a range of local groups.

With patients' consent chaplains contact local faith representatives to ensure continuity of care as patients move from our hospitals into the community.

Working with Trust staff and SANDS (the local Stillbirth and Neonatal Death charity) chaplaincy provided support for a non-religious paediatric memorial event as well as leading two ecumenical neonatal bereavement services open to the public.

At the request of the Care Quality Commission chaplains attended two public meetings held in Leeds to offer pastoral support for people participating in the events.

All the chaplains are active in their local faith communities and meet leaders of faith and belief groups on a regular basis. In circumstances where it would be inappropriate for a religious leader to conduct a hospital contract funeral (because of the known beliefs of the patient) chaplains liaise with local humanist officiants to ensure that a suitable and dignified service is provided.

In 2014-15, a project will begin to evaluate the introduction of chaplaincy volunteers in an oncology outpatient clinic. We also expect a research study to be completed this year that has looked at the effectiveness of active listening by volunteers in support of oncology patients.

Raising funds

A large number of donors and individuals contribute charitable funds towards our work. Their support enables us to develop the highest quality treatment and services, improve

the hospital environment and promote the wellbeing of our patients. The Board of Trustees is extremely grateful to them all.

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

In 2013-14, more than £5 million of charitable funding was spent across the Trust. Expenditure was supervised by the Patient, Staff and Support Services' two Special Advisory Groups, and was used for items to enhance the hospital environment for patients and provide additional equipment not budgeted for by the NHS.

The Charitable Foundation Trustees are committed to encouraging high quality, ethical research and development. This has a significant impact on clinical practice and patients' wellbeing.

During 2013-14, the Charitable Foundation gave specific support totalling £285,215 for a number of Pilot Project Awards. This scheme is designed to support pilot projects that will often lead to larger research grants and is managed by the Research and Development Special Advisory Group, chaired by Roger Cannon and Steve Smye, the Trust's Director of Research and Innovation.

This group ensures that appropriate research is linked to the strategy of the Leeds Teaching Hospitals NHS Trust to develop specific areas of strength and expertise.

The Leeds Children's Hospital Appeal raises money to enhance and provide a child-friendly environment and has funded additional state-of-the-art medical equipment. In 2013-14, the appeal successfully raised the funds to buy various pieces of equipment, equating to a spend of £279,706 for the Children's Clinical Services Unit.

THE LEEDS TEACHING HOSPITALS Charitable Foundation
REGISTERED CHARITY No 1075308

Mr Terry Roberts is one of the many volunteers working tirelessly for the Charitable Foundation and has raised over £100,000 over the years. Thank you to all the volunteers who work for the Charitable Foundation for their amazing contributions.

3.6 Emergency preparedness

During 2013-14, we successfully responded to a range of events, exercises and emergencies, which have thoroughly tested our emergency and business continuity plans.

In April 2013 the water supply to the St. James's University Hospital failed due to major flooding in the water pump room. A command and control team worked closely with Yorkshire Water and engaged with clinical teams to ensure patient care and safety was not compromised.

The Leeds General Infirmary declared a major incident in response to multiple seriously injured casualties following a serious vehicle collision and the Trust's Major Incident Plan was activated. This was the first major test of our new Major Trauma Centre since it became operational at the beginning of April 2013. Staff across the Trust were called upon to help and unfailingly demonstrated a quick response, flexibility and teamwork as our hospitals quickly prepared for a fast and evolving situation.

We responded to several periods of internal and external industrial action during the year. Plans were put in place across the Trust to ensure essential services for our patients were safely maintained throughout.

Elements of our Heatwave Plan were put into action during July 2013 when Leeds experienced a prolonged spell of hot, sunny weather making it the third warmest July in the United Kingdom since 1910. We anticipated the weather, leaflets were distributed and Trust-wide communication messages were relayed to staff to ensure measures were undertaken to reduce the heat build-up and maintain the comfort of our patients.

To help protect patients against the flu virus, for the fifth year running we increased the flu vaccine uptake amongst our frontline health care staff. During the 2013-14 flu season 75.4% were vaccinated in comparison to 51.3% the previous year. The Trust Occupational Health Team worked closely with over 150 peer vaccinators from wards and departments across the Trust to successfully exceed the Department of Health target of 75%.

Our learning from all these events will be used to further strengthen our emergency preparedness, resilience and response arrangements during 2014-15.

3.7 Equality and diversity

Leeds Teaching Hospitals NHS Trust is committed to challenging discrimination and promoting equality and diversity both as an employer and a major provider of health care services. It aims to make sure that equality and diversity is at the centre of its work and is embedded into its 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.

The Trust created the Equality and Diversity Strategic Group in November 2013, led by the Chief Nurse, to deliver our equality objectives. For day-to-day delivery of the equality and diversity agenda, the Trust has an Equality and Diversity Manager based in Patient Experience who works closely with the Head of Human Resources for Policy and Performance.

Setting and publishing of equality objectives

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

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

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

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

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

Throughout 2013-14 the following actions were achieved:

Equality Objective	Action Achieved 2013 to 2014
1	Improved collection and analysis of equality data on patient experience across the Trust through the Friends and Family Test.
	Improved collection of equality data on the experience of complainants.
	Trust commitment to deliver on the West Yorkshire Transgender Pledge in response to limited data on transgender.
	Trust commitment to participate in the Stonewall Health Champions Programme and Stonewall Healthcare Equality Index in response to limited data on sexual orientation.
2	Improved uptake on mandatory equality and diversity staff training (83% as at 31 Jan 14 from 67.1% in March 13).
	Further analysis of outcomes from equality data collected and analysed on staff.
	Review and implementation of revised equality and diversity content of leadership development programmes.
3	Collection and analysis of local and national patient survey results by protected characteristic.
	Output of patient advisory group meetings incorporated into governance structures.
	Review of progress against NHS Equality Delivery System benchmarking tool.
	Review of profile of Foundation Trust Membership.

Publishing of equality information

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

The following key actions were identified from the information published and have been built into the Trust's actions on equality and diversity for 2014-15:

Key Headline Actions for 2014 to 2015	
All **people** can access the Trust's services and when received experience the best possible clinical outcomes every time.	Maximise the use of the Patient Administration System and further develop the Friends and Family Test Framework to capture data on all protected characteristics.
	Based on the local findings of national surveys, seek verification and recommend action in partnership with other acute trusts across West Yorkshire in the following areas: • Asian patients/Accident and Emergency • Blind patients/Inpatients • Over 85s/Inpatients • Lesbian, Gay and Bisexual/ Accident and Emergency • Other Ethnic Groups/ Outpatients • 16 to 24/Accident and Emergency, Maternity
	Develop the profile of Foundation Trust Membership.
	Review the equality impact assessment process.
All **employees** are supported, representative of the local community and led to deliver on equality. Improve quality of profiling information on the Electronic Staff Records.	Include equality metrics on routine workforce performance data sets.
	Continue to prioritise employee engagement with an emphasis on the implementation of Trust values and inclusive engagement.
	Further analysis of outcomes from the equality data on employees to identify any remedial action.
	Continued focus on completion of equality and diversity mandatory training and review of further equality and diversity training requirements.

Section 4

Quality Account 2013-14

Quality Account 2013-2014

4.1 Chief Executive's statement from the Board

Introducing the Trust

The Leeds Teaching Hospitals NHS Trust is one of the largest hospital Trusts in the United Kingdom, seeing around 2 million patients every year 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

The Trust provides a comprehensive range of hospital services to the Leeds population of approximately 780,000 and also provides more specialist services to patients across the region and nationally, circa 3 million people. Some of our patients have very acute, complex and life threatening conditions or trauma, others we care for have less acute but life-limiting conditions. We also provide district general hospital services for the people of Leeds with a full range of services from birth through to old age. Our expertise and specialisms also allows us to care for people from all over the country and on some occasions from around the world.

We contribute to life in the Leeds city region, not only by employing 15,000 people in a range of different roles, but by supporting the health and well-being of the region and playing a leading role in research, education and innovation.

Development of the Quality Account

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

Chief Executive's Statement on Quality

On behalf of the Trust Board and staff working at Leeds Teaching Hospitals NHS Trust I am pleased to introduce you to our Quality Account for the year 2013/14.

Patient care is at the heart of everything we do. We aim to provide care that is of the highest quality and is safe and effective, offering the best experience for our patients.

This report focuses on the year 2013/14 (April 2013 to March 2014), describing our progress over the past 12 months against the quality improvements we set out to achieve and outlining our priorities for the year ahead. It is an open and honest account of the quality of services for which the Trust Board is accountable and it is a true and fair reflection of our performance in 2013/14.

We have made good progress in a number of areas, including falls prevention, pressure ulcer reduction, risk assessment relating to blood clots (VTE) and improving safety in the care of patients with nasogastric feeding tubes. We have continued to report low mortality rates and we have also reduced the rate of infections in our hospitals, including MRSA.

We recognise that whilst we have reduced the number of Clostridium difficile infections in our hospitals we did not achieve the target we set with our commissioners. We have also reported 8 Never Events in 2013/14. These are important priorities for us and you will find details of the actions we have taken to make improvements in these areas in our Quality Account.

We were pleased to receive the mortality and family experience reports from NHS England on Children's Heart Surgery, which confirmed that the care we provide for patients in this area is safe and effective. The concerns raised by families will lead to improvements in 2014/15 in the way we support them.

In 2014/15 we will work with the Yorkshire and Humber Improvement Academy to support the delivery of our quality goals and develop our strategy for quality improvement in conjunction with Salford Royal NHS Foundation Trust, nationally recognised experts in quality improvement. We will also work as part of a collaborative hosted by Leeds Institute for Quality Healthcare to redesign clinical pathways across health and social care to improve the experience of patients, focussing on patients with cardiovascular disease, chronic obstructive pulmonary disease (COPD) and Fractured Neck of Femur.

I hope you enjoy reading about the progress we are continuing to make in improving the quality of care here at Leeds Teaching Hospitals. Our staff are fully committed to the provision of safe and effective care for all our patients and we look forward to making further improvements in 2014/15. Our plans and priorities are explained further in this report and our progress will continue to be overseen and supported by the Trust Board.

Signed

Julian Hartley, Chief Executive

27 June 2014

Signed for, and on behalf of the Trust Board

4.2 Our priority improvement areas for 2014/2015

We recognise that quality improvement is a continuous process and we will maintain our progress to improve the quality of care we provide for our patients in a wide range of areas. We have worked with our clinicians, managers and our local partners at Leeds West CCG and Healthwatch Leeds to agree the key topics to focus on in 2014/15. These are our priority quality goals and represent the areas where we believe we need to continue to make further improvements to ensure that the care we provide for patients is the safest and highest quality.

The following priorities for the Trust have been identified for particular focus in 2014/15:

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

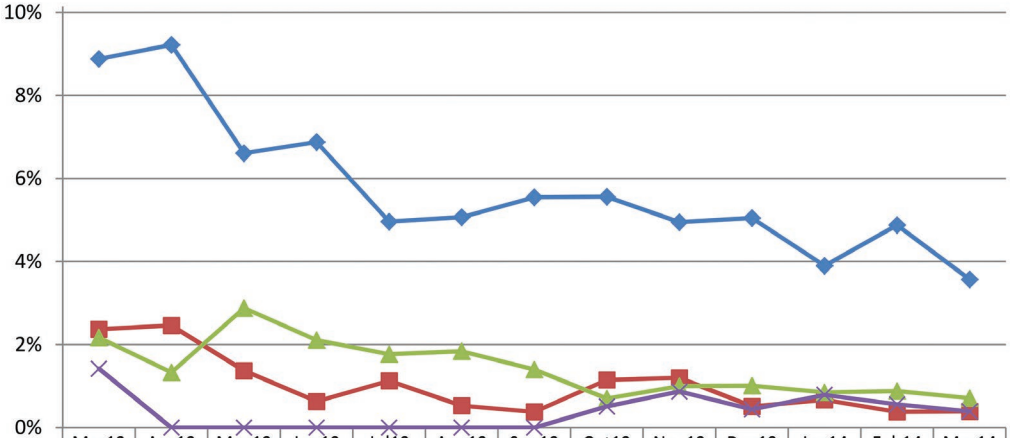
Clinical Effectiveness
Improvement in the care of patients when their condition deteriorates on our wards

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

These are not the only improvements we will be making in 2014/15, there are many other areas we will focus on and these are also highlighted in this quality account.

For example, we will focus on making improvements in harm-free care, as measured by the Safety Thermometer to reduce the prevalence of harm caused by pressure ulcers, falls, blood clots (VTE) and catheter-associated urinary infections. The Trust has demonstrated an increase in the number of patients being harm free during the last 12 months from 87.68% in April 2013 to 95.07% in March 2014.

Safety Thermometer: number (%) harms suffered



	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14
Pressure Ulcers	8.88	9.22	6.61	6.88	4.96	5.07	5.55	5.56	4.95	5.05	3.9	4.88	3.57
Falls	2.37	2.46	1.37	0.63	1.13	0.53	0.38	1.15	1.2	0.51	0.67	0.38	0.39
Catheter & UTI	2.17	1.33	2.88	2.11	1.77	1.84	1.4	0.7	1	1.01	0.85	0.88	0.71
New VTE	1.42	0	0	0	0	0	0	0.51	0.87	0.44	0.79	0.56	0.39
Patients	1476	1583	1528	1425	1412	1518	1567	1566	1496	1583	1640	1597	1542

We will aim to demonstrate further improvements in the experience of our patients through the feedback we get through the Friends and Family Test and improvements in the net promoter score that tells us how satisfied patients are with the care they receive.

We will make further improvements in our operating theatres, diagnostic and surgical areas to ensure patients receive the safest care and reduce the incidence of Never Events.

We will continue with our programme of work to improve the experience our patients have when they are discharged from hospital, to ensure they are fully aware of what to expect, understand their medications, know who to contact if they have any concerns and have the appropriate level of support provided for them.

Our quality goals will be communicated through the Trust's management structure to all levels of the organisation so that all staff are aware of these and their responsibility in supporting the plans to achieve the improvements identified. Progress will be reported to the Trust Board during 2014/15 to provide assurance that targets set out in the quality goals are being delivered.

4.3 Priority goals for improvement

4.3.1 Patient Safety

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

We know that patients are harmed as a consequence of falling whilst being cared for in our hospitals. This is the most common harm that is reported. We are committed to making further improvements in 2014/15 to reduce the numbers of falls and also the number of falls where severe harm was caused to the patient.

The Trust Falls Group has led many developments to reduce falls on our wards. This has involved introducing new care plans, risk assessments, staff training, falls prevention aids and Root Cause Analysis investigations to help us understand the cause of falls, take action to prevent these and to share learning. Whilst this improvement programme has helped to raise awareness of the importance of falls prevention, we have not seen a sustained change in the total number of falls (incidence) and the number of patients sustaining serious injury across our hospitals.

An example of a detailed programme of work led by the acute medical admission team to address the culture and behavioural barriers across multi-professional groups to falls prevention is provided in our quality account. The challenge for us in 2014/15 is to share the learning from this good work across the Trust to deliver the same improvements in all of our clinical areas.

We know that the national average for all falls prevalence is 2% and 0.2% for falls with harm. We have made good progress with this and we know we need to do more to sustain this improvement.

Figure 2 demonstrates these reductions in prevalence relating to patients who have suffered a fall from June 2012. This is now below the national average but we recognise we need to sustain this.

Figure 2: Proportion of patients that have suffered a fall in the last 72 hours

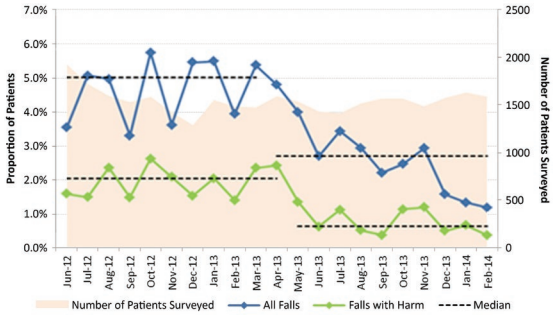
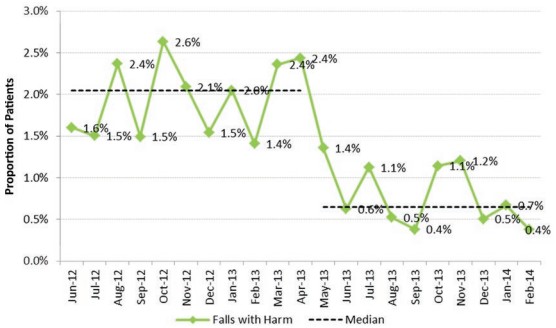


Figure 3 shows the proportion of patients who have suffered harm from a fall, which remains above the national average of 0.2%.

Figure 3: Proportion of patients that have suffered a fall with harm in the last 72 hours



Aims for 2014/15

We will continue to implement our programme of improvements relating to falls reduction in 2014/15. Our aim will be to:

- Reduce the incidence of serious harm following a fall in our hospitals by 50% by 31 March 2015 in those wards selected for the pilot.

How will this work be monitored?

In 2014/15 we will launch our patient safety quality improvement programme supported by Salford Royal (Haelo), a national leader in improving safety of care. This work will be supported by the Yorkshire and Humber Improvement Academy to help us to deliver sustained improvements in reducing the number and harm from falls. This will include specific support relating to falls reduction, providing monthly information relating to the number of falls and harm suffered as a result of this. Pilot wards will be identified for this improvement programme, to commence in July 2014.

The prevalence of falls (the number of falls at a given point in time) on our wards will continue to be monitored through the monthly Safety Thermometer return.

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

4.3.2 Clinical Effectiveness

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

We recognise that we need to continue to improve our response regarding the treatment and care of our patients when they deteriorate on our wards, to ensure they receive safe, timely and effective treatment and care. We know from our incident reports and investigations that we need to improve in this area.

It is recognised that many patients show signs of deterioration in the hours leading to cardiopulmonary arrest or admission to critical care. By closely monitoring changes in the

patient's condition, early signs of deterioration are more likely to be identified; actions can then be taken before a serious harm occurs.

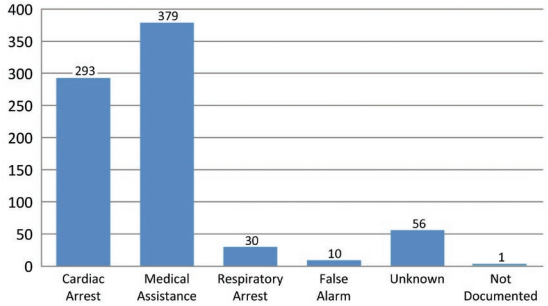
We currently have a procedure to identify and minimise the risks for patients deteriorating on our wards. We use the National Early Warning Scoring systems (NEWS) to detect early deterioration. These are adapted for adult, children and maternity care.

The aim of using these systems is to prevent harm and reduce in-hospital cardiac arrests through early recognition and treatment of the deteriorating patient. Each of the Trust's hospital main sites is supported by a team of specially trained nurses seven days per week who support clinical teams in the recognition and management of patients at risk (Adult Critical Care Outreach Team).

We are about to commence a patient safety programme of work to improve early recognition of patient deterioration. We have revised our procedure to help us minimise the risks associated with the management and care of the deteriorating patient. Our revised procedure supports national recommendations for recognising the acutely ill patient in hospital and guidance published by the Resuscitation Council (UK) (revised 2010).

We are able to measure this by counting the number of cardiac arrest (resuscitation) calls from our wards when patients deteriorate. If we improve the treatment and care in relation to our response to deterioration we would expect to see a reduction in the number of cardiac arrest calls from our wards.

Figure 4: Number of emergency calls from our wards in 2013



Aims for 2014/15

We will continue to implement our programme of improvements relating to the care of patients when their condition deteriorates on our wards in 2014/15.

- Our aim will be to reduce the total number of cardiac arrests that occur on those inpatient wards that are included in our programme for improvement by 70% by 31 July 2015.

How will this be monitored?

This will be a key priority in our patient safety quality improvement programme supported by Salford Royal (Haelo). This work will be supported by Yorkshire and Humber Improvement Academy, including specific support relating to care of the deteriorating patient and reduction in the number of cardiac arrests that occur outside our critical care units, providing monthly information relating to this. Pilot wards will be identified for this improvement programme, to commence in July 2014.

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

4.3.3 Patient Experience

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

We undertook a review of our complaints process and analysed a number of complaint responses that we had sent to patients. Through this we recognised that we could make further improvements in this area, particularly regarding the timeliness of our responses and the language we used in some of our letters, which in some cases did not contain sufficient compassion. Concerns regarding this were also raised through the review of children's heart surgery that was undertaken during the summer.

We subsequently developed a comprehensive improvement plan and this was included as one of the quality goals in the 2013/14 CQUIN scheme that was agreed with our commissioners at NHS Leeds West CCG.

Our Complaints Policy was revised in 2013/14. The refreshed policy took into account the publication of the Clwyd and Hart review to ensure that the recommendations were incorporated. The policy sets out to support staff to resolve complaints locally wherever possible, preferably face to face.

We have provided a summary of our progress relating to complaints from page 126 in our Quality Account, including the actions we have taken to improve the way we handle complaints and learn from what our patients tell us about their experience of care.

Aims for 2014/15

We will continue to implement our programme of improvements relating to complaints in 2014/15. Our aim will be to improve our response time so that 80% of complaints are responded to within 40 days by the end of 2014/15.

For complaints received in 2014-15 we will aim to reduce the number of complaints re-opened within 6 months because we have not satisfactorily addressed concerns in the first response by 50%.

How will this work be monitored?

In 2014/15 we will continue to implement our complaints improvement plan.

Progress in relation to this quality goal will be reported through the Trust's Patient Experience Sub-Committee, which reports to the Quality Committee, a committee of the Board. A report will also be provided at each Trust Board meeting.

4.4 Progress against our quality goals 2013/14

In 2013/14 we set specific quality goals to make further improvements relating to the prevention of pressure ulcers that cause harm to our patients, improve the care of people with dementia and improve the experience relating to discharge from our hospitals.

4.4.1. Patient Safety

Reduction in hospital-acquired grade 3 and grade 4 pressure ulcers

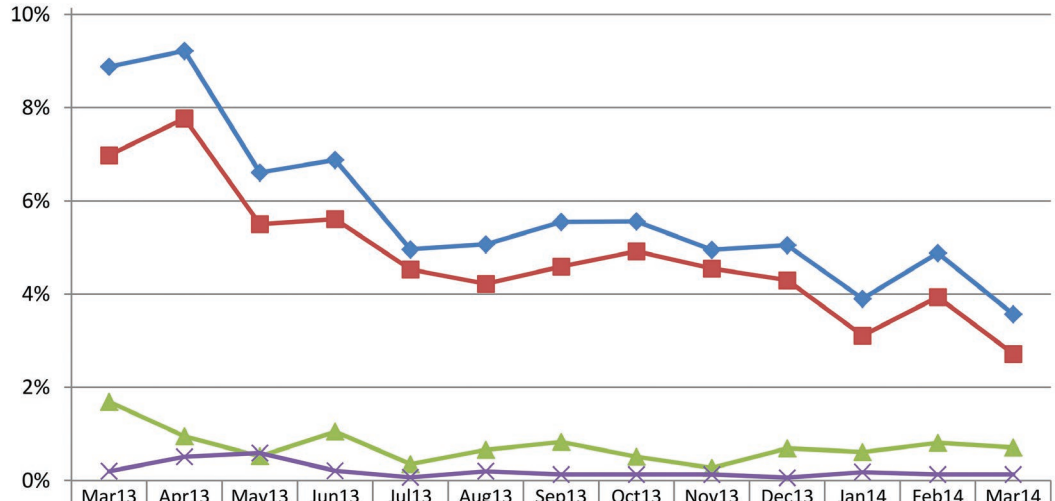
Pressure ulcers can occur in people who are unwell and immobile. They are categorised from one to four according to the level of severity; they can result in patients suffering pain, discomfort and reduced mobility, and may increase their risk of acquiring complications such as infection.

An improvement target was agreed with commissioners at NHS Leeds West CCG to reduce grade 3 pressure ulcers by 20% (36 in total) and grade 4 pressure ulcers by 50% (2 in total) and to reduce the prevalence for all pressure ulcers to 7.2% for the period April to September 2013 based on the monthly Safety Thermometer submission.

In 2013/14 we achieved the 50% reduction in category 4 pressure ulcers (2). Unfortunately, whilst we achieved the required reductions in the number of category 3 pressure ulcers in the first half of the year, this increased in Q3 and Q4 and we didn't achieve the 20% reduction (36) that we set as our ambition at the start of the year, reporting a total of 56 at the end of the year. This is reflected in our performance against the CQUIN goal that was agreed with commissioners in 2013/14 (see summary on page 139).

We have worked with our specialist Tissue Viability Team to ensure that all pressure ulcers are categorised (and not unstageable) and we have included category 3 pressure ulcers in our revised serious incident procedure. We know this has resulted in an increased reporting profile whilst this is embedded in our clinical practice and reporting culture. This was confirmed in an audit that we did in November 2013 of all patients in our hospitals, which showed that the reporting of pressure ulcers had increased by over 30% when this was reviewed against the direct observation of all patients in our hospitals. We did achieve the reduction in prevalence that was reported through our monthly Safety Thermometer return (see Figure 5).

Figure 5: Pressure ulcer by category (Safety Thermometer) 2013/14



	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14
All	8.88	9.22	6.61	6.88	4.96	5.07	5.55	5.56	4.95	5.05	3.9	4.88	3.57
Category 2	6.98	7.77	5.5	5.61	4.53	4.22	4.59	4.92	4.55	4.3	3.11	3.94	2.72
Category 3	1.69	0.95	0.52	1.05	0.35	0.66	0.83	0.51	0.27	0.69	0.61	0.81	0.71
Category 4	0.2	0.51	0.59	0.21	0.07	0.2	0.13	0.13	0.13	0.06	0.18	0.13	0.13
Patients	1476	1583	1528	1425	1412	1518	1567	1566	1496	1583	1640	1597	1542

Action plans have been produced to focus on the assessment and prevention of pressure ulcers in those specialty areas with the highest number of pressure ulcers, supported by the Trust's specialist Tissue Viability Team. Root Cause Analysis investigations have been undertaken for category 2 and category 3 pressure ulcers and improvement action plans developed. Category 3 and 4 pressure ulcers are being reported as Serious Incidents and investigated in line with our serious incident procedure.

Whilst we have made good progress in 2013/14 we recognise that we need to do more to reduce the number of pressure ulcers developed in our hospitals, particularly those that cause the most harm to our patients. We will continue to implement our improvement programme and work with our partners in primary and social care in 2014/15, focusing on the prevention of pressure ulcers.

4.4.2 Patient Experience

Improve the patient's experience of discharge

Improving the patient's experience of discharge continued to be one of our Quality Goals for a second year in 2013/14. This was because we were not satisfied with the level of progress we had made for our patients during 2012/13.

Through 2013/14 staff have worked hard to secure improvements in the patient's experience of discharge to achieve our quality goal of ensuring that by the end of March 2014 all patients would:

- Understand the need for, and side effects of their medicines
- Have a point of contact should they have any worries after leaving hospital
- Feel that they and their families have been involved in decisions about discharge.

To help us understand the progress that has been made towards these goals the Trust has reviewed the responses received as part of the National Inpatient Survey 2013, reviewed responses to the Friends and Family Test and identified where complaints, comments, compliments and patient postings (on the NHS Choices and the Patient Opinion website) mention patient discharge. The national inpatient survey asks patients specific questions about going home (discharge).

The results for 2013 show that of the 15 questions that ask about discharge, patients reported an improved experience on 12 questions. The inpatient survey results show that the Trust's performance improved for the three areas identified in the quality goal.

Leaving Hospital Picker Inpatient Survey Results 2013

Leaving hospital improved scores

- Discharge: did not feel involved in decisions about discharge from hospital
- Discharge was delayed
- Discharge: not given a reason for delay in discharge
- Discharge: not given any written/printed information
- Discharge: not fully told purpose of medication
- Discharge: not told how to take medication clearly
- Discharge: not given completely clear information about medicines
- Discharge: family not given enough information to help
- Discharge: not told who to contact if worried
- Discharge: did not receive copies of letters to GP
- Letters to GP written in way could understand
- Discharge: not fully told of danger signs to look for
- Discharge: delayed by 1 hour or more
- Discharge: not told how long delay in discharge would be
- Discharge: not fully told side-effects of medications

Key: Improved No change Deterioration

Through 2013/14 a number of changes have been put in place that are now improving the experience of patients when they are discharged:

- All patients are now provided with a discharge folder that contains information about what to expect and how to get help if this is needed when they are discharged from hospital. This folder has been reviewed and improved. The discharge folder now has printed on it essential information for patients about their medication, who to contact after discharge, and how to raise a concern
- 'Contact cards' have been introduced and are now given to patients. These provide details of the ward sister and who to contact if there is concern
- A ward health check was launched in January 2014. As part of the health check an independent audit of ten sets of nursing records is undertaken on each adult inpatient ward each month. This includes a review of the completeness of documentation regarding discharge planning, the identification of expected date of discharge (EDD) for patients, the presence of electronic discharge advice notes (e-DAN) and the use of discharge folders on wards. The results of the health check show an improving position
- The Trust has introduced a discharge checklist for patients discharged from older peoples, medical and paediatric wards and this has been rolled out to our general surgical wards in 2013/14
- The Trust Discharge Policy has been reviewed and updated to reflect changes in the Trust and best practice with regard to discharge. The review was informed by an interagency discharge workshop that was held in October 2013
- During the winter the discharge team was strengthened through the addition of a Matron to the team.

Looking forward to 2014/15 the Trust will be continuing to focus on improving the patients' experience of discharge through working with other health and social care providers in the city. This has been included as part of the local CQUIN scheme.

4.4.3 Clinical Effectiveness

Improving the care and outcomes for patients with dementia

Dementia is a condition which affects approximately 800,000 people in England and Wales: one in three people aged over 65 will have dementia by the time they die, and as life expectancy increases, more and more people will be affected. In 2013 the Prime Minister set a challenge to increase the number of people with a firm diagnosis of dementia to two-thirds by 2015 and also to improve the support they and their carers receive. People with dementia use 25% of adult general hospital beds, they often have longer lengths of stay, and have a high rate of readmission to hospital.

Leeds Teaching Hospitals NHS Trust is committed to improving the care for this vulnerable group of patients, and over the past year the Trust has continued to make significant improvements to the services it provides for people with dementia and their carers.

Key Achievements in 2013/14

Improving the Identification of People with Memory Problems

The Department of Health introduced a Dementia CQUIN in April 2012; this requires all hospitals to assess all people aged 75 years and over, admitted acutely to hospital with a length of stay of more than 72 hours, for the possibility of dementia.

Hospitals are required to achieve a compliance rate of 90% with all 3 stages of the CQUIN, namely to identify, assess and investigate, and refer. We achieved this target in December 2012 and continued to achieve it every month since then.

As a result 70 new patients (not previously known to have memory problems) are being detected each month and, once they are over their acute problem, referred back to their GP for further assessment in the community and consideration for referral to a memory clinic if their memory remains poor. In 2013/14 the Dementia CQUIN was expanded to include support of carers, and education and training.

The Trust's Dementia Champion, a Consultant Geriatrician, has been contributing to the process of redesigning the Memory Assessment Pathways in Leeds by using the CQUIN data. The expectation is that the redesigned pathway will help reduce waiting times for patients to be seen, and increase assessments and the number of people getting a firm diagnosis of dementia.

Supporting Carers of People with Dementia

Two thirds of people with dementia live at home (not in residential homes) with much of their care delivered by unpaid carers, many of whom are under considerable strain and/or have health problems of their own. Over the past year the Trust has held several consultations with carers including at the Bay Tree Resource Centre, Leeds, Carers Leeds Headquarters, and a Carers Coffee Morning in our hospitals.

Important themes are emerging on how carers perceive the Trust can improve services for people with dementia, including:

- Avoiding repeated ward moves (including side wards) which disorientate patients
- More flexibility with visiting hours
- Provide better recreational activities which will reduce boredom and wandering
- Provide better assistance with eating
- Improve staff training about dementia
- Provide carers with better information and support
- Improve the co-ordination of discharge arrangements, and give carers more notice.

In addition the Trust has surveyed the views of carers using a questionnaire (on-line and paper based) consisting of 4 simple questions:

- When the person you care for was in hospital, how involved did the ward staff make you feel with their care?
- When the person you care for was in hospital, how often did staff ask whether you were having difficulties or problems with caring?

- Did staff give you information about agencies in Leeds which might be able to help and support you as a carer?
- If you were given information, how useful was it?

The results of the carers' survey responses between August 2013 and March 2014 confirmed that we needed to do more work in all these areas.

Appointment of a Carer Support Worker

The carers' surveys told us that the Trust could provide better support and information for carers of people with dementia and as a result, in conjunction with Carers Leeds (a Third Sector agency in Leeds), the Trust has appointed a hospital based Carer Support Worker (CSW). The CSW takes referrals from all hospitals and wards within the Trust and to date has taken 81 referrals from 24 wards in the Trust; new referrals average 4 per week. The CSW provides much needed support for carers, providing advice, information and above all signposting them to the appropriate agencies for support. This service has been extremely successful and has been much appreciated by carers.

Improving Person-Centred Care

In 2013 the Trust introduced a 'Know Who I Am' document to enable carers to provide better background information on the person with dementia, facilitating better person-centred care. This document is being used for patients with dementia throughout the Trust, improving the quality of care provided.

In March 2014 the Trust introduced the Forget-Me-Not scheme to raise staff awareness that a person has dementia and that they should therefore modify their approach accordingly. This scheme was initially introduced on the Medicine for the Older People wards and some of the Trauma and Related Services wards. Our early experience is very encouraging.

Dementia Education and Training

The Trust has established an Education and Training plan which consists of Foundation (Introductory) training and three higher levels 1- 3 depending on the level of face to face contact staff have with people with dementia.

Working to become Dementia Friendly

To date, 997 staff have had Foundation training, 1835 Level 1 training, 150 Level 2 and 667 Level 3.

Key trainers have been identified for all Trust Clinical Service Units and staff groups. Priority was given to staff in areas where patient contact is high.

Plans for 2014 /15

For 2014/15 LTHT intends to do the following:

1. Work with other key stakeholders in the city to improve Memory Assessment Services and ensure more people in Leeds get a timely diagnosis of dementia and help achieve the 'Prime Minister's Challenge'
2. Roll out the Forget-Me-Not scheme to other wards in the Trust
3. Increase the number of staff trained in dementia
4. Develop Ward 14 at St James's Hospital as a dementia friendly ward and to encourage the development of other dementia friendly environments within the Trust.

4.5 Statements of Assurance from Trust Board

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

4.5.1 Review of Services

During 2013/14 the Leeds Teaching Hospitals NHS Trust provided NHS services across 90 specialist areas, known as "Treatment Functions" and/or sub-contracted NHS services, to a core population of around 780,000, and provided specialist services for 5.3 million people.

The income generated by the NHS services reviewed in 2013/14 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 Integrated Quality and Performance Report (IQPR) and internally through the performance review process. The Trust's clinical governance meeting structure also routinely reviews quality and performance measures to gain assurance on quality improvements.

4.5.2 Participation in Clinical Audits

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 40 specific national audits that all hospitals in England should contribute data to, if relevant to the services they provide. The Trust contributed data to 95% (35) of the recommended national clinical audits and 100% (2) of the confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust participated in are listed in Appendix C, together with individual participation rates.

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

National Clinical Audit Title	Reason for Non Participation
National Cardiac Arrest Audit	The Trust chose not to participate as it had its own local cardiac arrest audit process. A decision has been taken to participate in this audit from 2014/15 onwards.
National Comparative Audit of Blood Transfusion - Management of Patients in Neurocritical Care Units	The Trust planned to participate in this audit based on the initial proposed methodology. At the time of the audit it became clear the required datasets were significantly more extensive than those proposed initially. It was not feasible to accurately collect the data with the resources available. This audit is not being repeated.
Inflammatory Bowel Disease: Biologic Therapy	We already collect data on patients treated with biologics (since 2006), and publish our outcomes in peer reviewed journals. The national audit collected a more limited dataset, and participation would have taken a large amount of specialist nurse time.
Emergency Use of Oxygen	The Trust implemented a new prescription booklet, including a new system for oxygen prescription, very soon after the data collection period for this audit. Auditing the old process of oxygen prescribing would not have been relevant to the new systems in the Trust. Local audits of oxygen prescribing continued to be carried out throughout 2013.

The reports of 13 national clinical audits, and of 617 local clinical audits, were reviewed by the Trust in 2013/14. 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.

Nasogastric Feeding

Improvement work has taken place in the Trust since 2011 relating to care of patients who are fed via a nasogastric (NG) tube. NG feeding audits were included as part of the Trust's 2013/14 Annual Clinical Programme to assess if the improvement work had made a difference. The results of the audit in Q1 of 2013/14 showed practice in the Trust had improved significantly, and was more in line with the National Patient Safety Agency (NPSA) guidance on NG tubes. Following the results of this audit, revisions were made to the Trust's guidance on NG tubes, and changes were also made to training programmes. The results of the re-audit in Q3 again showed an improvement across the Trust.

Audit of Rejected Urine Samples

A urine sample is important in diagnosing urinary tract infections, and rejection of samples from the laboratory can delay diagnosis of infection, delay the start of treatment with correct antibiotics, and extend the length of a patient's stay in hospital. An audit carried out on Medicine for Older People wards in March 2013 showed 17% of urine samples were rejected from the laboratory for not having the required information completed. Posters and educational updates were produced for ward areas as a result of this audit to remind those sending samples what needs to be included when ordering tests; an electronic system for ordering tests (Ordercomms) was introduced soon after. A re-audit carried out in December 2013 on Medicine for Older People wards showed that only 5% of samples were rejected, and no electronically requested samples were rejected.

Sentinel Stroke National Audit Programme (SSNAP)

Review of SSNAP results to June 2013 showed when the Trust administered thrombolysis treatment to patients who had suffered a stroke, the timeframe in which thrombolysis was started was better than the national average. To ensure more stroke patients receive thrombolysis, changes to doctor rotas have been made and additional nurses have been recruited. Since the start of January 2014, thrombolysis has been available 24/7 in Leeds.

Audit of Febrile Seizures in the Paediatric Emergency Department (ED)

In January 2014 an audit was carried out comparing the care provided in our Paediatric Emergency Department to children who had a fit brought on by a fever to recommendations from the National Institute for Health and Care Excellence (NICE). The audit showed that all patients who should have been, were referred for further assessment by the paediatricians, and that all patients who were discharged were first reviewed by a senior doctor. The audit also showed that whilst some tests were performed for every patient, other tests were not. It was also identified that verbal and written advice was not always provided to patients and GPs when patients were discharged. Actions put in place as a result of the audit included developing a febrile seizure guideline for the ED, and developing teaching for new junior doctors.

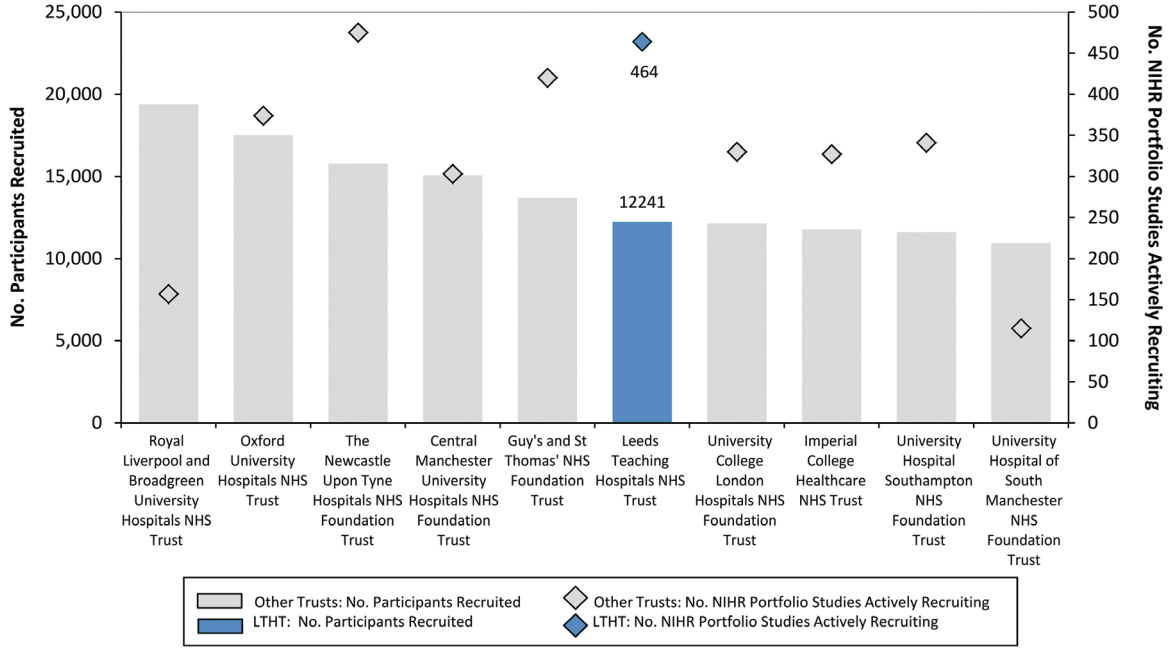
4.5.3 Participation in Clinical Research

We know that high quality clinical research and innovation improves outcomes for patients. The aim of the Trust's Research and Innovation (R&I) strategy is to create a centre of excellence for research and innovation. Our ambition is to deliver "research for all" by significantly increasing opportunities for Trust patients to take part in research studies. Key to our success is our strong and enduring partnership with the University of Leeds which is underpinned by world class facilities and prestigious research grants. We have also worked hard to embed the management of research and innovation within normal Trust business with expert support for both managers and researchers from our central Research and Innovation Team.

NIHR Clinical Research Network

During 2013/14 the Trust remained one of the best-performing trusts in England for projects recognised by the National Institute for Health Research (NIHR) playing a leading role in recruiting patients into high quality studies. This year we have involved 12,241 patients in 464 research studies as shown in the graph below.

R&I Participation - top 10 trust comparison, 2013/14



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

Biomedical Research Unit (BRU) in Musculoskeletal Disease

The activities of the NIHR BRU centre around the principle that targeted individualised therapy for patients will result in improved outcomes. Their research strategy is to capitalise on emerging research opportunities through interdisciplinary partnerships, particularly those with engineering sciences. Activities within NIHR BRU contribute to international knowledge, transforming basic biomedical research into responsive patient care. The Trust NIHR BRU is currently the only one in Yorkshire and the Humber region.

Colorectal Therapies Healthcare Technology Co-operative (HTC)

The HTC is focused on developing novel solutions for both the needs of patients who suffer from colorectal disease and the challenges

faced by the clinicians treating them. In order to do this the HTC is developing a network of academic, NHS, industry, and patient partners which aims to be the first port of call for those involved in the treatment of colorectal disease.

One particular project, the 'Appy Operation, entails the development of a "healthcare app" to enhance patient-healthcare interaction and communication throughout the pre-, peri- and post-operative stages. In conjunction with patient groups and healthcare professionals in Leeds a prototype has been developed. The 'app' collects the routinely collected information from the patient and provides them with details of their operation through multimedia which can be watched at the patient's leisure.

Diagnostic Evidence Co-operative (DEC)

The funding for the DEC in Leeds was awarded in September 2013; by working with patients, industry and NHS commissioners, the Co-operative will evaluate and provide evidence on diagnostic tests in musculoskeletal, renal and liver disease which has the ability to change practice and improve outcomes for patients.

Clinical Research Facility (CRF) for Experimental Medicine

The establishment of the Leeds CRF has led to a structured and integrated approach to the delivery of experimental research across the organisation. It has brought together established research groups to carry out experimental medicine trials in close association with pharmaceutical and other partners. The Leeds CRF has three hubs:

- Oncology/Haematology is based in the Bexley Wing at St James's Hospital
- Musculoskeletal is based at Chapel Allerton Hospital adjacent to the BRU
- Cardiology is based in Jubilee Wing, Leeds General Infirmary and has recently undergone significant refurbishment, funded by the Leeds Teaching Hospitals Charitable Trustees.

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

This year saw the CLAHRC for Leeds, York and Bradford hand over to the new CLAHRC for Yorkshire and the Humber after five years of funding during which there have been many major achievements including:

- **The Addition Research in Acute Settings (ARiAS)** theme, in partnership with the Trust, developed a training programme for staff to help them identify people admitted to their ward who have an alcohol or drug problem and to encourage them to engage with the specialist in-reach service from the Leeds Addiction Unit. The training has laid the ground work for introducing a number of Alcohol Champions within the Trust with the support of the Leeds Addiction Unit
- **The Improving Prevention of Vascular Disease in Primary Care (IMPROVE-PC)** theme helped initiate an analysis of integrated neighbourhood teams. This allowed the development of materials and tools, and a framework to support service improvement plans based on service user feedback. These are being implemented across four integrated neighbourhood teams by Leeds Adult Social Care in collaboration with Leeds Community Healthcare.

Medical Technologies

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

Informatics

Information extracted from large clinical and health data sets will play a critical role in developing new treatments and monitoring the effectiveness of existing therapies. The Trust was also a partner in a major award (£7m)

from the Medical Research Council to create an integrated medical information system, which will enable the Trust and University to play a leading role in this exciting area.

Cancer Research UK Leeds Centre (CRUK)

Funding for the Cancer Research UK Leeds Centre has been successfully renewed for another 3 years. The CRUK Centres are one of the charity's highest strategic priorities. They drive local partnerships and high-calibre collaborations between universities and NHS Trusts under a united strategy to accelerate the translation of research into practice. Researchers at the Leeds Centre will focus on two interrelated themes; Viruses and Immunology, and Radiation Biology and Radiotherapy. Work in these areas already demonstrates the large-scale and productive nature of cancer research in Leeds and forms a platform for our strategies to become world-leading in each theme.

4.5.4 Goals Agreed with Commissioners

A special scheme to encourage our Trust to improve quality in priority areas was agreed nationally and also with commissioners at NHS Leeds West CCG and the Specialist Commissioners. The scheme is called Commissioning for Quality and Innovation, or CQUIN. The CQUIN payment framework is an incentive scheme which rewards the achievement of quality goals to support improvements in the quality of care for patients.

A proportion of the Trust's total contract income is allocated to the CQUIN scheme as an incentive to make improvements in quality; the value of the scheme remained at 2.5% of total contract income in 2013/14.

In 2013/14 the Trust was required to achieve 4 national goals, 6 local goals and 6 goals set by the Specialist Commissioning Group (SCG). In addition to this the Trust was required to submit quality data relating to a range of specialist conditions set by the Specialist Commissioners. Last year, 2.5% of our clinical income was conditional upon achieving quality improvement and innovation goals agreed with our main Commissioners of services through CQUIN. This equated to more than £16.1 million of our total income. The Trust delivered all of its CQUIN targets for specialist commissioners in 2013/14 and the majority of its CQUIN targets for local Commissioners.

The specific CQUIN goal that was not achieved in all 4 quarters of the year relates to a reduction in category 3 pressure ulcers.

Delivery of CQUINs 2013/14

	Indicator	Quarterly performance			
		Q1	Q2	Q3	Q4
National	VTE risk assessment and Root Cause Analysis				
	Friends and Family Test				
	Dementia risk assessment and referral				
	Safety thermometer: falls, pressure ulcers, VTE, catheter-associated urinary tract infection				
Local	Pressure ulcer reduction (Category 3 and 4)				
	Improving the management of patients with asthma in the emergency department				
	Implementation of plan to improve patient experience				
	Improve health through addressing unhealthy lifestyle behaviours (Making Every Contact Count - smoking, alcohol, obesity)				
	Patient discharge - checklist implementation				
	Development of joint pathway in emergency care for referral and treatment of young people who self-harm				
SCG	Cardiac surgery - improve time waiting for operation (acute)				
	Increasing access to intensity Modulated radiotherapy (IMRT)				
	Neonatal care - improvement in discharge				
	Neonatal care - reducing re-admissions				
	Paediatric intensive care - reduce out-of-network transfers				
	Provide data returns for quality dashboard				

Achieved	Partially achieved	Not achieved	Data not required

The CQUIN scheme for 2014/15 has been agreed with commissioners; a summary can be seen in Appendix D.

4.6 What others say about Leeds Teaching Hospitals NHS Trust

4.6.1 Care Quality Commission

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

The Trust is required to be compliant with sixteen essential standards of quality and safety. To help Trusts monitor their performance against these standards the CQC developed a Quality and Risk Profile scorecard (QRP) for each healthcare provider. This helps Trusts to assess where risks lie, supporting the Trust's own internal monitoring of quality. This was replaced by a new Intelligent Monitoring Report that was published in October 2013 as part of the new inspection regime. This involves a range of indicators to help the CQC assess the level of risk to quality and safety in an organisation.

Compliance inspection visits 2013/14

The CQC has undertaken two unannounced compliance inspection visits in 2013/14.

The CQC undertook an unannounced compliance inspection visit at the St James's Hospital location in May 2013. They visited an older people's ward, oncology and surgical day unit. This was a responsive visit following concerns that had been raised with the CQC. The following Outcomes were reviewed:

Outcome reviewed	Judgement
Outcome 1 - Respecting and involving people who use services	Compliant
Outcome 4 - Care and welfare of people who use services	Compliant
Outcome 8 - Cleanliness and infection control	Compliant
Outcome 13 - Staffing	Compliant

The CQC reported positive experiences from both patients and staff during their visit and judged the Trust to be complaint against the Outcomes reviewed.

The CQC also visited St James's Hospital location in May 2013 to undertake a review of the application of the Mental Health Act (MHA) relating to detention and its associated Code of Practice. This was a planned visit as part of a national programme of reviews involving acute provider organisations. An action plan was developed to address the areas of improvement identified following the review, notably regarding the assessment of patients detained under Section 5(2) under the Mental Health Act.

The CQC visited the maternity and emergency care departments at LGI and St James's Hospital locations in October 2013. This was a planned (unannounced) visit and involved a larger inspection team, including clinicians, inspectors and specialist advisers. The CQC reviewed the following outcomes:

Outcome reviewed	Judgement
Outcome 1 - Respecting and involving people who use services	Compliant
Outcome 4 - Care and welfare of people who use services	Compliant
Outcome 13 - Staffing	Compliant
Outcome 16 - Assessing and monitoring the quality of service provision	Compliant
Outcome 17 - Complaints	Compliant

The CQC reported very positive experiences of patients and staff in these areas and judged the Trust to be complaint against the Outcomes reviewed.

Comprehensive inspection March 2014

There have been significant changes to the inspection process in 2013/14. Following publication of the first CQC Intelligent Monitoring report, the Trust was placed in wave 2 of the new comprehensive inspection programme that was introduced in September 2013. This is because the risk assessment

placed the Trust in Band 1 (higher level of risks identified) based on the specific indicators used for the period of time reviewed. The specific risks related to the incidence of Clostridium difficile infection, whistleblowing alerts, education concerns, incidence of Never Events, referral to treatment times and outcomes from the staff survey. These risk areas have been subject to programmes of improvement and progress was reflected in the publication of the second Intelligent Monitoring report in March 2014, which placed the Trust in Band 4 (lower risk).

The comprehensive inspection took place week commencing 17 March 2014. This was preceded by a detailed programme to prepare for the inspection, led by the Chief Nurse. This involved engaging with a wide range of staff groups at all levels of the organisation and the provision of information to the CQC inspection team to assist with their inspection. The inspection was extremely thorough, involving visits to a wide range of clinical areas across the Trust, including all locations. The CQC returned to do an unannounced visit at the LGI and St James's Hospital locations on Sunday, 30 March 2014 to complete their inspection, focusing on the care provided to patients out of hours during the weekend (Sunday). Whilst the inspection visit was concluded at the end of 2013/14, the draft report was still to be received.

4.6.2 NHS Litigation Authority

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

In November 2011 the Trust was assessed and retained its Level 1 accreditation under the NHS Litigation Authority (NHSLA) Risk Management Standards for Hospital Trusts (acute services). Level 1 was also achieved by maternity services in September 2012. In both assessments the Trust achieved the highest possible score. This shows that our risk management policies and procedures are of a high standard, providing guidance on delivering safe services to patients and our staff.

During 2013/14 the NHSLA announced that following a comprehensive review of their standards and assessment process they would make no further changes to their standards. They also concluded that they would conduct no further assessments after March 2014. In their place, the NHSLA will establish a Safety and Learning Service. This service has the same aims as the standards in that it will support all trusts in improving patient and staff safety, and reducing harm. During 2014/15 there will be three specific focus areas, namely: Maternity Services, Surgery, and Accident and Emergency care. Whilst these changes are introduced the Trust will retain its Level 1 accreditation.

4.6.3 Dr Foster Hospital Guide

On 8 December 2013 Dr Foster published the 12th edition of their annual Hospital Guide. The report for 2013 focussed on 5 key areas:

- Mortality
- Weekend Care
- Commissioning
- Drug & Alcohol Admissions
- Doctor Survey.

Only the Mortality and Weekend Care sections of the Guide contain Acute Trust level information.

4.6.4 Mortality

Summary of the Trust's position

Mortality Metrics	LTHT Rate	Expected/ National Rate	Range (99.8% control limit)	
HSMR - 1 Year	92.7	100	94.1	106.1
HSMR 100 - all inpatient activity	92.2	100	94.7	105.5
HSMR - 3 Years	93.1	100	96.6	103.5
Deaths after Surgery	101.6	100	75.1	131.1
Deaths in Low Risk Diagnosis Groups	0.7%	-	0.4%	1.1%
HSMR (1 Year) - St. James's University Hospital	89.7	100	93.3	107.0
HSMR (1 Year) - Leeds General Infirmary	100.1	100	88.7	112.2

The Trust has for a number of year's consistently maintained its mortality rates, called HSMR and SHMI, within or better than the expected range and this is reflected again in the 2013 Dr Foster Hospital Guide.

The Trust is named in the Guide as being in the top 25% of all trusts as having a HSMR significantly lower than expected and top 20% with a lower than expected mortality rate on 2 or more of the 4 main mortality measures (HSMR, SHMI, Deaths after Surgery & Deaths in Low-risk Conditions). The Trust did not have any mortality rate higher than expected.

The 2013 Guide also reported HSMR for our two main hospital sites, St James's Hospital and LGI. The HSMR for each site are as expected, or lower than expected.

In the 2013 guide Dr Foster examined other measures of care.

Weekend Care

The tables on the following pages show Trust level performance in each of the 4 areas covered by the weekend care analysis.

Mortality

Weekday v Weekend Metrics	LTHT Rate	Expected/ National Rate	Range (99.8% control limit)	
HSMR for Emergency Admissions (Weekday)	91.7	100	93.0	107.4
HSMR for Emergency Admissions (Weekend)	89.9	100	88.0	113.1
HSMR for Emergency Admissions for patients with Cancers (Weekday)	71.8	100	83.1	119.4
HSMR for Emergency Admissions for patients with Cancers (Weekend)	87.8	100	69.2	139.1
HSMR for Emergency Admissions excluding patients with Cancers (Weekday)	95.4	100	92.3	108.1
HSMR for Emergency Admissions excluding patients with Cancers (Weekend)	90.2	100	87.1	114.0
SMR for Elective Surgery (Monday)	126.1	100	40.4	197.0
SMR for Elective Surgery (Friday)	153.3	100	34.4	218.0

Trust mortality rates when comparing weekdays and weekends are all as expected or better than expected.

Readmission

Weekday v Weekend Metrics	LTHT Rate	Expected/ National Rate	Range (99.8% control limit)	
28 Day Emergency Readmissions by day of Discharge (Weekday)	92.3	100	96.8	103.2
28 Day Emergency Readmissions by day of Discharge (Weekend)	93.0	100	94.0	106.2
28 Day Emergency Readmissions by day of Admission (Weekday)	91.9	100	96.8	103.2
28 Day Emergency Readmissions by day of Admission (Weekend)	94.3	100	94.5	105.8

The Trust is named in the Guide as one of six trusts having very low readmission rates for both weekday and weekend.

Scans

Weekday v Weekend Metrics	LTHT Rate	Expected/ National Rate	Range (99.8% control limit)	
MRI on day of Admission: Weekday v Weekend	0.62	0.58	0.4	0.9
Upper GI Diagnostic Test on day of Admission: Weekday v Weekend	0.92	0.62	0.5	1.6

The Trust is within the expected range when comparing weekday and weekend access to scans.

Fractured Neck of Femur

Weekday v Weekend Metrics	LTHT Rate	Expected/ National Rate	Range (99.8% control limit)	
FNOF: No Operation within 2 days of Admission	42.0%	-	16.4%	26.8%
FNOF: No Operation within 2 days of Admission (Fri - Sat)	39.1%	-	15.5%	35.6%
FNOF: No Operation within 2 days of Admission (Sun - Thur)	43.2%	-	14.6%	26.7%
Reduction of Fracture on day of Admission: Weekday v Weekend	0.99	0.90	0.8	1.3

The Trust does not show significant differences between weekday and weekend performance relating to the treatment times for fractured neck of femur (FNOF), however overall rates are significantly below that expected for a Trust of our size. Poor performance against this Dr Foster indicator is recognised and the Trust has submitted the following response to Dr Foster in relation to the FNOF metrics:

'The Leeds Teaching Hospitals NHS Trust fully recognises the figures presented on operations within 2 days for Fractured Neck of Femur (FNOF). In 2012/13 the Trust agreed a local Commissioning for Quality & Innovation (CQUIN) target with commissioners to improve FNOF operating times. The metric chosen was the % of patients admitted with a fractured neck of femur who are clinically fit for surgery to be operated on within 48 hours. This metric was measured using National Hip Fracture Database data as opposed to Secondary Uses Service (SUS) data, as used in the Dr Foster

metric, this enabled exact admission and operation times to be used in calculating time to surgery, something which is not possible using SUS data. The metric also included the relevant exclusion of patients where surgery within 48 hours was not considered clinically appropriate. The Trust agreed a target of achieving 88% of patients meeting the standard by the end of the year; the Trust successfully achieved this target with 95% of patients receiving an operation within 48 hours of admission in quarter 4 of 2012/13.'

'The importance of this measure is the link between delays in operation and the risk of death. Previous Dr Foster Hospital Guides featuring the FNOF operation within 2 days metric have also featured FNOF mortality rates, this has provided valuable context to the measure. Over the last 3 years the Leeds Teaching Hospitals NHS Trust has consistently achieved a significantly lower than expected relative risk for in-hospital mortality for FNOF (LTHT 69, national average 100, source: Dr Foster Quality Investigator). We are confident that the majority of patients in our care are getting their operations at the right time to maximise their chances of recovery.'

4.6.5 Information Governance and Data Quality

Statement on relevance of Information Quality and actions to improve

The Department of Health requires hospital Trusts to ensure they hold 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.

During 2013/14, as part of the Trust's commitment to improving and assuring the quality of its data, a project was established to conduct a comprehensive review of Trust data collection and assurance processes. A baseline data quality assessment of all clinical systems and key audits, submissions and data flows was conducted using the 'Data Quality Diamond' methodology. A formal report was produced and presented to the Trust Information Governance Sub-Committee detailing the findings of the assessment and making recommendations for improvement during 2014/15, these included:

- Establishment of a Clinical Information & Outcomes Team
- Leadership on Data Assurance at Board Level
- Establishment of a central repository of all data collections and flows
- Development of comprehensive Standard Operating Procedures, Training Programme and supporting Data Quality Reporting.

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 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are published nationally.

The percentage of records in the published data to February 2014 which included a valid NHS number was:

- 99.8% for admitted patient care - 0.7 percentage points above the national average
- 99.8% for outpatient care - 0.5 percentage points above the national average
- 96.3% for accident and emergency care - 0.5 percentage points above the national average.

The percentage of records in the published data to February 2014, which included a valid General Medical Practice Code was:

- 100% for admitted patient care - 0.1 percentage points above the national average
- 100% for outpatient care - 0.1 percentage points above the national average
- 99.9% for accident and emergency care - 0.8 percentage points above the national average.

The above figures do not take into account any improvements which will be made following the annual refresh of data which takes place in April/May 2014.

Clinical Coding

Ensuring that the clinical information recorded for our patients is complete, accurate and reflective of the care and treatment given is important to the effective management of the quality and effectiveness of our clinical services and the recovery of income for the care we deliver. The Trust has a continuous programme of audit and training in place to ensure high standards of clinical coding are delivered. During 2013/14 the programme included work to support, develop and assure clinical coding in;

- Palliative Care
- Stroke
- Complex Surgery
- Fractured Neck of Femur
- Mortality Alert Review Process
- Consultant Reviews.

The Trust participated in the national Payment by Results (PbR) clinical coding audit during 2013/14, undertaken by the Audit Commission. These audits provide a summary of the accuracy of clinical coding across the NHS and help inform improvements in practice. The Trust accuracy rates reported for primary and secondary diagnosis and treatment coding in the preliminary report were:

- 95.5% primary diagnosis coding accuracy
- 91.4% secondary diagnosis coding accuracy
- 90.6% primary treatment coding accuracy
- 61.5 % secondary treatment coding accuracy
- 94.5% coding accuracy that attributed to the correct Health Care Resource Group.

The national position, for comparative purposes, is yet to be published by the Audit Commission.

An action plan was implemented during 2013/14 to address recommendations made to the Trust following the previous year's PbR audit; clinical engagement was a high priority and with the support of the Medical Director (Quality & Governance) the coding team have:

- Delivered presentations around the Trust to the clinical teams
- Expanded ward based coding to enable closer links to the medical staff
- Attended regular meetings with clinicians to review coding
- Attended junior doctor induction days
- Worked with areas to improve documentation, accuracy and information access.

The timeliness of accurately coded data is of particular importance to the Trust in terms of income recovery via the national PbR process. The clinical coding department has greatly improved on the timeliness of the coded data during 2013/14 and has achieved the target of 100% completion at the final PbR submission date (Freeze Date) in every month since June. Focus is now shifting to ensuring that all coding is complete by the 5th working day of each month, bringing the Trust in-line with the best peer performance.

	Apr-13	Jan-14
Month End	66.4%	76.2%
5th Working Day (after Month End)	80.3%	89.3%
Payment by Results Flex Date	86.4%	95.9%
Payment by Results Freeze Date	99.9%	100.0%

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 2013/14 the Trust increased its submission score by 8% and submitted an additional 10 factors at Level 3 Compliance. This demonstrates to patients and service users that the Trust has robust controls in place to ensure the security of patient and staff information.

In accordance with national guidance, Information Governance awareness and mandatory training procedures must be in place to ensure that staff are appropriately trained. The Trust achieved its target for training of staff in Information Governance for the fourth consecutive year and is enhancing training programmes to ensure that training is up to date and relevant for next year.

National Audit of Elective Care Waiting Times 2013/14

In May 2013 the National Audit Office (NAO) commissioned a study to examine the performance, recording and management of elective care waiting times in England. The purpose of the audit was to focus particularly on checking Trusts' recording of waiting times.

Against this background, the report examined:

- Performance nationally against the waiting time standards;
- how waiting times are measured and reported, and
- management of the challenges.

In January 2014 the results of the audit were published and within the report it was identified that the Trust had a significant error rate, particularly in relation to the recording of clock starts (when the waiting time is recorded as beginning). The findings of the report indicated that local variations in how the waiting time rules were applied meant that the performance of individual trusts was not directly comparable. Following the publication of the national report the Trust recognised that the published results had not been validated in line with the standard process for audits. An internal audit was commissioned and the validated audit showed that the Trust was not an outlier in clock start errors. The errors found were mainly due to missing information from referral agencies. A detailed action plan has been put in place to address the weaknesses identified.

IG Toolkit Final Ratings

Assessment	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Grade
Version 11 (2013-2014)	0	0	23	22	45	82%	Satisfactory
Version 10 (2012-2013)	0	0	33	12	45	74%	Satisfactory
Version 9 (2011-2012)	0	0	42	3	45	68%	Satisfactory
Version 8 (2010-2011)	0	0	45	0	45	66%	Satisfactory

4.7 Patient safety

The following section highlights some of our achievements in relation to improving quality throughout 2013/14 and our plans for 2014/15.

4.7.1 Nurse Staffing

We recognise that the availability of the right staff, in the right place, delivering the right care has a direct impact on the quality of care for our patients. In 2013/14 we have focused on improving staffing levels of registered nurses and healthcare support staff. This has involved the use of evidence based tools, such as the AUKUH Acuity/Dependency tool, to review nurse staffing across the Trust, and specific national tools in areas such as intensive care. The Trust Board has agreed in principle the proposals to invest in nurse staffing based on the national 1:8 recommendation.

NHS England has set out the expectations that all health care organisations should meet in relation to getting nursing, midwifery and care staffing right so that they can deliver high quality care and the best possible outcomes for their patients.

Improving Recruitment

Registered Nurses

The nursing and midwifery recruitment teams have been working hard to attract high quality registered nurses and midwives to Leeds Teaching Hospitals. Events in 2013/14 have included:

- An Open Day for Registered Nurses at St James's Hospital where 69 new nurses were successfully recruited. A further similar event is planned for June 2014
- Working collaboratively with the University of Leeds and Leeds Metropolitan University to attract their newly qualifying nurses to start their careers as a Registered Nurse at Leeds Teaching Hospitals. The recruitment programme in March and April resulted in 126 successful applicants
- Trust Nursing representation at two registered nurse recruitment fairs in Ireland with 11 successful candidates appointed
- In March, attendance at the Royal College of Nursing (RCN) Bulletin Jobs Fair in Glasgow, and a Theatres Open Day in the Trust resulted in a lot of interest and potential new recruits. The applicants from these are going through the recruitment process at present.

Future events include a Children's Nurses Recruitment Open Day which is taking place in May 2014, and we will have representation at the RCN Congress in Liverpool in June.

The team has established a recruitment mentor scheme where successful candidates are linked to a staff member in the clinical area where they will be employed whilst they are undergoing NHS recruitment checks. The aim of this is to make the candidate feel like a valued member of the team right from the start. This will help to make new recruits feel welcome and reduce the number of staff who drop out or find alternative employment during the recruitment processes.

Beyond this the team are constantly looking for new and innovative ways to recruit nurses, and are working collaboratively with Clinical Service Units and Universities to reach potential applicants in a challenging climate and a competitive market where nurses are in short supply.

Healthcare Support Workers

The Apprentice Clinical Support Worker and Trainee Assistant Practitioner programmes continue to go from strength to strength. The number of apprenticeship places has been increased to 220 per year, with 10 intakes across the year.

Places for the next group of 20 Trainee Assistant Practitioners are about to be advertised and places are expected to be filled quickly. On completion of training the Band 4 Assistant Practitioners work in direct support of registered nurses to assess, plan implement and evaluate care for patients. These new roles are found in an increasing number of clinical specialities where they are seen as highly valued members of the healthcare team.

The Workforce Team have also been working on developing clear, eye catching promotional material that outlines the nursing 'career ladder' within the Trust, from Band 1 through to Band 5 and beyond, so that potential applicants are encouraged to apply, they know what they are applying for, and they have a good understanding of potential career progression.

Matching staffing levels to patient needs

Nurses within the Trust have been measuring for some time the amount of nursing care time that patients require, based on how sick they are (acuity) and how dependent on staff they are for their needs (dependency). More recently the nurses have been using the national Safer Nursing Care Tool (SNCT). This tool allows nurses to analyse the acuity and dependency of the patients on the ward and identify the required staffing levels to meet their needs.

A repeat of the patient acuity and dependency audit is planned for adult areas for later in 2014 to check for seasonal variations in patient acuity and dependency. This will include adult inpatient wards, children's services, maternity services and urgent care (emergency department). This is now a national requirement, with a report on nurse staffing to be provided to Trust Board.

Monitoring and reporting staffing levels

A new tool has been developed called the Ward Workforce Health Check, a computer-based tool that collates information on numbers of staff in post, vacancy levels, use of agency staff, and absences for sickness or other reasons, to give an indication of the staffing levels on each ward at any particular time. This has been developed alongside the quality health check that involves a range of indicators to help us understand about the quality of care provided on each of our wards. The information is updated daily and is available to staff via the ward large screen electronic displays. It is also displayed on the Ward Health Check Boards at the entrance to wards for patients and visitors to review.

There are occasions where wards will not have the staff on duty they require to meet the patients' needs, and this is managed by the Senior Sisters in the first instance with a clearly defined escalation process that enables the swift movement of nursing staff across the Trust to provide mutual aid where it is required. The Director of Nursing (Operations) and Chief Nurse are involved in this escalation process, and where significant risks remain, they will agree the approach to be taken.

The Ward Workforce Health Check system provides detailed and summary reports of nursing and midwifery staffing for review at the Trust Board each month.

Future investment in nursing

The Chief Nurse, has secured approval from the Trust Board for an additional £6 million investment in nursing and midwifery staffing for 2014/15. Over the next two years the investment will be used to achieve the following:

- To have inpatient wards staffed to levels recommended from the outcome of the Safer Nursing Care audit, and at a minimum level of one nurse to eight patients
- To have staffing levels in specialist areas that meets the recommendations of national guidance for Maternity Services, Paediatrics, and Critical Care
- The creation of a Maternity staffing pool, to respond to the variations in demand for services
- The provision of additional time for supervisory leadership for Sisters, Charge Nurses and Team Leaders.

4.7.2 Ward Healthcheck

In December 2013 the first Ward Health Check nursing metrics audits were undertaken. These have been developed to help us identify good practice and areas where improvements may be required using a range of indicators that tell us about the quality of care provided. The auditors (made up of senior nurses) examined 10 patients nursing documentation folders per ward.

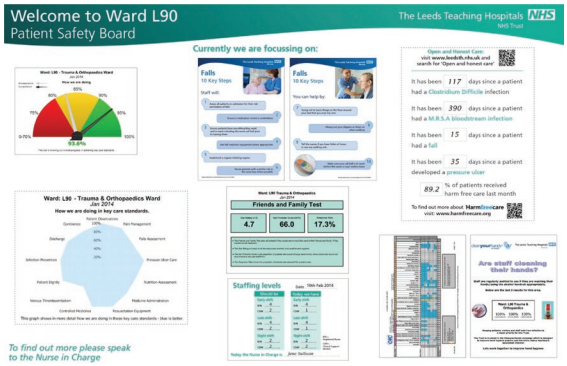
76 adult inpatient wards were audited in December against 13 areas of care. Paediatric and Maternity wards have now been included in the audits, taking the number of inpatients wards audited to 99.

The areas of nursing documentation audited were:

- Falls assessment
- Pressure Ulcers
- Nutrition assessment
- Medicine administration
- Controlled Medicines
- Patient Observations
- Pain management
- Infection Prevention and Control
- Patient Dignity
- Continence assessment
- Discharge
- Venous Thromboembolism
- Resuscitation equipment.

The information generated from the Ward Health Check audits are produced in a dial and spider diagram displayed on each ward on the Patient Safety Boards. Other key ward information displayed is the 10 Keys Steps (improvements the wards are working on), staffing levels, Open and Honest Care, Friends and Family results and cleaning and infection prevention audits.

Patient Safety Board (Healthcheck)



4.7.3 Reducing rates of Healthcare Associated Infections (HCAI)

Our aim is to eliminate all avoidable hospital associated infections, such as MRSA and Clostridium difficile (CDI). This has continued to be a challenge in 2013/14, although we have made good progress and we continued to reduce the number of patients who developed infections whilst in our care.

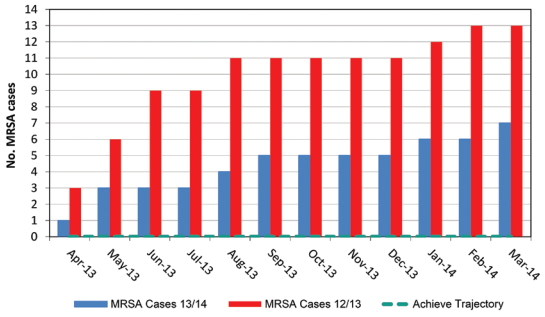
The key objectives achieved in 2013/14 included:

- Increased deployment of hydrogen peroxide vaporisation technology in the cleaning of our wards
- Enhanced recruitment and retention of facilities staff in order to maintain cleaning standards
- Introduction of Adenosine Triphosphate (ATP) and other technologies to objectively measure the quality of environmental cleaning
- Creation of cohort isolation facilities for patients with confirmed Clostridium difficile infection (CDI)
- The appointment of a CDI Nurse Specialist
- The introduction of new Infection Prevention guidelines for managing patients with CDI
- Improved diagnostic testing for CDI, including the introduction of CDI Polymerase Chain Reaction (PCR)
- The roll out of daily chlorhexidine body washing in selected patients with an increased risk of MRSA colonisation
- Increased capacity of a theatre-based line insertion service
- The creation of an Outpatient IV antibiotic therapy service
- The creation of Infection Prevention and Control Groups within each bed-holding Clinical Service Unit.

MRSA

In 2013/14, 7 patients developed an MRSA bacteraemia whilst in our care, compared to 13 in 2012/13; this equates to a reduction of 46%, which is a significant improvement and reflects the work we have done to improve this. Nationally each NHS Acute Trust had a trajectory set at zero. The longest period of time we went without an MRSA bacteraemia during this period was 143 days. This shows that we can achieve our aim of zero avoidable MRSA bacteraemia.

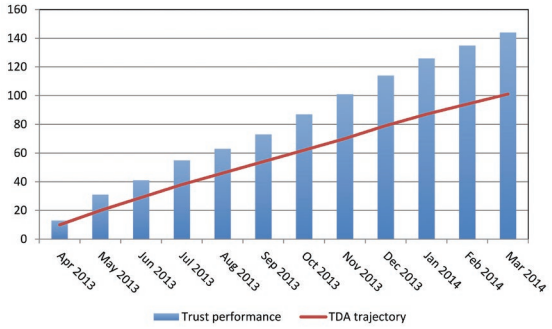
Progress against the MRSA target (cumulative)



CDI

Whilst we have reduced the number of patients who developed CDI in our hospitals, we didn't achieve the required reduction in CDI in 2013/14 and we know we need to make further improvement in this. The number of patients who developed CDI during 2013/14 was 144, a 6% reduction compared to 154 cases reported in 2012/13. The last quarter of 2013/14 has started to show significant improvements.

Number of CDI cases attributed to the Trust (cumulative)



For example, the Children's CSU had 17 cases in 2013/14 with only 2 of these occurring in the last quarter. The biggest improvement was observed in the Leeds Cancer Centre, with only 13 cases seen in 2013/14, compared to the 24 reported in 2012/13.

Although the 144 cases in 2013/14 represented an improvement on previous years we did not achieve our agreed national trajectory of 101 cases. Our CDI objective for 2014/15 has been set at 127 cases.

Indicator	Reporting Period	Trust Performance	National Average	National Range
CDI Rate per 100,000 bed days (Patients 2+)	2012/13	26.1	17.3	0.0 to 30.8
	2011/12	28.6	22.2	0.0 to 58.2
	2010/11	37.2	29.7	0.0 to 71.2

Objectives for 2014/15

In terms of infection prevention and control we would like to be ranked as one of the top performing health organisations in the country.

The targets we have set for 2014/15 are:

- Zero avoidable MRSA bacteraemia
- No more than 127 cases of CDI.

The Trust intends to take the following actions to improve this reduction and so the quality of its services by:

- Enhanced roles and responsibilities for Clinical Service IPC Groups and the way they interact with the Trust's Infection Prevention & Control Committee
- A greater shift from 'reactive' to 'proactive' IPC interventions
- Formal agreements with our commissioners about the way CDI cases are reviewed and counted towards sanctions
- Greater integration of the Lead Infection Control Doctor into Clinical Leadership meetings
- Improved IPC assurance mechanisms in relation to decontamination
- Introduction of new guidance to manage carbapenemase-producing organisms
- The introduction of a new CQUIN to reduce the incidence of catheter-related bloodstream infection
- Use patient feedback about hand hygiene performance of our staff
- Increased provision of hand washing facilities at ward entrances
- Continued development of the hydrogen peroxide vaporisation programme
- Increased frequency of toilet cleaning in high risk areas
- Use of the Safety Thermometer to reduce Catheter-Associated urinary tract infections
- Improved IPC-related training for junior doctors.

Medicines Management to support reducing rates of Healthcare Associated Infections (HCAI)

The use of antimicrobials is associated with an increase in colonisation of resistant bacteria and related to an increased incidence of Clostridium difficile infection. Activities that will be undertaken through the medicines management and pharmacy service to drive down the use of broad spectrum, intravenous antibiotics, inappropriate or long courses of antibiotics include:

- Ensuring all inpatient and outpatient antibiotic courses match the indication stated on the prescription; increasing the number of Antimicrobial Stewardship ward rounds by pharmacy to monitor this
- Following up microbiology laboratory results to ensure optimisation of antimicrobial choice and to de-escalate or stop where appropriate
- Improving the education of prescribers, nurses and other relevant staff, both through formal learning and at ward level through feedback
- Implementing the Department of Health/ Public Health England Antimicrobial Prescribing and Stewardship Standards
- Continuing to update patient pathways to allow earlier discharge of patients; for example, roll out of the home IV antibiotics (OPAT) service to include respiratory and non-ambulatory cellulitis patients where appropriate
- Extending the weekday vancomycin and aminoglycoside level monitoring system to weekends
- Improving the communication of lessons learned from incidents and audits to all staff
- Working more closely with primary care to improve the quality of GP and Out of Hours antimicrobial prescribing to decrease the patient population admitted with HCAIs
- Implementing the NHS England five year antimicrobial resistance plan when available.

Antibiotic (Abs) Prescribing 2013/14 Performance

	No of patients on Abs %	% **with** indication	% Abs **with** duration or review	% of Abs orally	% of Abs IV	% of IV Abs given for >48hr	% possible for oral switch
2008	35%	80%	62%	54%	46%	50%	10%
2009	28%	91%	72%	49%	52%	59%	6%
2010	27%	87%	87%	47%	53%	54%	3%
2011	27%	92%	92%	49%	51%	56%	3%
2012	28%	91%	91%	46%	54%	51%	3%
2013	28%	91%	90%	45%	55%	55%	3%
2014	28%	92%	91%	45%	54%	57%	4%

The proportion of patients on antibiotics at any one time remains lower than the national prevalence of 34%. Antimicrobial quality prescribing indicators remain consistent, and higher than nearly all Trusts in England. The proportion of patients on IV antibiotics remains consistent, but those on antibiotic treatments for longer than 48 hours has increased to 57%. The antimicrobial section of the new drug chart will help us to make improvements in this area.

Our prescribing rates of antibiotics linked with a higher risk of causing Clostridium difficile infection remain at lower levels compared to our peers.

4.7.4 Falls prevention

In October 2013 a project was started with the Yorkshire and Humber Improvement Academy to reduce patient falls on the Acute Medical Floor at St James's Hospital. The project has been led by the multi-professional staff on the 4 acute wards who share and learn from each other with weekly updates and support from experts at the Improvement Academy.

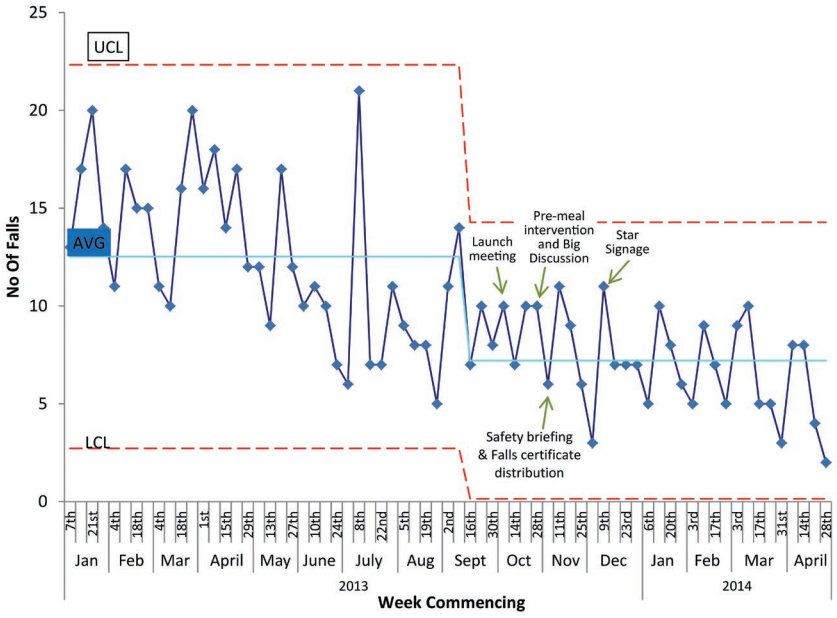
This project has set out to address the cultural and behavioural barriers across multi-professional groups to falls prevention. Early results suggest a significant reduction in the number of falls on the Acute Medical Floor.

A number of different interventions have been used including:

- a daily multi-professional falls safety briefing (a 5 minute "time out for falls prevention")
- signs by patient's besides and on patient boards indicating a high risk of falling
- toileting prompts pre-meals
- sharing results and lessons through newsletters, run charts and visual displays of "days since last fall"
- certificates awarded to wards for going 10 days, 20 days, and 30 days without a fall
- education of staff
- better equipment availability (including fall sensors)
- dedicated leaders for improvement on each ward
- falls star to identify patients at risk of falling.

There has been a significant drop in the number of falls across the Acute Floor since the project began with the average number of falls per week dropping from 12.5 before the project, to just 7.5 falls per week in January 2014.

January 2014 Chart: Falls on the Acute Medical Floor



All 4 of the wards taking part have now received at least 2 bronze certificates for going at least 10 days without a fall and 2 wards have been awarded a silver certificate for going over 20 days without a fall. Staff feedback about the project has been positive and teams who are continuing to test interventions say that they feel empowered to make sustained improvements.

This work complements developments introduced by the Trust Falls Group to reduce the number of inpatient falls, with a focus on team behaviour and ward culture. As a part of the Trust's Quality Improvement Programme, the methodology used in the Acute Medical project will be promoted to help reduce falls on a wider scale.

4.7.5 Reducing harm from preventable venous thrombo-embolism (VTE)

We know that venous thromboembolism (VTE), or blood clots, can be linked to preventable deaths in the UK. Assessment of adult patients at admission for their risk of developing blood clots or their risk of bleeding helps us decide how best to care for each patient.

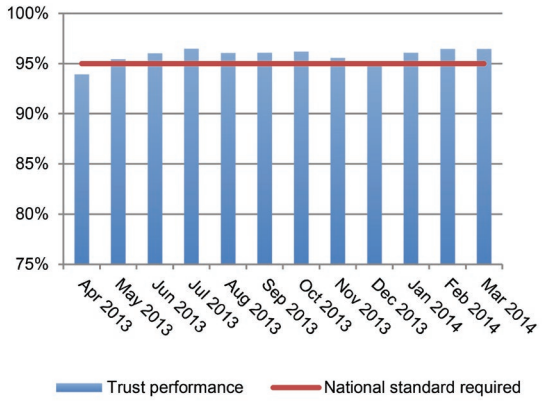
The Trust has continued to achieve the target of ensuring that 95% of adult patients are risk assessed for VTE within 24 hours of admission in 2013/14, consistently achieving this level of performance. The table below shows the percentage of patients who have had a VTE risk assessment in 2013/14.

Percentage of patients who have had a VTE risk assessment in 2013/14

Indicator	Reporting Period	Trust Performance	National Average	National Range
Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)[1]	Q4 2013/14	96.32%	95.96%	78.86 to 100%
	Q3 2013/14	95.66%	95.71%	74.09 to 100%
	Q2 2013/14	96.21%	95.78%	81.70 to 100%
	Q1 2013/14	95.11%	95.42%	78.78 to 100%

[1] *Excludes independent sector providers*

Percentage of patients assessed for VTE in 2013/14



An audit of appropriate VTE prophylaxis (prevention) in autumn 2013 showed that 92% of patients were on appropriate preventative treatment (thromboprophylaxis) which is calculated according to their weight and renal function. The main learning point was that all patients should be weighed on admission and the weight be recorded on the prescription chart for all patients. Steps have been made to increase the number of patients weighed and work is underway with medical, nursing and pharmacy teams to ensure this is documented for all patients on the prescription chart.

We agreed a standard with our commissioners for a Root Cause Analysis (RCA) to be undertaken when a patient develops a VTE during their hospital admission; this has been introduced to help us understand the causes and take action to reduce the numbers occurring. Table 16 shows that the Trust is meeting the targets set for RCA completion in 2013/14, which was included in the local CQUIN scheme to help with these improvements. The next steps are to increase the numbers of RCAs completed and ensure regular learning from these events is shared across the Trust.

VTE Incidence

	Q1	Q2	Q3	Q4
No. of Hospital Admissions	55538	57011	56899	55774
No.of VTE identified cases	172	156	123	119
No. of New HAT (Hospital Associated Thrombosis)		58	45	50
No. of HAT as % of Admissions		0.10%	0.08%	0.09%
No. of HAT as % of VTE identified cases		37.18%	36.59%	42.02%

VTE Root Cause Analysis (RCA)

	Target Proposal	Q1	Q2	Q3	Q4
No. of HAT requiring RCA (Root Cause Analyses)	Q2 = 30% Q3 = 40% Q4 = 50%	64	58	45	50
No. of RCA completed		16	24	18	25
% of RCA completed		25.00%	41.38%	40.00%	50.00%
No. of HAT considered preventable		1	0	0	2

4.7.6 Preventing harm from misplaced nasogastric (NG) tubes

It is recognised nationally that patients are harmed by being fed through nasogastric tubes when they are not in the correct place. This is included in the list of Never Events published by the Department of Health to describe specific incidents that should be prevented if the correct procedures are in place and are followed consistently by clinical staff. There have been 4 of these Never Events at the Trust since 2011 (occurring in June 2011, Oct 2011, Sept 2012 and June 2013). These have all been subject to a serious incident investigation to help us understand the causes and to take action to reduce the risk of recurrence.

Since 2011 the Trust has undertaken an innovative approach to improving nasogastric feeding tube safety, overseen by a steering group and clinical lead. New guidelines were issued and a bedside care plan was produced (this is a multi-professional document prompting and confirming all necessary checks on tube insertion and on-going care are in place) to provide guidance to staff to support safe practice. In 2012, an Enteral Feeding Specialist Nurse was appointed to lead on nasogastric tube safety and nurse training.

The Trust also collaborated with the Bradford Institute of Health Research to identify and address the barriers to behavioural change around nasogastric feeding tube safety. As a result, interventions developed included posters, screensavers, a nasogastric tubes awareness day, the availability of pH testing paper on all wards, development of an e-learning package, and practical training for junior doctors and nursing staff supported by competency assessments.

The Trust also designed, piloted and launched a nasogastric tube safety pack in collaboration with commercial partners which was launched nationally.

The steering group led on the implementation of a number of additional improvements, including 'hot reporting' of nasogastric tube x-rays in the radiology department by trained radiographers. This involves radiographers interpreting the

x-ray, and if the tube is misplaced, it is either removed in the department or correctly placed before the patient returns to the ward to reduce the risk of harm caused by feeding through the misplaced tube.

The culmination of these interventions has resulted in a cultural change that staff are more willing to challenge and escalate unsafe practice. The Trust has been recognised for their success in leading behaviour and cultural change specific to nasogastric tube safety with national and regional recognition, and as a result was shortlisted for a Medipex NHS Innovation award for developing the nasogastric tube safety pack with the commercial sector. We have also shared our improvement journey at NHS behavioural change workshops.

4.7.7 Safeguarding vulnerable people

We have continued to implement improvements to the arrangements we have in place for protecting our most vulnerable patients from harm, including the provision of education and training to staff. Our governance arrangements for safeguarding vulnerable people have been strengthened through the establishment of Trust Wide Safeguarding Adult and Children's Steering Groups. These groups have revised their aims to take into consideration the objectives of the Leeds Safeguarding Adult's and Children's Boards. Quality and performance monitoring and reporting has also been revised to provide strengthened assurance to the Trust and external agencies.

A new Head of Safeguarding was appointed in October 2013 and investment in additional

posts was made to support the safeguarding agenda and implementation of the Mental Capacity Act (2005). Additionally, the safeguarding adult's and children's teams were realigned into one department led by the Chief Nurse. These changes have led to a more efficient oversight of safeguarding in the Trust and reinforced the Trust's multi-agency representation and engagement. The Trust policies and procedures on safeguarding have been reviewed and revised following the CQC inspection, and now include a set of standard operating procedures for the Mental Health Act (1983) and the Mental Capacity Act (2005).

External audits commissioned by the Leeds Safeguarding Children's Board have provided assurance on the Trust's successful improvements for safeguarding. In addition, the Trust was commended for its co-operation with the West Yorkshire Police in an investigation in 2013.

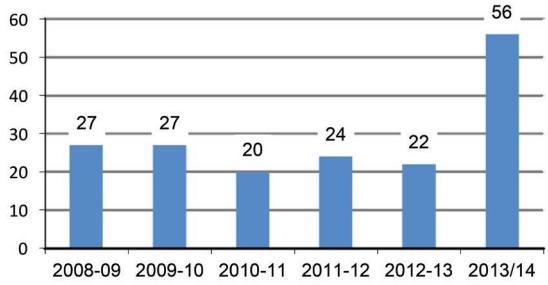
4.7.8 Serious Incidents

The Trust is 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. The Trust seeks, where at all possible, to prevent the occurrence of serious incidents by taking a proactive approach to the reporting and management of risk to ensure safe care is provided to patients.

The Chief Medical Officer and Chief Nurse meet with the corporate team on a weekly basis to review all potential serious incidents and complaints to ensure these are appropriately investigated and immediate actions are taken where required to reduce the risk of recurrence. The Trust Board receives a bi-monthly report on new serious incidents and assurance on those incidents where the investigation has concluded, including the actions that have been taken to reduce the risk.

This year has seen an increase in the number of serious incidents reported. Part of this can be attributable to a change from 1 January 2014, to declare all category 3 pressure ulcers as serious incidents. This accounts for 19 of the Level 3 serious incidents in the final quarter of 2013/14.

Number of serious incidents reported (by year)



The Trust is now reporting category 3 pressure ulcers as a Level 3 serious incident as part of the programme of improvement to reduce the incidence of harm from more severe pressure ulcers (in addition to category 4 pressure ulcers). Category 3 pressure ulcers are subject to Root Cause Analysis investigation led by the responsible specialty team, as agreed with commissioners at NHS Leeds West CCG in December 2013 to ensure the Trust was in line with other health care organisations for comparison purposes.

The Trust receives a 6 monthly report on patient safety incidents. The most recent summary that has been published is set out in the table opposite.

We have introduced a process where we undertake a detailed review of all incidents that are reported in the category serious harm or death with our clinical teams, to ensure these incidents are both reported and managed appropriately.

Patient safety Incidents (NRLS) April - September 2013

Indicator	Reporting Period	Trust Performance	National Performance	National Range[1]
Rate of patient safety incidents (per 100 admissions)	1 Apr 13 - 30 Sep 13	9.92	7.98	4.87 to 12.84
	1 Oct 12 - 31 Mar 13	9.5	7.48	3.21 to 13.7
Number of patient safety incidents that resulted in severe harm or death	1 Apr 13 - 30 Sep 13	33	18	1 to 46
	1 Oct 12 - 31 Mar 13	12	19	2 to 74
Percentage of patient safety incidents that resulted in severe harm or death	1 Apr 13 - 30 Sep 13	0.34%	0.34%	0.03% to 0.88%
	1 Oct 12 - 31 Mar 13	0.12%	0.43%	0.06% to 1.44%

[1]*National Acute Teaching Hospital Average*

Learning from incidents

The Trust has published fortnightly bulletins since December 2013, under the heading "Quality and Safety Matters". These have focused on a series of topics arising from serious incidents and complaints, to highlight the reasons why these are important and the things that need to be done to help reduce the risk. These have been sent to all wards and departments within the Trust to ensure that all staff are aware of these risks and what they need to do about them. The topics included in 2013/14 are as follows:

- Never Events, including wrong site surgery, retained instruments and harm caused by feeding through a misplaced naso-gastric tube
- Pressure ulcers
- Falls
- Safeguarding patients from harm
- Nurse staffing
- Care of the deteriorating patient
- Improving the patient experience
- Whistleblowing
- Care of the dying patient
- Correct patient identification.

The Trust has also published a bi-monthly Learning Points Bulletin, including specific case studies and summaries of incidents to identify the important learning points and actions to be taken. We will continue to publish these in 2014/15 to help raise awareness and share learning from incidents.

Never Events

The National Patient Safety Agency (NPSA) published guidance on Never Events, which took effect from April 2009. Never Events are defined as:

"Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented."

The NPSA list of Never Events was expanded in 2011 from the original eight following engagement with the NHS, patients and the public. There are now 25 Never Events in total. The Never Events list provides an opportunity for commissioners working in conjunction with Trusts to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur. Nationally the most commonly reported Never Events relate to retained foreign objects after surgery, wrong site surgery, and wrong implant.

We have reported eight Never Events during 2013/14 under the following headings:

- 1 misplaced nasogastric tube
- 3 retained swabs (breast surgery, maternity unit, cardiac catheter theatre)
- 2 retained pedicle tabs (spinal surgery)
- 1 retained micro-vascular clamp (Ear, Nose and Throat Surgery)
- 1 wrong lens implant (Ophthalmology).

All of these Never Events were reviewed with the Trust's Chief Medical Officer and Chief Nurse and also with our commissioners at NHS Leeds West CCG. These have all been investigated in line with our serious incident procedure and reviewed with the clinical teams involved to ensure the appropriate actions have been taken locally to reduce the risk of recurrence.

The Trust Quality Committee has reviewed an Assurance Framework looking at how the risks of all 25 Never Events have been addressed to ensure that we have the right controls in place to prevent these from happening. Actions are being taken, not only to address the gaps where these have been identified through investigations into Never Events, but also to minimise the risk of those which have not occurred within the Trust. We have focused particularly on improving safety in our operating theatres and the management of patients who are fed through a naso-gastric tube.

A workshop was run by our partners from the local area team in March 2014, in conjunction with commissioners, focusing on the role of human factors and behaviour on the prevention of serious incidents, including Never Events. The workshop was attended by staff from all of the hospitals in our region to share learning from Never Events, including the actions that been taken in each organisation to reduce the risk of recurrence. This has been used to establish a network of staff to support continued improvements in this area.

This has been an important priority for the Trust in 2013/14 and we will continue to work with clinical teams and our commissioners in 2014/15 to make further improvements in these areas to stop Never Events from happening.

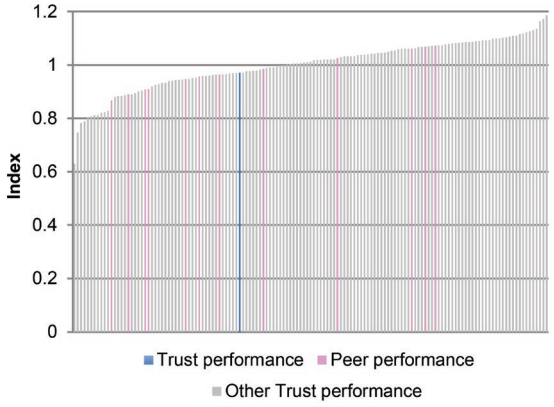
4.8 Clinical effectiveness

4.8.1 Hospital mortality

A new national measure of hospital mortality was introduced in October 2011 - the Summary Hospital-Level Mortality Indicator (SHMI). This considers the total number of deaths for the whole hospital and compares it to the number of expected deaths for the hospital. All Trusts need to monitor their SHMI results and carry out further investigations if performance is worse than expected. The latest data continues to show that the Trust is performing better than would be expected:

- The Trust's SHMI result for the latest available period of October 2012 to September 2013 was 97.09, against a standard index of 100. This means that there were 2.91% fewer deaths at the Trust than expected, taking account of the type of patient treated
- The graph below shows performance for all hospitals in England. Of the 142 Trusts included in the publication, LTHT was ranked 27th; we were therefore amongst the best performing Trusts.

Benchmarked SHMI results: Oct 2012-Sept 2013



We will ensure the continued good performance in this area and maintain the quality of our services by monitoring performance on an ongoing basis and ensuring that any mortality alerts are investigated. In the period of this report the Trust had no national mortality alerts.

The second measure often used to assess mortality is the Hospital Standardised Mortality Ratio (HSMR). The methodology for calculating this is different from the SHMI as it is limited to deaths that occur in hospital related to a defined set of 56 conditions. The Leeds Teaching Hospitals NHS Trust's HSMR has consistently shown that we have fewer deaths than expected in view of the type of patients we treat. Using this measure, our latest score, for the period July 2012 to June 2013, was 91.17, compared to the national value of 100. This means that we have 8.83% fewer deaths than expected.

The 2013 Keogh review into deaths in hospitals highlighted the importance of regular monitoring of Hospital deaths and the need across the NHS to be able to identify where deaths could have been avoided. Even though we have lower than expected mortality rates the Trust has formed a new mortality review group to improve further our learning from our regular review of the cause of death, and is working with our partners in the Yorkshire & Humber Improvement Academy on a specific project to improve the identification of patients who died where their care could have been improved.

Indicator	Reporting Period	Trust Performance	National Average	National Range
SHMI	Oct 12 to Sep 13	97.09	100.00	63.01 to 118.59
	Jul 12 to Jun 13	95.15	100.00	62.59 to 115.63
	Apr 12 to Mar 13	93.95	100.00	65.23 to 116.97
Percentage of deaths with palliative care coding[1]	Oct 12 to Sep 13	17.00	20.92	0 to 44.9
	Jul 12 to Jun 13	17.50	20.27	0 to 44.1
	Apr 12 to Mar 13	17.40	19.93	0.1 to 44

[1]Combined rate provided

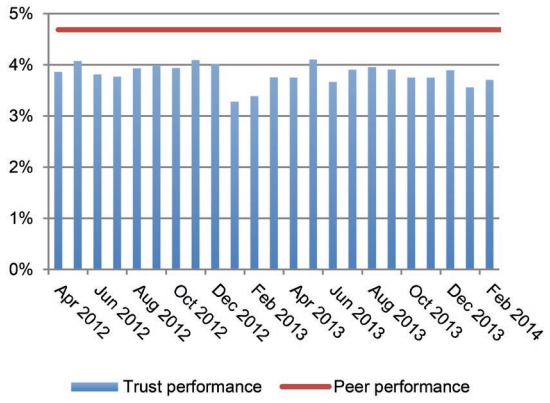
4.8.2 Readmissions

It is important to reduce to a minimum the number of patients being re-admitted to hospital after they are discharged home. Whilst we recognise that many readmissions to the Trust are unavoidable, we need to reduce the number of these as far as possible to improve our patients' experience and reduce the potential harm associated with readmission to hospital.

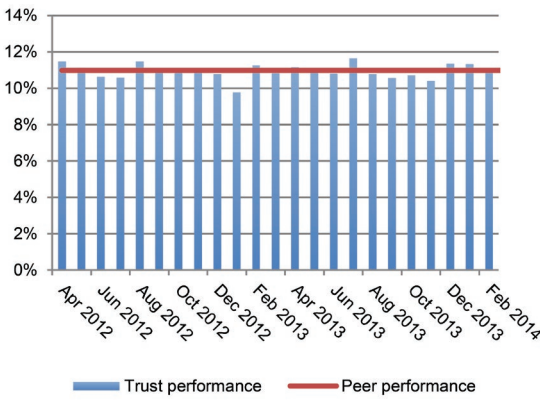
Readmission to hospital may be unavoidable for the following reasons:

- Patients requiring cancer treatment
- Patients who may be better cared for in the community but provision is unavailable
- Patients readmitted for a condition unrelated to their previous hospital stay.

Readmissions to the Trust within 30 days of discharge: elective spells



Readmissions to the Trust within 30 days of discharge: non-elective spells



Compared to our peer hospitals, the overall Trust readmission rate is consistently below the peer average for elective admissions and around the peer average for non-elective admissions.

Indicator	Reporting Period	Trust Performance	National Average[1]	National Range[1]
Percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the trust within 28 days of being discharged	2011/12	9.0%	9.3%	0 to 12.5%
	2010/11	9.1%	9.2%	0 to 12.4%
	2009/10	10.4%	9.4%	0 to 13.9%
Percentage of patients aged 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged	2011/12	13.6%	12.0%	0 to 13.6%
	2010/11	13.3%	12.0%	0 to 13.3%
	2009/10	12.9%	11.6%	0 to 12.9%

[1]*National Acute Teaching Hospital Average*

The Trust aim for 2013/14, as set by the TDA, was to ensure that no more than 10.9% of patients were readmitted as an emergency within 30 days of discharge, following elective or non-elective treatment.

The Trust achieved against this standard, with the year-end position in March 2014 showing readmission rates at 6.8%.

However, benchmarking data suggests that there are core non-elective pathways that can be improved in order to prevent patients being readmitted to hospital. This work will be undertaken by the unplanned care board who are working to integrate services better with community providers to;

- Ensure seamless transfer of care
- Utilise alternative pathways to admission where possible to maintain patients in their own home
- Make improvement to specific pathways for patients with mental health issues or who require hospital admission related to drug or alcohol abuse.

4.8.3 Patient Reported Outcomes Measures (PROMs)

Patient Reported Outcome Measures (PROMs) aim to measure improvement in health following certain elective (planned) operations. This information is derived from questionnaires completed by patients before and after their operation. It is therefore important that patients participate in this process, so that we can learn whether interventions are successful.

The table below shows pre-operative participation rates for the last 2 years. There has been an improvement in the number of patients completing the pre-operative questionnaires for both varicose vein, hernia procedures and knee replacement. However, work is currently ongoing to ensure that all applicable patients are offered the opportunity to take part in this.

Pre-operative participation rates

	2012/13		2013/14	
	LTHT	National	LTHT	National
Hip replacement	80%	83%	77%	88%
Knee replacement	88%	90%	100%	95%
Groin hernia	45%	57%	65%	67%
Varicose vein	28%	44%	38%	42%

Source: IC PROMs Data Quality Dashboard, published 16 April 2014

Information relating to patients reporting improvements following these procedures was last published for the period April 2012 to March 2013. This showed that the Trust was

above the national average in terms of patients reporting improvements following hip and knee replacement and hernia repair, but below average regarding improvement following varicose vein procedure.

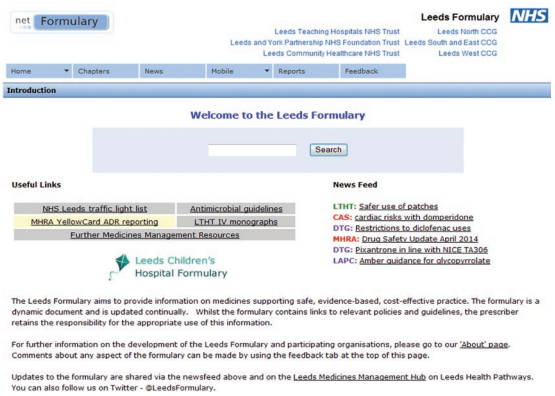
4.8.4 Medicines Management

The range of information about medicines in the Trust that is contained in the on-line NetFormulary continues to be improved and is available to Hospital doctors, GPs, pharmacists and nurses as well as members of the public through our Trust internet pages. This will help healthcare staff and patients ask more questions about medicines.

We are developing new mobile device applications, to make the content of the NetFormulary and information about medicines more widely available, during 2014/15.

In 2014/15 we are going to develop and promote a city wide campaign aimed at getting more patients to bring their own medicines into hospital with them. By working jointly with partners in the city we can all help to reduce waste with medicines. This should reduce duplication and potential confusion for patients whilst making the best use of resources. The work involves the hospital and the ambulance services, community matrons, social services, community pharmacies, patient support groups and GPs working together.

We think that this will make it simpler for patients to understand their medicines and help us prepare their discharge medicines sooner.



Electronic Discharge and Prescribing

The electronic discharge information system continues to be used throughout our hospitals to provide clear information to GPs about changes made to patients' medicines whilst they have been in hospital. By the end of 2013/14 over 80% of patients had their information transferred to their GP within 24 hours of their discharge from hospital. We will continue to work improving this percentage.

Leeds Teaching Hospitals NHS Trust plan to introduce an electronic system to support the prescribing and administration of medicines across our hospitals. We plan to purchase a suitable system in 2014/15 and to have tested it on some of our ward areas by the end of the year.

Discharge Medicines

In 2013/14 the Trust continued to work to improve the quality of information offered to patients about their discharge medicines and tried to introduce systems to help ensure that all patients left hospital with the medicines supplies that they personally needed.

The Trust Pharmacy Medicines Information helpline provides a telephone point of contact so that patients or their relatives and carers can speak directly to a member of the pharmacy team to ask for advice or information about their medicines. The helpline received 539 telephone calls from patients last year. Mid-year we introduced an email service as an alternative means of contacting the team; the use of this is small at the moment but is growing.

Percentage of prescriptions prepared in under 2 hours

Hospital	2012/13	2013/14
Leeds General Infirmary	88%	93%
St James's Hospital including Bexley Wing	88%	92%
Chapel Allerton	80%	83%

4.9 Patient experience

4.9.1 Friends and Family Test (FFT)

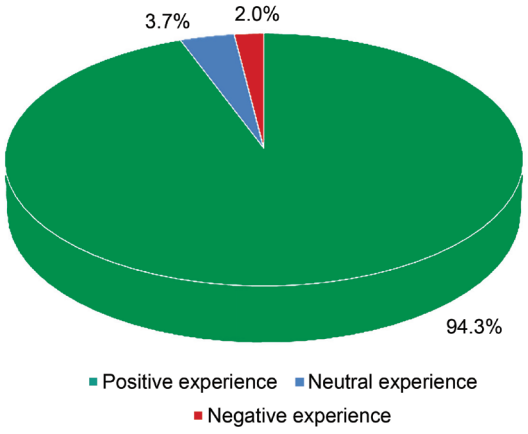
The Friends and Family Test (FFT) is a national initiative to help us get feedback from our patients about their experience of care and help us to understand their level of satisfaction. This has been implemented across all Trust adult inpatient wards, emergency departments and all maternity services.

During 2013/14, patients who were admitted to hospital as well as those attending our Accident and Emergency departments were asked to complete a FFT questionnaire. In terms of the number of patients completing these forms we had a higher response rate at the end of the year than our nationally set target of 20% (24.9%). In terms of the proportion of positive recommendations, our overall results were consistently better than the national average position, which was reflected in our overall net promoter score (67) in 2013/14.

Since the introduction of the FFT in April 2013 the Trust has received over 50,000 individual comments from patients on their experience of the care we provide.

94% of the comments received via FFT are associated with a positive rating.

Patient evaluation of their experience of care



The Trust has worked closely with NHS England in 2013/14 to pilot the FFT in outpatient and day case areas. Following the official pilot in December 2013, the Trust now offers patients the opportunity to feedback their experiences in all our day case services.

In common with the national picture the FFT process is predominately paper based, however from January 2014 a free SMS text messaging service was provided for patients discharged from the Trust's emergency departments. The introduction of this service more than doubled the amount of feedback we received about our emergency departments.

We recognise that children and young adults required a unique approach in order for all their views to be clearly heard. Building on the feedback we received from FFT in our teenage oncology units, and learning from existing and very successful involvement activities in children's services, from May 2014 we introduced a dedicated children's FFT process. We are already planning to improve and develop this service with the introduction of an electronic tablet running a bespoke 'Children's App'.

All Friends and Family feedback, including free text comments, is available to local teams within 36 hours of the patient completing the form so that they can respond to issues or concerns that are raised by patients. This is made possible by the Trust's Ward Healthcheck Electronic Dashboard which enables teams to easily search and analyse their own feedback.

With over one million attendances at our outpatient departments, we recognise the unprecedented potential for valuable patient insight which exists within the outpatient services we provide. Patients who use these services can often tell us about whole patient pathways through large sections of our organisation. NHS England requires that FFT is implemented in all areas by April 2015 and work to implement outpatient FFT at Leeds Teaching Hospitals is already well underway.

Across the Trust, feedback received via FFT has driven a number of improvements, these include; the revision of visiting times to allow for greater carer involvement, increased comfort in waiting areas, and environmental improvements aimed at increasing stimulation and fighting boredom for inpatients. In other areas the feedback has led to service focused changes such as the staging of admission times in same day surgical units. Many areas have produced their own public information boards with a theme of 'you said we did' to provide information on their responses to feedback.

4.9.2 Staff Friends and Family Test

Each year, the annual staff survey asks staff to rate the following question: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation". In 2013 we saw a significant improvement in our response to this question, with more staff recommending the Trust as a place of treatment, increasing from 47 in 2012 to 58 in 2013 against a national average of 64, which represents a 23% increase. This reflects the considerable work which is taking place with our staff to ensure that our hospitals continue to provide the highest standards of care.

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

Reporting period	Trust performance	National average[2]	National range
2013[1]	58%	64%	40 - 94%
2012	47%	62%	35 - 94%
2011[1]	55%	62%	33 - 96%

[1]Percentage of staff agreeing with statement that if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation

[2]The national average for the staff survey is based on acute trusts

4.9.3 National Patient Surveys

Alongside the Friends and Family Test, and in conjunction with the Picker Institute, the Trust participates in a number of national patient survey programmes.

By comparing year on year results, these surveys allow the Trust to be more assured about the success and sustainability of the improvements we make across the year in response to what our patients tell us.

The results of the inpatient survey show that the experience of patients has improved significantly against eight questions relating to admission, what to expect after procedures and discharge. The best experiences were reported in areas such as provision of information for planned admission, cleanliness and patients feeling safe.

Respondents to the survey also told us that we need to do more to shorten delays in discharge and communicate more effectively with patients and relatives about the reasons for delays. A full time Matron was recruited in December 2013 to lead improvements in discharge pathways, patient preparation for discharge, and increase collaboration and communication with patients and their carers about discharge from hospital.

The maternity survey 2013 demonstrates improvements across the maternity pathway. Key findings of the survey were:

- 81% of maternity patients felt they were involved enough in decisions about their ante-natal care
- 87% of women reported being treated with respect and dignity during birth and labour; 60% reported the same in hospital after birth.

The majority of women involved in the survey felt that maternity services in Leeds were providing adequate care and a positive experience. However, we need to improve effective information giving and communication which is essential, especially at busy times to ensure consistent support advice and compassionate care.

The Trust's responsiveness to the personal needs of its patients (inpatient survey)[1]

Reporting period	Trust performance	National average[2]	National range
2013	65.6	68.1	57.4 - 84.4
2012	65.0	67.4	56.5 - 85.0
2011	64.0	67.3	56.7 - 82.6

[1]Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (score out of 100)

4.9.4 Listening to our patients - local surveys

Patient Stories

We are encouraging patients and relatives to tell us about their experience in other ways. Filmed patient stories are proving to be a particularly effective way to communicate patient views and experiences to our staff. They successfully convey complex emotions and make a connection with audiences which can otherwise be lost in paper transcripts.

We have a growing library of these films available to all our staff on the Trust's webpages. Every meeting of the Trust Board begins with a new patient story film to focus members on the patient perspective and influence the discussions that take place. Every story is different depending on the patients and carers involved, and the issues they are describing. The films cover areas where we provided compassionate, individualised care alongside times where it is clear we need to improve. Many other senior team and committee meetings have followed the board's example and now either include a patient film or a patient or relative telling their story in person. Examples of some of the patients stories we have filmed this year include:

- Teenage experience of cancer
  A group of teenagers who are receiving treatment in Leeds for cancer tell their story of what it is like to be a patient in the teenage cancer unit and the positive experience of care that they have received.
- Improving experience through listening to parents
  One of our patients had a poor experience of our services with her child who has learning disabilities. The story outlines the changes we made to improve the care they received and how that took into account their needs relating to the adjustments they required.
- Faith matters
  Focuses on a relative's experience following the death of their father when some of our processes didn't take into account the religious needs of the family at a very difficult time. The story outlines the changes that have been made to ensure we support families to meet the requirements of their faith when dealing with bereavement.

4.9.5 Involvement

The Trust has continued to develop its relationships with patients and stakeholders. We have been working closely with Healthwatch Leeds, Leeds Involving People (LIP), and Carers Leeds throughout the year.

During this year we have worked closely with our partners at Healthwatch Leeds to help us improve the quality of care and the experience of our patients. We were pleased to attend a workshop with Healthwatch Leeds in January 2014 to discuss what quality means for patients at the Trust and to help inform our priorities for improving quality in 2014/15. Staff at Healthwatch Leeds have worked with patient groups to gather views on what was important to them in terms of quality, consulting with over 70 people and provided a report for the Trust. They told us about the things that were important to them, including:

- improving discharge support and information
- avoiding discharges late at night
- prompt delivery of discharge medication
- support for older people, especially stroke patients
- improvements in nurse staffing, particularly at weekends
- improvements in the care of people with mental health problems

- improvements in maternity care
- information about how to make a complaint.

The feedback has been really helpful to us, building on the results of the national surveys and views expressed through the Friends and Family Test. This feedback has been used directly to inform our priorities for 2014/15, including our goals for improvement relating to discharge planning, handling complaints and nursing staffing.

Healthwatch Leeds has undertaken regular visits to all our hospitals and covering a number of our clinical specialties. During these visits, the Healthwatch team and it's volunteers independently survey patients, families, carers, and the public about their experiences of our services. This has been extremely helpful to us. The results of the visits are reported and any recommendations and actions discussed. Many areas have been visited on a rotational basis; however visits to other areas such as the emergency departments and the Dental Hospital have been arranged at the request of Healthwatch members in response to their own conversations with the public.

Visits to our wards and departments have also been undertaken by our commissioners at NHS Leeds West CCG and this has also helped us to get more feedback from patients, families and staff about their experience of care and working in the Trust.

Healthwatch Leeds has helped the Trust to identify and approach volunteers who are willing and able to become involved with groups in local clinical areas and also at higher levels, such as the Patient Experience Sub-Committee which plays a key strategic role in shaping patient experience across the Trust.

The Trust has developed a Patient & Public Involvement Strategy. This sets out the vision, commitment and priorities for involving patients and the public at Leeds Teaching Hospitals NHS Trust. This includes involvement in the way that we design, deliver and continuously improve the quality of services we provide by delivering safe, effective and individualised care for every patient every time.

The strategy and priorities for involvement were developed following an engagement event held in May 2013. This was followed by a number of workshops and meetings with patients and the public. These included representatives of patient panels and user groups, local interest groups and stakeholders. Trust staff were also involved in this process.

The strategy has a two year implementation span but has already resulted in significant changes to volunteering and its contribution to improving the quality of the patient experience.

4.9.6 Carers

The Trust recognises the contribution that carers make in supporting the people they care for and as an organisation we are committed to improving the carer's experience of our services.

Working in partnership with Leeds Involving People (LIP), the Trust has committed to a series of engagement events in 2014/15. The inaugural event took place on 30 April 2014 and focused on carers.

The event was very well attended with over 60 members of the public who were carers, cared for or both. Representatives also attended from the wider health community, voluntary and charity sectors. Hundreds of views and ideas were captured for how, working together, we can improve the lives of carers and service users. Many of those present had attended similar events in the past and said it was different this time:

"I felt really listened to"

"The energy in the room was fantastic; everybody was there and committed to making things better!"

"It was great that we identified that with some really simple changes we can quickly make a difference"

Topics for future events will be strongly influenced by the outcomes of prior events and patient feedback.

The Trust has been working with The Carers Strategy Implementation Partnership (CSIP) and is in the process of developing the Carers Strategy for Leeds 2014/2016. The vision of the strategy is that carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.

The Trust has been working in partnership with Carers Leeds since last year and now has an on-site Dementia Carer Support Worker from Carers Leeds. This service has done a lot to help carers of people with dementia.

4.9.7 Volunteers

The Trust is very grateful to all of its volunteers who carry out a variety of roles across the Trust, helping to enhance the patient experience of our service.

The Patient Experience Team has reviewed the recruitment process for volunteers and introduced a rolling programme of volunteer recruitment which is supported by our Human Resources department to streamline the process and reduce delays. A new volunteer database has been developed which allows a more detailed analysis and reporting of volunteer activities and will provide valuable information on the profile of volunteers, helping us to carry out targeted recruitment programmes to ensure we have a diverse team.

Volunteers have been introduced to the emergency departments and to assist at the self-check in kiosks in outpatients.

One area where our ward volunteers are making a difference is by assisting patients with meals. A volunteering opportunities booklet has been developed for prospective volunteers and is available on the trust website. Volunteers are now wearing a uniform making them more visible across the Trust.

Our volunteers make a significant contribution to our patient services and we will continue to work with them to improve the services for patients in 2014/15.

4.9.8 Complaints and Patient Advisory Liaison Service (PALS)

In 2013 the Chief Nurse led an in depth review of the complaints handling process across the organisation to ensure we provided the highest quality, honest, compassionate and complete responses to all complainants.

Some of the improvements we have made include:

- a local standard was agreed to respond to all complainants within 40 days
- all of our complaint investigations and responses are reviewed independently by a senior manager as part of a "buddy" system that we introduced. The purpose of this was to ensure that all responses contained an appropriate and sincere apology, were written clearly using language that was easy to understand, addressed all the concerns raised and were compassionate and empathetic in the overall tone
- final complaint responses are reviewed and are signed by the Chief Executive, Chief Nurse or Chief Medical Officer
- a satisfaction survey has been sent with our complaint response letter to provide assurance that we are improving the way we handle complainants and take further action where this is required
- complaints posters and leaflets have been made available and displayed in our hospitals. The complaints team have undertaken regular visits to clinical and public areas to ensure information was available
- a detailed complaints report is provided at every Trust Board Meeting
- in May 2013 we started to use filmed patient stories to capture patient and family experiences at the Trust Board and its supporting committees. This has helped to set the tone of our Board meetings and make it clear that the experience of our patients is our number one priority
- the Trust became a co-signatory to 'Speak Out Safely' a national campaign by the Royal College of Nursing. This means we encourage

any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity

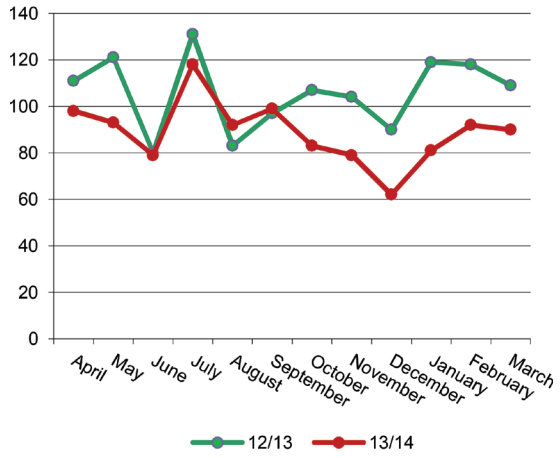
- during the period 1 April 2013 - 31 March 2014, 59% of complaint responses achieved their target response date. 98.1% complainants received an acknowledgement letter within three days.

The Trust is involved in an ongoing programme of performance monitoring and auditing of the complaints handling process. The detailed report on complaints provided at every meeting of the Trust board includes performance data, alongside information and narrative on the precise nature of both formal and informal complaints received by the Trust. The information in the report is broken down into complaint themes, management units, and individual speciality areas. Detailed information is also provided relating to complaints where the Parliamentary and Health Services Ombudsman is involved.

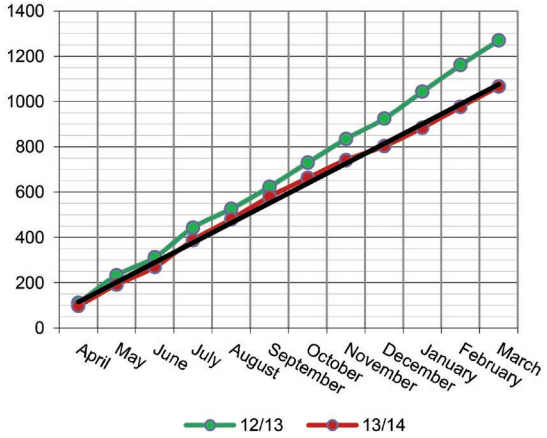
We are working with our clinical teams and managers to address complaints through local resolution wherever we can as we recognise that this is what our patients, families and carers want us to do to help us to resolve complaints in a more timely way.

We have seen a reduction in the number of formal complaints received compared to last year of nearly 20%.

Number of complaints received (by month)



Number of complaints (cumulative)



In addition to the fall in the number of complaints received, there have been 40% fewer re-opened complaints and a 50% reduction in the number of complaints which were referred to the Parliamentary and Health Services Ombudsman.

The national inpatient survey 2013 conducted by the Picker Institute demonstrated that the Trust has significantly improved in respect of the number patients who received information on how to complain and the number of patients who were asked to give a view on the quality of their care.

The Trust is committed to improving in response to complaints and examples of this are regularly reported to the Trust Board and shared across the organisation. These improvements can arise from individual complaints and be specific to a speciality. For example, as a result of a complaint highlighting inadequate mobility assessment for patients who are discharged home with crutches and a plaster cast; a new 'get up and go test' has been introduced by the department for all patients over the age of 65 and any who have lower limb injuries which alter mobility. This is a protocol to follow to assess mobility and ensure patients will be safe at home.

A number of complaints may highlight a similar issue and require a more widespread change. For example, following complaints highlighting poor communication at discharge, a Trust wide project was undertaken to review all aspects of the discharge process. This has resulted in a number of changes around discharge planning. It has also led to further work, including ward areas that have been involved in a research project called 'patient reporting and action for a safe environment - PRASE'. This project has helped ward staff test different ways of working to ensure that after the ward round every patient's discharge plan is discussed with them and their relatives. The discussion involves checking patients know about their medicines, their understanding of what the doctors have said to them and what things are required before a patient can go home.

The Chief Nurse and her team continue to work to improve our responsiveness and reduce the time we take to investigate and resolve complaints. In particular the Deputy Chief Nurse and the Director of Nursing (Operations) are personally overseeing the Trust's longest standing and most complex complaints to ensure these are resolved.

Investment has been secured to strengthen the Trust's Patient Advice and Liaison (PALS) Service. This will improve and expand the Trust's ability to personally respond to the concerns of our patients.

We undertook a complaints satisfaction survey in March 2014 to see how well we were doing in terms of the improvements we set out to make. We contacted 20 people who had complained. This told us that whilst 69.5% of our patients said they found it easy to follow our complaints procedure, 50% said that our response did not meet the deadline. This shows that we still have more work to do and this is why this is a priority goal for improvement in 2014/15.

4.9.9 Improvements in patient and carer information

The Trust is committed to providing high quality information for patients and carers. The patient information procedure has been revised and sets out the requirements for the Trust to produce, provide and manage high quality information for patients and carers.

Information relating to discharge was identified by patients and staff as a key priority. Patients told us they were worried about what they could and could not do after discharge from our wards, and that we were not always clear about who they should contact if they had problems soon after they went home. In response the Deputy Chief Nurse and Heads of Nursing across the organisation led a review which resulted in a redesign of the information available for patients. This discharge booklet and information card is now in place across all areas to address the primary concerns of our patients.

Families and the carers of our patients told us that they did not always know about the services and support available to them. To improve this, to avoid disjointed care following discharge, we have worked in partnership with Leeds Directory and other external agencies to improve discharge experience. Leeds Directory staff visited all wards in our Acute Medicine CSU during October 2013. Information from Leeds Directory and Carers Leeds is now provided in the Trust alongside our own discharge information in a new dedicated discharge folder provided for our patients.

4.9.10 #hellomynameis

One of our senior doctors has led a campaign to improve the experience of our patients by making sure that care is personalised at all times through raising awareness of the importance of health care staff introducing themselves by name to patients at all times.

Dr Kate Granger has been receiving treatment for terminal cancer and she has shared her experience of treatment and care with a large number of staff in the Trust, and she has also

shared this with other health organisations to help us learn from this. She has used social media to promote her campaign and this has now spread to hospitals across the world.

We will be launching the #hellomynameis campaign at the Trust in the first week of July 2014 starting with five open events at which Dr Kate Granger will come and speak to us about her experiences as a patient and doctor. Staff at the Trust feel passionately about this campaign and we know we have much to learn from it to ensure we provide care that is person-centred and compassionate at all times. Kate can be followed on Twitter @GrangerKate or on the #hellomynameis website.

4.10 Performance against national priority indicators

The Trust's performance against the national priority indicators is summarised in Appendix E.

4.11 Quality Account Appendices

Appendix A

Statements from Local Stakeholders about The Leeds Teaching Hospitals NHS Trust on the Annual Quality Account

Statement from NHS Leeds West CCG

NHS Leeds West Clinical Commissioning Group (CCG) welcomes the opportunity to provide this statement for Leeds Teaching Hospitals NHS Trust's (LTHT) Quality Account for 2013-14. The Quality Account has been reviewed in accordance with the National Health Service Regulations. NHS Leeds West Clinical Commissioning Group (CCG) is providing this statement on behalf of all three Leeds CCG's (NHS Leeds South and East and NHS Leeds North) following consultation with them and the Specialist Commissioning Team for NHS England.

With responsibility for the quality of services it commissions from the Trust, the CCG is continuing to develop constructive and challenging relationships with the Trust's clinicians and managers, monitoring performance through monthly Leeds CCG and LTHT Quality Group meetings. These meetings seek to ensure structures, systems, processes and outcomes are addressed to improve issues around the safety, effectiveness and experience of patient care with the Trust.

We have reviewed the Quality Account and we believe that the information published is detailed, clear and comprehensive and provides a fair and accurate representation of the Trust's achievements and how it has been working to continuously improve the quality of care it delivers.

The Trust has made marked improvements over the last year ensuring that fundamentals are in place in order to measure performance systematically and consistently over time. We believe the development and use of tools

such as the Safer Nursing Tool and Ward Health Check to monitor and measure care across the ward areas has provided the staff with an additional impetus in their strive for excellence. The CCG welcomes the planned future investment in nursing as it recognises the potential for staffing capacity and capability issues moving forward. Demonstrating a genuine concern about staff health and its drive to be a 'learning organisation' will also support the Trust in maintaining its existing staff and to attract and recruit the best new staff.

The CCG believes there is a desire and enthusiasm throughout the Trust to improve patient safety. It has a clear and focused approach, recognising that patient safety is everyone's responsibility requiring involvement that includes frontline staff, patients, the public and the CCG. The Trust has exhibited such a culture in welcoming the CCG to undertake regular quality visits to areas within the Trust as identified by the CCG. A series of nine visits have been planned to date and four completed.

An outcome of the CCG requested 'Never Events Review' referenced in the report, has been to organise a further quality visit to inform and assure the commissioners that lessons are being learned and resultant changes shared and embedded in practice. The CCG welcomes the Trust prioritisation of Never Events and open approach to prevent them from happening.

The CCG recognises that over the last year the Trust has invested in improvements in the quality of complaints responses. The impact of this initiative was to initially delay replies for a number of complainants. The response times then required improvement. Maintaining a balance between the quality and timeliness of responses continues to be work in progress for the Trust, however the CCG acknowledges the continuing efforts being made in this area and the ambitious targets to reduce the number of complaints re-opened within six months because concerns have not been satisfactorily addressed in the first response.

We are pleased that the Trust achieved most of the requirements of the Commissioning for Quality and Innovation (CQUIN) scheme .The CQUIN scheme for 2013/14 reflects the ethos of the Trust to improve quality as priorities for both the organisation and commissioners. Additional information on the work the Trust has been undertaking covering the CQUINs and the impact this has made on patient care and outcomes would have added value to the report. For the coming year the CCG recognises the continuing challenges faced regarding communication across the interfaces of care. It welcomes the joint work LTHT plans with Leeds Community Health Trust to further develop their work on discharge in the 2014/15 CQUINs, building on the success of the work last year of the CQUIN for referral of young people who self harm through the development of a joint A&E pathway, between LTHT and Leeds Community Healthcare NHS Trust.

We have seen significant work being undertaken to try to reduce pressure sores and improvements to try and meet the infection control targets. Both issues continue to be challenges for all our local health organisations for the coming year and we are pleased that LTHT is committed to making significant improvements in 2014/15. Trust plans to meet infection control targets (MRSA & Clostridium difficile) have provided assurance for the CCG.

Although not detailed in the report, commissioners welcome the progress toward the timely implementation of both the Francis recommendations and NICE quality standards. Additional information on Trust compliance with safeguarding and with the Mental Capacity Act and Deprivation of Liberty Safeguards would also have added value to the Quality Account.

The commissioners particularly commend the work undertaken in raising falls awareness in the Trust and its approach to improving patient experience and the range of initiatives that have been and continue to be progressed going forward into 2014/15. The CCG acknowledges and values the Trust priorities in the coming year including aims to improve the treatment of fracture neck of femur and reduce the number of cardiac arrests. It is hoped as part of this

work the Trust will participate in the National Cardiac Arrest Audit and the remaining two Department of Health national audits not undertaken this year or as a minimum provide justification for not participating.

Leeds Teaching Hospital was one of the first Trusts in the country to formally undergo an inspection by the Care Quality Commission using their revised inspection regimen. At the time of writing this response the CCG have not received the CQC report.

The commissioners look forward to working in partnership with LTHT to deliver this year's quality targets and improve care for our patients.

Comments from Healthwatch Leeds on Leeds Teaching Hospitals NHS Trust Quality Account 2013/14

These comments are based on the assumption that we (Healthwatch) are required to express views about Quality Accounts from the patient/customer perspective. Specifically:

1. Is the Account written in plain English and the content understandable to as many people as possible?
2. Does the Account reflect the priorities of the local population?
3. Does the Account demonstrate that patients/customers and the general public have been involved in its production?
4. Is there evidence in the Account of patient/customer consultation in respect of service design and delivery?

1. Is the Account written in plain English and the content understandable to as many people as possible?

Quality Accounts are expected to include information about all aspects of the organisation's work – vision, priorities, strategy and operational activity. In our view this Quality Account provides a large amount of information but is not particularly accessible, there was no glossary attached to the version circulated to us. The size of the report is also a barrier, the attachment size required separate arrangements as it exceeded usual inbox size restrictions. It would be good practice if a summary of this report was in Easy Read.

2. Does the Account reflect the priorities of the local population?

For Healthwatch Leeds the time provided for comment remains a challenge as we comment on a number of accounts around the same time of the year. We did do some work with the Trust earlier this year as outlined on page 57 but would have welcomed additional evidence that local engagement activity influenced the priorities set by the Trust.

We recognise that the Trust reports a significant increase of engagement with both patients and carers and their staff and see this as a positive approach by the Trust. We look forward to the Trust continuing active engagement and would welcome more detail in the progress of their involvement strategy and the improvement of their complaints process next year.

There are a number of reported improvement and development activities that reflect good practice and national priorities including improved staffing ratios, dementia care and patient safety. We recognise the Trust has initiated significant organisational change and look forward to seeing evidence of improved patient experience as a result. We welcome the examples about how improvement is implemented.

3. Does the Account demonstrate that patients/customers and the general public have been involved in its production?

There are references to the involvement strategy which we take as to mean that some involvement has taken place but the amount of engagement in the actual production of the accounts is not clear.

Healthwatch Leeds having the opportunity to comment on the style and presentation of the Account is only a part of involving the public.

4. Is there evidence in the Account of patient/customer consultation in respect of service design and delivery?

There are examples of patient/customer involvement but we could not identify examples of involvement that linked directly to service design and/or delivery.

Conclusion

The Quality Account for the Leeds Teaching Hospitals Trust is extensive and reports a wide range of activity related to patient safety and quality. There is less clarity of how engaged the public was in setting future priorities or in engaging in the actual production of the account, we would welcome more information on these aspects in the next set of accounts.

Independent Auditor's Limited Assurance Report to the Directors of Leeds Teaching Hospitals NHS Trust on the Annual Quality Account

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Leeds Teaching Hospitals NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to May 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to May 2014;
- feedback from Leeds West Clinical Commissioning Group dated 30 May 2014;
- feedback from Local Healthwatch dated 27 May 2014;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 26 September 2013;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey dated February 2014;
- the latest national staff survey dated December 2013;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 2 May 2014;
- the annual governance statement dated 29 May 2014;
- Care Quality Commission [Intelligent Monitoring Report dated 1 April 2014]; and
- the results of the Payment by Results coding review dated May 2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Leeds Teaching Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Leeds Teaching Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;

- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or nonmandated indicators which have been determined locally by Leeds Teaching Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

No.1 Whitehall Riverside

Leeds LS1 4BN

24 June 2014

Appendix B: Glossary of Terms

Acute Hospital Trust: An Acute Hospital Trust is an NHS organisation responsible for providing healthcare services.
Board (of trust): The role of the Trust's Board is to take corporate responsibility for the organisation's strategies and actions.
Care Quality Commission (CQC): The Care Quality Commission is the independent regulator of health and social care in England.
CQC Intelligent Monitoring Report: The CQC Intelligent Monitoring tool has been developed to give inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust or a specialist NHS trust. The system is built on a set of indicators that look at a range of information including patient experience, staff experience and performance. The indicators relate to the five key questions that will ask of all services: are they safe, effective, caring, responsive, and well-led?
Clinical Commissioning Group (CCG): An NHS organisation responsible for improving the health of local people, developing services provided by local GPs and their teams (called primary care) and making sure that other appropriate health services are in place to meet local people's needs.
Clinical Audit: Clinical audit measures the quality of care and services against agreed standards, and suggests or makes improvements where necessary.
***Clostridium Difficile* Infection (CDI):** *Clostridium difficile* is a type of bacteria. *Clostridium difficile* infection usually causes diarrhoea and abdominal pain, but it can be more serious in some patients.
Clwyd and Hart Review: The Clwyd-Hart report, published in October 2013, is a review of NHS complaints handling launched by the Secretary of State for Health, and is aimed at ensuring that all hospitals listen to and act upon the concerns of patients.
Commissioning for Quality and Innovation (CQUIN) payment framework: The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation.
Department of Health (DoH): The Department of Health is 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.
Dr Foster Intelligence: Provider of healthcare information and analysis. The Trust subscribes to a number of Dr Foster's tools to support clinical, efficiency and market share analysis.
Friends and Family Test: The Friends and Family Test is a national NHS tool allowing patients to provide feedback on the care and treatment they receive and to improve services. It asks patients whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment.
Haelo: Haelo is an innovation and improvement centre which hosts improvement experts, clinicians, improvement fellows and researchers to improve population health and healthcare.
Healthwatch Leeds: Healthwatch is the new independent consumer champion that gathers and represents the public's views on health and social care services in England. It operates both on a national and local level and ensures that the views of the public and people who use the services are taken into account.
Hospital Standardised Mortality Ratio: The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

Information Governance Toolkit: The NHS Information Governance Toolkit ensures necessary safeguards for, and appropriate use of, patient and personal information.
Integrated Quality and Performance Report (IQPR): The Trust's monthly performance report to the Board on quality, finance, productivity and activity.
Keogh Review: A review conducted by Sir Bruce Keogh (NHS Medical Director for England) of the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators, the findings and recommendations of which were published in July 2013.
Leeds City Council Scrutiny Board for Health: This Board carries out Leeds City Council's statutory role to scrutinise local National Health Service (NHS) bodies.
Leeds Directory: The Leeds Directory offers the choice of over 1700 businesses and organisations to help support older people and disabled people to live independently.
Leeds Involving People: is an organisation that represents the independent voice of people through the promotion of effective involvement. It involves the community in the development of health and social care services by ensuring their opinions and concerns are at the centre of decision making processes.
Methicillin Resistant Staphylococcus Aureus bacteraemia (MRSA): MRSA is a bacterial infection.
Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSA): MSSA is a bacterial infection.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice across England and Wales, and makes recommendations for improvement.
National Early Warning Scoring Systems (NEWS): The National Early Warning Score (NEWS) is a guide used by hospital nursing & medical staff to determine the degree of illness of a patient, and is based on physiological measurements.
National Institute for Health and Care Excellence (NICE): The National Institute for Health and Clinical Excellence (NICE) is 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): National Institute for Health Research (NIHR) 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.
The NHS Litigation Authority (NHSLA): The NHSLA is a not for profit organisation which handles negligence claims and works to improve risk management practices in the NHS.
National Patient Safety Agency (NPSA): The National Patient Safety Agency leads and contributes to improved, safe patient care by analysing trends in incidents, informing and supporting the health sector.
National Reporting and Learning System (NRLS): The system 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.
netFormulary: the netFormulary is the online medicines formulary for the Leeds Teaching Hospitals NHS Trust (LTHT). It makes the decisions of the LTHT Drug and Therapeutics Group publicly available and provides links to further information on the medicines which are supported for use by the hospital. This helps to support the safe, evidence-based and cost effective use of medicines within the Trust.
Net promoter score: The Net Promoter Score is the difference between the percentage of users who would recommend your services minus the percentage of those who would not.
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): The 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): PROMs are a measure of quality from the patient perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre and post operative surveys.
Payment by Results (PbR): Payment by results is the tariff system that governs payments to hospitals by local NHS commissioning organisations. It seeks to ensure fair funding for hospitals for the work they do.
Root Cause Analysis investigations: RCA investigations provide a systematic framework for reviewing patient safety incidents, claims and complaints. Investigations can identify what, how, and why patient safety incidents have happened in order to reduce the risks of incidents happening again.
Safety Thermometer data collection tool: The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care.
Secondary Uses Service: The 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.
Specialist Commissioning Group (SCG): Responsible for commissioning specialised services before the NHS reforms in 2013/14.
Venous thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vein can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT).

Appendix C Trust Participation in NCEPOD Studies and National Audits

Summary tables of participation in NCEPOD Studies and DoH recommended national audits

National Confidential Enquiry	Participation Rate*
Lower Limb Amputation	100%
Tracheostomy Care	14%**

National Audit	Participation Rate*
Adult Critical Care (ICNARC Case Mix Programme)	100%
National Audit of Seizure Management	100%
National Emergency Laparotomy Audit	100%
National Joint Registry	98%
Paracetamol Overdose (care provided in Emergency Departments)	100%
Severe Sepsis and Septic Shock (adults)	76%
Trauma Audit and Research Network	68%***
National Comparative Audit of Blood Transfusion - Use of Anti-D Prophylaxis	100%

National Comparative Audit of Blood Transfusion - Audit of Patient Information and Consent	100%
National Bowel Cancer Audit	100%
National Head and Neck Cancer Audit	100%
National Lung Cancer Audit	100%
National Oesophago-Gastric Cancer Audit	100%
Myocardial Ischaemia National Audit Project (MINAP)	99%
Adult Cardiac Surgery Audit	100%
Cardiac Arrhythmia	100%
Congenital Heart Disease	100%
National Audit of Percutaneous Coronary Interventional Procedures	100%
Heart Failure	100%
National Vascular Registry	Denominator not known
Paediatric Bronchiectasis	100%
National Diabetes: Core Audit	100%
National Diabetes Inpatient Audit	100%
National Pregnancy in Diabetes Audit	38%
National Paediatric Diabetes Audit	100%
Inflammatory Bowel Disease: Inpatient Care	100%
National Review of Asthma Deaths	100%
UK Renal Registry	100%
National Hip Fracture Database	100%
Sentinel Stroke National Audit Programme	88%****
Rheumatoid and Inflammatory Arthritis	100%
Patient Reported Outcome Measures - Varicose Veins	38%
Patient Reported Outcome Measures – Hernia	65%
Patient Reported Outcome Measures - Hip Replacements	77%
Patient Reported Outcome Measures - Knee Replacements	100%
Epilepsy12	58%
MBRRACE-UK (Maternal, infant and newborn programme)	88%
Moderate or Severe Asthma in Children (care provided in Emergency Departments)	100%
National Neonatal Audit Programme	100%
Paediatric Asthma	100%
Paediatric Intensive Care Audit Network (PICANet)	100%
National Neonatal Audit Programme (NNAP)	100%

Paediatric asthma	98%
Paediatric fever	100%
Paediatric Intensive Care Audit Network (PICANet)	100%

* Participation rate is calculated as the number of patients for whom data have been submitted as a proportion of the number for whom data should have been submitted.

** Full participation in this study was more challenging than other studies, and this was the experience of Trusts nationwide. NCEPOD will not be using the methodology used in this study again.

*** Participation rate for the period April to December 2013.

**** Participation rate for the period April to December 2013 for the 72 hour patient cohort. For January to March 2014, the Trust will also participate for the post-72 hour patient cohort.

Appendix D: Commissioning for Quality & Innovation (CQUIN) scheme 2014/15

Leeds Teaching Hospitals Trust 2014/15 CQUIN Summary

CQUINs – LOCAL	
1.1	Friends & Family Test - Implementation of Staff Questionnaire by 30 June 2014
1.1.1	Friends & Family Test - Early Implementation in Outpatients & Day Case Departments by 1 October 2014
1.2	Friends & Family Test - Increase/Maintain Response Rates in A&E and Inpatient Areas
1.3	Friends & Family Test - Increase/Maintain Response Rates in Acute Inpatient Services
2.1	Patient Safety Thermometer - Reduction in Pressure Ulcer Prevalence
2.2	Continued Reduction in all Pressure Ulcers (incidence)
2.3	Patient Safety Thermometer - Reduction in Prevalence of Falls
3.1	Dementia & Delirium - Find, Assess, Investigate, Refer (FAIR)
3.2	Dementia & Delirium - Clinical Leadership
3.3	Dementia & Delirium - Supporting Carers
4	Promoting Healthy Lifestyle: Making Every Contact Count
5	Implementation of Electronic Outpatient Clinic Letters
6	Improve Patient Experience of Discharge
7	Catheter Related Blood Stream Infection Surveillance
8	Respiratory Care Bundles - Improving Management of Patients with Asthma in A&E
9	VTE Root Cause Analysis
10	Best Start - Children with Complex Needs

CQUINs - SPECIALISED COMMISSIONERS (1)	
1.1	Friends & Family Test - Implementation of Staff Questionnaire by 30 June 2014
1.1.1	Friends & Family Test - Early Implementation in Outpatients and Day Case Departments by 1 October 2014
1.2	Friends & Family Test - Increase/Maintain Response Rates in A&E and Inpatient Areas
1.3	Friends & Family Test - Increase/Maintain Response Rates in Acute Inpatient Services
2.1	Patient Safety Thermometer - Reduction in Pressure Ulcer Prevalence
2.2	Patient Safety Thermometer - Continued Reduction in Category 2 & 3 Pressure Ulcers
2.3	Patient Safety Thermometer - Reduction in Prevalence of Falls
3.1	Dementia & Delirium - Find, Assess, Investigate, Refer (FAIR)
3.2	Dementia & Delirium - Clinical Leadership
3.3	Dementia & Delirium - Supporting Carers
11	Preventing Unplanned Re-admissions to PICU within 48 hours
12	Hepatitis C Multidisciplinary Teams
13	% Increase in Patients Enrolled in Clinical Trials (where these exist)
14	Quality Dashboards
15	QIPP - Procure ICD/CRT device costs at national lower quartile average prices
16	QIPP - Implement best practice on radiotherapy fractions
17	QIPP - Significantly reduce excess bed days in high specialty areas
18	QIPP - Establish service and clinical audits against clinical thresholds
19	QIPP - Reduce outpatient new to follow-up ratios to meet best practice national quartile for identified service lines
CQUINs - SPECIALISED COMMISSIONERS (2)	
1.1	Friends & Family Test - Implementation of Staff Questionnaire by 30 June 2014
1.1.1	Friends & Family Test - Early Implementation in Outpatients and Day Case Departments by 1 October 2014
1.2	Friends & Family Test - Increase/Maintain Response Rates in A&E and Inpatient Areas
1.3	Friends & Family Test - Increase/Maintain Response Rates in Acute Inpatient Services
20	National (cancer & non cancer) Screening Programmes - Increase Uptake in Breast Screening
21	National (cancer & non cancer) Screening Programmes - Ensure all eligible Diabetic patients are included within Diabetic Eye Screening Programme Register
22	Secondary Dental Care Services - Reporting Requirements

National Indicators / Quality Requirements - AF Quality and Governance						
Category	**Indicator**	**TDA Thresholds**	**Jan-14**	**Feb-14**	**Mar-14**	**YTD**
Access Metrics	Referral to treatment within 18 weeks - admitted	≥ 90%	86.0%	88.7%	89.3%	85.7%
	Referral to treatment within 18 weeks - non-admitted	≥ 95%	95.0%	95.5%	96.0%	95.7%
	Referral to treatment within 18 weeks - incomplete	≥ 92%	94.6%	95.2%	95.4%	n/app
	Referral to treatment within 18 weeks - over 52 week waiters (incomplete waits)	0	0	0	0	n/app
	Diagnostic waits within 6 weeks	≥ 99%	99.0%	99.2%	97.8%	n/app
	Last minute cancelled operations not re-booked within 28 days	0%	Q4: 5.0%			
	Urgent operations cancelled for the second time	0	Unavailable [8]			
	A&E 4 hour	≥ 95%	96.1%	93.9%	96.9%	96.4%
	Cancer 62 days - GP referral	≥ 85%	78.5%	79.3%	Reported a month in arrears	82.6%
	Cancer 62 days - referral from screening service	≥ 90%	100.0%	97.0%		95.8%
	Cancer 31 days - first treatment	≥ 96%	96.2%	97.8%		97.3%
	Cancer 31 days - second or subsequent surgery	≥ 94%	94.3%	97.4%		96.8%
	Cancer 31 days - second or subsequent drug treatment	≥ 98%	100.0%	100.0%		100.0%
	Cancer 31 days - second or subsequent radiotherapy	≥ 94%	93.3%	97.8%		97.7%
	Cancer 2 week wait - suspected cancer	≥ 93%	87.0%	95.0%		93.3%
	Cancer 2 week wait - breast symptoms	≥ 93%	93.8%	94.4%		92.5%
Outcomes Metrics	30 day emergency readmissions (Elective & non-elective)	≤ 10.9%	6.8%	6.7%	Reported a month in arrears	6.8%
	Incidence of MRSA	0	1	0	1	7
	Incidence of C. Difficile	YTD: ≤ 101 13/14: ≤ 101	12	9	9	144
	Medication errors causing serious harm - Number	0	0	0	Reported a month in arrears	1
	Harm free care (pressure sores, falls, CUTI and VTE) - Safety Thermometer (Snapshot)	≥ 92%	93.8%	93.7%	95.1%	n/app
	Serious incidents - Number	n/app	6	12	12	56
	Serious incidents - Rate per 1,000 bed days	≤ 1.23	0.11	0.24	0.23	0.09
	Never events	0	0	1	1	7
	E. Coli cases	n/app	44	47	47	573
	E. Coli cases - Rate per 100,000 bed days [3]	≤ 94.9	80.0	95.6	88.8	92.4
	MSSA cases - Rate per 100,000 bed days [3]	≤ 9.02	10.9	10.2	9.4	10.0
	Maternal deaths	13/14: ≤ 1	0	0	Reported a month in arrears	1
	Summary Hospital-level Mortality Indicator (SHMI)	National Ave: 100	July 2012 to June 2013: 95.15			
	Hospital Standardised Mortality Ratio (HSMR) *(2012/13 rebased)*	National Ave: 100	July 2012 to June 2013: 91.17			
	Venous thromboembolism (VTE) risk assessment	≥ 95%	96.1%	96.5%	Reported a month in arrears	95.8%
Quality Governance Indicators	Patient satisfaction (friends and family) - Response rate[1]	Q1 ≥ 15% By Q4 ≥ 20%	22.4%	26.5%	25.9%	21.0%
	Nurse: bed ratio [5]	0.1 : 1 to 4.4 : 1	1.92 : 1	1.92 : 1	1.92 : 1	n/app
	% of nurses registered nurses [6]	≥ 60%	70.3%	70.2%	69.8%	-
	Mixed sex accommodation	0	0	0	0	0

Indicators awaiting clarification

National Indicators / Quality Requirements - AF Quality and Governance						
Category	**Indicator**	**TDA Thresholds**	**Jan-14**	**Feb-14**	**Mar-14**	**YTD**
CQC Concerns	Warning notice	TBC	None	None	None	None
	Civil and/or criminal action	TBC	None	None	None	None
Outcomes Metrics	Admissions of fullterm babies to neonatal care	TBC	3.9%	2.3%	4.0%	3.3%
	Meticillin Sensitive Staphylococcus Aureus (MSSA) cases	YTD: ≤ 60 13/14: ≤ 60 [2]	6	5	5	62
	C-section rates (Emergency and Elective LSCS)	TBC	21.4%	21.8%	Reported a month in arrears	20.3%
	Open CAS Alerts (Exceeding the deadline for action) [4]	TBC	5	5	4	n/app
	WHO surgical checklist compliance	TBC	97.3%	97.8%	97.0%	n/app
3rd Party Reports	*Any relevant report including safeguarding alerts, serious case reviews, ad hoc reports from MPs, GMS, Ombudsman, Commissioners, litigation etc.*	n/app	n/app			
Quality Governance Indicators	Patient satisfaction (friends and family) - Net Promoter Score (DH) [1]	TBC	65	62	64	67
	Patient and carer voice	TBC				
	Board turnover *(12 months rolling average)*	TBC	44.0%	44.0%	45.1%	n/app
	Sickness/absence rate *(12 months rolling average)*	TBC	4.1%	4.1%	4.2%	n/app
	Proportion temporary staff – clinical and non-clinical	TBC	8.7%	8.5%	9.8%	n/app
	Staff turnover *(12 months rolling average)*	TBC	10.8%	10.6%	10.6%	n/app
	Complaints - Rate per 10,000 occupied bed days [3]	TBC	14.7	18.7	17.0	17.2
	% staff appraised [7]	TBC	52.0%	57.4%	61.6%	n/app

[1] For adult inpatients, A&E attenders and Maternity services.

[2] Trajectory agreed with Clinical Commissioning Group (CCG).

[3] Rate based on internal monthly overnight bed occupancy data.

[4] Threshold not yet published by the TDA (although anticipated to be 0).

[5] Figures shown for are based on snapshots of number of registered nurses (FTE) (excluding midwives) against the average number of available overnight General & Acute beds as reported in the latest KH03 quarterly return.

[6] These figures show the number of full time equivalent (FTE) registered nurses (including midwives) as a proportion of all FTE nurses employed by the Trust at the end of each month.

[7] Percentage of staff who have an in date appraisal at month end.

[8] Data currently under review.

Section 5

Summary financial statement for 2013-14

Summary Accounts for 2013-14

5.1 The Leeds Teaching Hospitals NHS Trust - Summary financial statements 2013-14

These financial statements are summaries of the information contained in the Annual Accounts of the Leeds Teaching Hospitals NHS Trust. The Trust's auditors have issued an unqualified report on the Annual Accounts. Full sets of accounts are available on request and enquires should be addressed to:

Tony Whitfield
Director of Finance
The Leeds Teaching Hospitals NHS Trust
St James's University Hospital
Beckett Street
Leeds, LS9 7TF

Full sets of accounts are also available via the Trust's website: **www.leedsth.nhs.uk**

These accounts for the year ended 31 March 2014 have been prepared by the Leeds Teaching Hospitals NHS Trust under section 232 schedule 15 of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statement of comprehensive income for the year ended 31 March 2014

	2013-14 £000	2012-13 £000
Gross employee benefits	**(599,030)**	(583,729)
Other operating costs	**(422,624)**	(394,020)
Revenue from patient care activities	**875,760**	814,685
Other Operating revenue	**169,156**	187,759
Operating surplus/ (deficit)	**23,262**	**24,695**
Investment revenue	**87**	85
Other gains and (losses)	**53**	61
Finance costs	**(12,759)**	(12,985)
Surplus/(deficit) for the financial year	**10,643**	11,856
Public dividend capital dividends payable	**(10,147)**	(10,358)
Retained surplus/ (deficit) for the year	**496**	**1,498**
Other Comprehensive Income		
Net gain on revaluation of property, plant & equipment	**5,050**	0
Reclassification Adjustments		
On disposal of available for sale financial assets	**(5,050)**	0
Total Comprehensive Income for the year*	**496**	**1,498**
Financial performance for the year		
Retained surplus/(deficit) for the year	**496**	1,498
IFRIC 12 adjustment (including IFRIC 12 impairments)	**969**	1,238
Adjustments in respect of donated gov't grant asset reserve elimination	**150**	353
Adjusted retained surplus/(deficit)	**1,615**	3,089

A trust's reported NHS financial performance position is derived from its retained surplus/ (deficit), but adjusted to take account of the revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) in 2009-10). NHS trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's financial performance.

The retained surplus is adjusted to take account of the costs of a change in accounting treatment of donated assets. The cost represents the difference in value between depreciation on donated assets which, until 2011-12, was funded from a reserve account and donations credited to income in the year which, until 2011-12, were credited to the reserve.

The Trust is deemed to have met the statutory break even duty in both 2013-14 and 2012-13.

Statement of financial position as at 31 March 2014

	31 March 2014 £000	31 March 2013 £000
Non-current assets:		
Property, plant and equipment	**598,468**	601,898
Intangible assets	**840**	707
Trade and other receivables	**11,615**	10,592
Total non-current assets	**610,923**	**613,197**
Current assets:		
Inventories	**17,635**	16,676
Trade and other receivables	**48,141**	35,590
Cash & cash equivalents	**23,236**	24,348
Total current assets	**89,012**	**76,614**
Total assets	**699,935**	**689,811**
Current liabilities		
Trade and other payables	**(93,923)**	(85,410)
Provisions	**(3,172)**	(2,356)
Borrowings	**(4,459)**	(4,229)
Capital loan from Department	**(3,356)**	(3,356)
Total current liabilities	**(104,910)**	(95,351)
Net current (liabilities)	**(15,898)**	(18,737)
Non-current assets less net current liabilities	**595,025**	594,460
Non-current liabilities		
Trade and other payables	**(2,315)**	(2,154)
Provisions	**(5,517)**	(5,988)
Borrowings	**(202,771)**	(207,229)
Capital loan from Department	**(38,642)**	(41,998)
Total non-current liabilities	**(249,245)**	(257,369)
Total Assets Employed:	**345,780**	337,091
Financed by:		
Taxpayers' Equity		
Public Dividend Capital	**293,954**	290,811
Retained earnings	**(29,990)**	(35,536)
Revaluation reserve	**81,816**	81,816
Total Taxpayers' Equity:	**345,780**	337,091

The summary financial statements were approved by the Board on 29 May 2014 and signed on its behalf by Julian Hartley, Chief Executive.

Statement of changes in taxpayers' equity for the year ended 31 March 2014

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2013	**290,811**	**(35,536)**	**81,816**	**0**	**337,091**
Changes in taxpayers' equity for 2013-14					
Retained surplus for the year	0	496	0	0	496
Net gain on revaluation of property, plant, equipment	0	0	5,050	0	5,050
On Disposal of Available for Sale financial Assets	0	0	(5,050)	0	(5,050)
New PDC Received - Cash	3,143	0	0	0	3,143
Other Movements	0	5,050	0	0	5,050
Net recognised revenue for the year	**3,143**	**5,546**	**0**	**0**	**8,689**
Balance at 31 March 2014	**293,954**	**(29,990)**	**81,816**	**0**	**345,780**
Balance at 1 April 2012	**290,701**	**(37,076)**	**81,816**	**42**	**335,483**
Changes in taxpayers' equity for 2012-13					
Retained surplus for the year		1,498			1,498
Transfers between reserves		42	0	(42)	0
New PDC Received	110				110
Net recognised revenue/(expense) for the year	**110**	**1,540**	**0**	**(42)**	**1,608**
Balance at 31 March 2013	**290,811**	**(35,536)**	**81,816**	**0**	**337,091**

Statement of cash flows for the year ended 31 March 2014

	2013-14 £000	2012-13 £000
Cash Flows from Operating Activities		
Operating Surplus	**23,262**	24,695
Depreciation and Amortisation	**31,842**	31,247
Donated Assets received credited to revenue but non-cash	**0**	(933)
Interest Paid	**(12,763)**	(12,981)
Dividend Paid	**(10,014)**	(9,984)
(Increase) in Inventories	**(959)**	(253)
(Increase) in Trade and Other Receivables	**(17,282)**	(4,551)
(Decrease)/Increase in Trade and Other Payables	**10,053**	(854)
Provisions Utilised	**(1,269)**	(809)
Increase in Provisions	**1,614**	1,978
Net Cash Inflow from Operating Activities	**24,484**	27,555
Cash Flows From Investing Activities		
Interest Received	**87**	85
Payments for Property, Plant and Equipment	**(26,704)**	(29,901)
Payments for Intangible Assets	**(340)**	(701)
Proceeds of disposal of assets held for sale (PPE)	**5,607**	85
Net Cash (Outflow) from Investing Activities	**(21,350)**	(30,432)
Net Cash Inflow/(Outflow) Before Financing	**3,134**	(2,877)
Cash Flows From Financing Activities		
Public Dividend Capital Received	**3,143**	110
Loans received from DH - New Capital Investment Loans	**0**	9,000
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(3,356)**	(3,131)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI	**(4,228)**	(4,012)
Capital grants and other capital receipts (excluding donated cash receipts)	**195**	745
Net Cash Inflow/(Outflow) from Financing Activities	**(4,246)**	2,712
Net (Decrease) in Cash And Cash Equivalents	**(1,112)**	(165)
Cash and Cash Equivalents at 01 April 2013	**24,348**	24,513
Cash and Cash Equivalents at 31 March 2014	**23,236**	24,348

5.2 Note to the summary financial statements

Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000	2012-13 Number	2012-13 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**209,644**	**416,828**	202,344	391,868
Total Non-NHS Trade Invoices Paid Within Target	**140,055**	**274,411**	161,645	312,084
Percentage of NHS Trade Invoices Paid Within Target	**66.81%**	**65.83%**	79.89%	79.64%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**6,023**	**50,641**	5,114	**44,157**
Total NHS Trade Invoices Paid Within Target	**881**	**7,464**	1,649	**17,662**
Percentage of NHS Trade Invoices Paid Within Target	**14.63%**	**14.74%**	32.24%	40.00%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The Late Payment of Commercial Debts (Interest) Act 1998

The Trust has not made any payments under the terms of this legislation in either the current or preceding financial year.

The work of the Audit Committee

The Audit Committee is a well-established part of the Trust's governance arrangements. We are tasked with ensuring that there is an effective system of internal control and providing the board with an independent and objective view of the Trust's financial, governance, risk management and internal control arrangements. The Committee operates in accordance with best practice as set out in the 2011 NHS Audit Committee Handbook.

At the start of the year, Caroline Johnstone chaired the Audit Committee and its members were Mark Abrahams and Professor David Cottrell; all of whom were independent non-executive directors of the Trust. The Chair of the Trust is not a member of the Committee. In September 2013, Professor Cottrell stepped down from the Board and the Audit Committee. In January 2014, Allison Page became an independent non-executive director of the Trust and a member of the Audit Committee. Allison is a solicitor and a partner at DLA Piper LLP, one of the world's largest specialist business law firms.

During the year, the Audit Committee met six times and has completed a comprehensive work programme of independent scrutiny of the Trust's governance arrangements and organisational changes across a wide range of activities. The Committee:

- considered regular reports from the Trust's external auditors (Grant Thornton), including on the Trust's accounts for 2012-13 (which received an unqualified audit opinion)
- considered regular reports from the Trust's internal auditors who conduct a risk based programme of reviews of financial and operational areas. The Committee closely monitors the implementation by management of recommendations arising from these reports and oversees the Trust's counter fraud arrangements.

The Committee also held a series of discussions of key risk areas, at which relevant executive directors attended to inform its work.
One additional meeting of the Committee focused entirely on the new approach to risk management in the Trust

The Committee reports to the Board formally on its work through this annual report and at each Board meeting as appropriate.

Overall, the Committee received a limited level of assurance about the Trust's governance arrangements, risk management processes and internal control systems. The Trust was placed into level 4 escalation by the NHS Trust Development Authority early in the year and, in a year of huge change across the board, we have been impressed that significant progress has been made. However, there is much further work to do in embedding and developing the assurance framework, including risk registers, and in addressing the inherent risks in the major changes being effected across the Trust. These include the management structure, finalising the 2015 annual and five year plans, establishing clear planning processes for the future, the quality and nature of board reporting and the speed of implementation/ responding to audit recommendations and reports of progress against targets (financial or operational).

In line with best practice suggested by the National Audit Office, members of the Audit Committee confirm that they have complied with their obligations to the best of their ability and the Board are asked to note the content of this report.

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.

You can also become involved in our drive to become a Foundation Trust by joining us as a member and sharing your views with us.

For membership queries or to make a general comment, please visit our website at **www.leedsth.nhs.uk**.

Summaries of this document can be made available, by arrangement, in large print, Braille and community languages, from:

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