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Part 1: Chief Executive’s Statement from the Board

1.1 Introducing the Trust

The Leeds Teaching Hospitals NHS Trust (LTHT) is one of the largest and busiest NHS acute health providers in Europe, a regional and national centre for specialist treatment, a world renowned biomedical research facility, a leading clinical trials research unit, and also the local hospital for the Leeds community. This means we have access to some of the country’s leading clinical expertise and the most advanced medical technology in the world. Each year we treat around 1.5 million patients across 7 hospital locations:

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

We have a £1 billion budget, providing local and specialist services for our immediate population of 770,000 and regional specialist care for up to 5.4 million people.

Our patients are at the heart of everything we do. We employ almost 17,000 people who are committed to delivering high quality care to all our patients all of the time. We also have an international reputation for excellence in specialist care, research and medical training. We contribute to life in the Leeds region, not only by being one of the largest employers, but by supporting the health and well-being of the community and playing a leading role in research, education and innovation.

1.2 Development of the Quality Account

Our Quality Account for 2017/18 has been developed with our staff, stakeholders and partner organisations, including clinicians and senior managers, commissioners at NHS Leeds Clinical Commissioning Group (CCG), and Healthwatch Leeds. It has been approved by the Trust Board.
1.3 Chief Executive’s Statement on Quality

On behalf of the Trust Board and staff working at Leeds Teaching Hospitals NHS Trust, I am pleased to introduce you to our Quality Account for the year 2017/18.

Once again we had much to be proud of in our achievements during the last 12 months. We have continued to make improvements in quality and safety whilst facing significant financial and operational challenges, these achievements are highlighted in the Quality Account.

We have also continued to experience pressures relating to emergency admissions and capacity within our hospitals throughout the year, which has affected all NHS trusts, particularly during the winter months. We have worked with our partners in health and social care to improve the flow of patients and facilitate timely discharge, including working with them on improvement programmes, Perfect Week in October 2017 and a Multi-Agency Discharge Event (MADE) in March 2018. The aim of these programmes was to identify delays in the system, unblock them and simplify patient flow, working in collaboration with our partners. We have expanded the service we established with Villa Care at Wharfedale hospital last year to additional wards at St James’s hospital. This will continue to be a priority in 2018/19, focusing on patients in our hospital beds who have been assessed as being medically fit for discharge.

Last year we reported that Leeds Teaching Hospitals NHS Trust was chosen to be one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known locally as the Leeds Improvement Method, providing a framework for improving quality and efficiency across the organisation. We have continued to develop this approach in 2017/18 and we are making excellent progress. We are training more staff in staff in lean methodology and this is making a big impact on the services we provide for patients as it continues to be embedded in our safety culture. This is underpinned by our Quality Improvement Strategy 2017-20. You will see the progress we have made against this in the Quality Account together with the goals for continued improvement in 2018/19.

“Caring the Leeds Way - Our Professional Commitment” was launched throughout the organisation in April 2016 as part of our nursing, midwifery and AHP strategy and we have continued to deliver the goals in our strategy in 2017/18.

Once again we were delighted with the results of the NHS Staff Survey and we were one of the highest performing Trusts nationally compared to the previous year’s results. This shows the impact the Leeds Way continues to have in the Trust and the values that underpin this, creating a positive culture where staff feel engaged.

We have worked with our clinicians, managers and local partners at Leeds Clinical Commissioning Group and Healthwatch Leeds to identify the priorities set out in our Quality Account for 2018/19. I hope you enjoy reading this summary of our achievements in 2017/18 and the work we have to done improve quality and safety in our hospitals.

Signed

Julian Hartley, Chief Executive
18 June 2018

Signed for, and on behalf of the Trust Board
Part 2: Improving our Quality of Service

2.1 Progress against our Quality Goals 2017/18

Clinical Effectiveness
We know continued pressures on our capacity, impact the ability to manage effectively and optimally all our patients within both emergency and elective pathways, which is why our Leeds Improvement Method Value Streams (see section 3.1) were selected and supported by the Guiding Board to improve flow across different areas of the Trust.
- Chapel Allerton Orthopaedic Centre - elective pathways in total hip and knee replacement patients
- Timely discharge - Abdominal Medicine & Surgery, specifically focusing on prostate surgery patients
- Step down from Critical Care to Neurosciences
- Capacity and Flow within Ophthalmology Outpatient Services
- 7 day service and 14hr consultant review within Acute Medicine

Patient Safety
Nationally set priorities, our continued commitment to provide harm free care, alongside feedback from patients and carers helped us to shape our areas of focus for Quality Improvement. These include:
- Improving the care of patients with acute kidney injury (see section 3.2.1)
- Improving the care of patients with sepsis (see section 3.2.2)
- Improving the recognition and response of the patient clinically deteriorating (see section 3.2.3)
- Reducing the incidence of falls and harm sustained by patients following a fall (see section 3.2.4)
- Reducing harm and Improving Patient Safety Culture by Integrating Daily Patient Safety Huddles on Wards (see section 3.2.5)
- Reducing the number of hospital acquired pressure ulcers (see section 3.2.6)
- Improving care for patients with Parkinson’s (see section 3.2.7)
- Reducing healthcare associated infections and promoting the best use of antibiotics (see section 3.2.10)

Patient Experience
Our staff, local partners, HealthWatch Leeds, and our patients and their carers helped us determine our patient experience priorities (see section 3.3.2):
- Demonstrating patient and public feedback is used to support service and Trust developments
- Learning from what patients and families tell us - implementing ‘Always Events’
2.2 Our Priority Improvement Areas for 2018/19

We know from our Quality improvement work in recent years that early improvements in patient experience and processes occur, but delivering true impact on patient outcomes across the Trust (for example reducing cardiac arrests and falls) takes several years of commitment to both identifying the interventions that make a difference and adapting these at scale across the Trust. This is matched by the findings from the Virginia Mason Institute that work streams can take 3 years or more to improve outcomes for patients.

Therefore our priorities for the Trust for 2018/19 were identified as:

- Those existing improvement programmes that need ongoing commitment to ensure improvements already made are sustained, spread and embedded across the Trust
- Alongside supporting new areas of work to continually improve the services we provide.

The overarching principle for all these work streams is their importance to provide a positive patient experience, high quality care, with optimal outcomes. They have been grouped under the section headings below for the requirements of this Quality Account document.

Patient Safety

We continue to support our Patient Safety and Harm Free Care Improvement Programmes to improve outcomes further and spread the improvements Trust wide. These include: Acute Kidney Injury, Sepsis, Pressure Ulcers, Antimicrobial Stewardship, Falls, Deteriorating Patient, Safety Huddles, Parkinson’s, and Maternity Services. New areas of focus include: improving the quality of care for patients requiring joint replacements, and medication safety.

Clinical Effectiveness

We continue to support the sustainment and spread of improvements within all our Leeds Improvement Method Value Streams from 2017/18, for example:

- Learning from the TURP pathway to focus on more discharge pathways with Abdominal Medicine and Surgery
- Learning from improvements within Acute Medicine to improve patient flow in Emergency Department
- Embedding improvements in flow within Outpatient Services

Alongside supporting new areas of work in 2018/19 to improve flow in:

- Adult Cardiac Surgery
- And among patients medically optimised who remain in hospital for longer than 21 days.

Patient Experience

Our identified new areas of commitment here are:

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

Progress against all our quality objectives will continue to be monitored, measured, and reported to the appropriate governance groups and committees within our Quality Committee Structure and summaries provided to the Quality Assurance Committee.
2.2.1 Quality Improvement Strategy

We published our first Quality Improvement Strategy in 2014 and are really proud of the improvements we have achieved in the last 4 years. Having created excellent foundations to take our ambitions significantly further, we updated our Strategy for 2017 - 2020, which was approved by our Trust Board in March 2017.

In our 2017-2020 Quality Improvement Strategy we reflect on the progress we have made and set our ambitions for the next 3 years, including areas we wish to improve even further, as well as setting new priority areas. It focuses on four main areas, with patient experience at the heart.

This strategy is shaped by:
- Working with our staff and patient representatives
- Our current work with the Virginia Mason Institute and partner organisations
- Our collaborative quality improvement work, supported by partners, including the Improvement Academy

Quality Improvement Framework 2018/19

[Diagram shows various elements including Evidence Based, Innovation, Learning, Leadership, Harm free care, Patient Experience, Integrated care with partners, Local Improvement, Local small scale quality improvements, and Leeds Improvement Method Value Streams.]

- Harm free care: Developing a world-class culture of “first do no harm” to deliver the safest healthcare in the UK. This will focus on harm free care in our wards.
- Patient Experience (harm free care): Integrated care focusing on the health and social care of patients with specific conditions.
- Integrated care with partners: Working with partners in health and social care to develop improvements in care for the whole of the pathway of care for patients with specific conditions.
- Leeds Improvement Method Value Streams: A programme known at the Trust as the Leeds Improvement Method. LTHFT is one of only five trusts in the UK to work with the prestigious Virginia Mason Institute on this programme known at the Trust as the Leeds Improvement Method.
2.2.2 Leeds Improvement Method

The Quality Improvement Strategy brings together our existing approaches to improvement; utilising both Lean Methodology and the IHI Model for Improvement, to form the Leeds Improvement Method (LIM). Our underpinning philosophy of LIM is that everyone working at LTHT is empowered to make improvements in their daily work bringing the benefits of a safe, high quality experience, for every patient and member of staff.

The Leeds Improvement Method aims to reduce variation and waste, alongside using small scale tests of change to continuously improve. Quality improvement works best when those involved directly in the work are empowered to make changes and use local measurement to make further improvements.

In LTHT we have already seen the value of using improvement science. Utilising these approaches throughout the organisation will enable LTHT to achieve the ambitions set out in the strategy and become a place where everyone is committed to continually improving the quality of care for our patients.

During 2017/18 we continued to grow, scale up and spread implementation of the Leeds Improvement Method, working with the prestigious Virginia Mason Institute.

Our education, training and development programme, which has been fully integrated into our Leadership programmes and the core induction programme for all staff, has engaged with over 4,500 staff in the use of the method.

to date. We have also invested in developing 250 leaders with more specialised skills in the use of the management method, known here as Lean for Leaders. This course runs over 12 months, builds on the Leeds Way values, and represents an intense immersion in the philosophy, method and behaviour required of an operational leader here at Leeds. This competence has been embedded in the job descriptions for all core operational (Clinical and Non Clinical) leadership roles, reflecting the importance of this work here at Leeds.

The patient experience and quality teams have been working together to deliver a series of workshops entitled ‘Making Quality Count’. The aim of these is to engage patients and families in quality improvement activities in the trust. Leading the work has been a representative from patient experience; a quality/clinical perspective and also two lay patient representatives.

Together the group has designed a process by which clinical teams and patients develop the skills and knowledge to take part in/lead QI projects facilitating staff and patients working together to achieve a truly patient centred improvement. We also invite patients, carers and their families to attend and be skilled up in QI via our LTHT QI training programme alongside staff.

We have trained over 250 staff members in QI methodology, approximately 50 patients have attended the ‘Making Quality Counts’ sessions and so far six patients have completed the full QI training sessions, with more on the waiting list to attend.

LIM Underpinning the Leeds Way
Part 3: Review of Quality Programme

3.1 Leeds Improvement Method Value Streams

Five work areas launched in 2016/2017, known as Value Streams, continue to embed the use of the Leeds Improvement Method to create positive step changes in safety, quality and experience for their patients.

Key Achievements for 2017/18

Elective Orthopaedic - Total Hip and Knee Replacement

Discharging Transurethral Resection of the Prostate (TURPs) Patients
Critical Care and Neurosciences working collaboratively to improve patient care as patients move from Critical Care wards to Neurosciences wards

A reduction in set up time for an eDan from 29 minutes to just 6 minutes where systems have been populated with information by clinicians at the time rather than retrospectively.

Creating visibility of information

Using systems to drive daily work

Reducing time to make decisions

Starting the first patient on time at 8am

Ophthalmology and Outpatients services working collaboratively to improve patient experience during an Ophthalmology Outpatient Appointment

Setting up effectively for our patients.

Replenishing stock in flow

Check in patients in flow

Learning to use our technology to its optimum.
**Emergency and Specialty Medicine – Time to First Consultant Review**

**Aims for 2018/19**

We will be continuing to scale up and spread this work across the Trust through the further development of our Lean for Leaders programme. This will be underpinned by continuing the development of the education and training curriculum, particularly focussing on practical work with the tools and techniques and coaching staff to work effectively with them.

In April 2018 we are confident that we will gain formal accreditation from Virginia Mason Institute demonstrating our continued discipline in maintaining the integrity of the method.

We are increasing the size of our Kaizen Promotion Office (KPO), the team who deliver this work in the Trust in recognition of our progress so far and our need to scale up and spread.
3.2 Patient Safety

3.2.1 Acute Kidney Injury (AKI)

Background
Acute Kidney Injury (AKI) is a major cause of harm, with half a million people sustaining AKI in England every year. It has a major impact on patients, including increased length of stay in hospital, the risk of progression into chronic kidney disease, and an increased risk of dying. It is estimated that AKI could be preventable in 20-30% of cases, so making improvements in the detection and treatment of AKI can make a big difference for our patients.

LTHT was part of a Health Foundation ‘Scaling up Improvement Programme’ in 2016. The STOP AKI care bundle was introduced to improve the care of patients with AKI by increasing awareness, education and management of this cohort of patients.

Key Achievements in 2017/18
- An AKI alert is now visible on all wards within the Trust, allowing staff from all areas to complete the care bundle when the patient is identified as having AKI.
- AKI status now links from the eWhiteboard to eObservations to alert staff of the requirement to complete an AKI assessment or follow policy related to the patient’s current AKI status.
- The AKI staging and advice regarding on going care is now automatically populated in the Electronic Discharge Advice Notice (EDAN).
- Management of hydration and in particular patients with AKI is now a part of monthly Ward Healthcheck audits
- Patient information leaflets have been developed in different formats to increase patient awareness.

Aim for 2018/19
Our ambition is to continue to support the on-going use of the electronic alert. Education and training will be a key focus in 2018/19 to ensure that all staff are aware of AKI diagnoses and management, and the importance of including information on the EDAN; this will ensure continuity of care and treatment throughout the patient pathway.
3.2.2 Improvement in the Care of Patients with Sepsis

Background
Sepsis is a life-threatening condition that arises when the body's response to an infection causes it to attack its own tissues and organs. There are around 260,000 cases of Sepsis each year in the UK; recognising the signs early and treating without delay is crucial. LTHT is committed to ensuring Sepsis is identified and treated promptly. We are focusing on a number of measures and processes to reduce the burden and devastating impact Sepsis can have.

Trust staff continue to use the successful BUFALO sepsis intervention bundle and, particularly during 2017/18, focus has been on ensuring early identification of sepsis via screening and prompt administration of antibiotics. These are crucial aspects of sepsis management and form part of the national sepsis CQUIN which LTHT has been engaged with since 2016.

Implementation of our adult sepsis screening tool, both the paper-based and electronic version within the electronic observations (e-obs) system

Implementation of our paper-based paediatric sepsis screening tool

Educational events across the Trust including;
- World Sepsis Day (WSD)
- Providing regular feedback to staff who have been involved in the care of Septic patients

Further roll-out in terms of support and resources to additional wards and departments

Introducing elements of quality improvement (QI) methodology to support our aims including developing the existing sepsis steering group into a wider sepsis collaborative

Survey undertaken focused on the barriers effecting prompt prescribing of antibiotics for sepsis treatment

The use of eObs, eMeds and PPM has revolutionised the way the CQUIN data is collected.

Aims for 2018/19
We will continue our focus on patient safety in relation to Sepsis and continue to align our work with the four national Commissioning for Quality and Innovation Framework (CQUIN) targets.

We will be holding a Stamp out Sepsis (SOS) in May 2018, providing opportunity for healthcare professionals to attend this unique educational event.

Having achieved the 2016/17 CQUIN for Sepsis we will be appointing a Sepsis Nurse is to bolster the capacity of the sepsis team to deliver the roll out across the whole Trust using the Leeds Improvement Method QI methodology and a collaborative approach to this. A key target for this year is to improve time to deliver of antimicrobials to patients with Red Flag Sepsis from the time they trigger a screen on eObs.

Key Achievements in 2017/18
During 2017/18 the LTHT Sepsis Team focused on ensuring safe, high quality, compassionate care, by providing staff with access to a variety of tools and resources to support our sepsis work. These include:-

- Continued use of LTHT's BUFALO treatment bundle including BUFALO bags equipped with all the necessary items to take a sample of blood for culture testing
3.2.3 Deteriorating Patients

We want to continue to improve the treatment and care of our patients when they deteriorate on our wards, to ensure they receive safe, timely and effective treatment and care, and better end of life care.

In July 2014 we started a collaborative with 14 wards trialling small scale tests of change, to reduce avoidable deterioration. Following testing, an intervention bundle of the most successful changes (including escalation of care stickers, and a brief guide for staff recording observations) was created, and tested across all pilot wards, before beginning to scale up to other Trust areas.

Achievements in 2017/18

- In 2017/18 we scaled up the intervention bundle further, to Trauma and Related Services, Neurosciences, Womens CSU, and Head and Neck CSU.
- We have seen a 25% reduction in cardiac arrest calls across LTHT and 32% at SJUH.
- The rate of cardiac arrests per 1000 admissions at SJUH is now 25% lower than the national average.
- Trust wide we have had 31% less cardiac arrests than 2015 (108 people), and 7% (19 people) less than 2016.

Aims for 2018/19

In 2018/19 we aim to complete scale up across the Trust, support adaptation of interventions in non ward areas and develop new innovations to strive towards a goal of a 50% reduction in cardiac arrest calls across the Trust.
Throughout the year, CSUs have worked to reduce falls. Oncology CSU held a falls awareness week for staff to attend looking at all aspects of falls prevention and seeking innovative ideas to pilot. Abdominal Medicine & Surgery CSU have focused on improving compliance with falls prevention training. Despite continued operational pressures, monthly variations of falls incidences represent natural variation.

Leeds Teaching Hospitals participated in the Royal College of Physicians Inpatient Falls Audit in 2017. Areas of good practice highlighted included, being good at ensuring that call bells were within reach of patients and continence care plans were used widely.

**Aim for 2018/19**
Our ambition is to:

- Achieve a 10% reduction in the number of patient falls
- Achieve 90% compliance with staff training - aided by the falls prevention e-learning package.
- Embed use of delirium assessments and care plans.
- Pilot a visual assessment tool from the Royal College of Physicians.

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### 3.2.4 Reducing Patient Falls

**Background**
Falls are the most common cause of injury in a hospital and result in both psychological and physical harm including: bleeding, fractures or even death in vulnerable patients. Falls have an annual cost to the National Health Service (NHS) of £2.3 billion, with an average cost of £2,600 per fall.

**Key Achievements in 2017/18**
There has been a sustained reduction in all falls and falls with harm as measured by the monthly prevalence audit as part of the Safety Thermometer.

Since April 2017 falls with harm have seen a statistically significant reduction of 62% with the mean recalculated from 0.39% to 0.15%.

Following the success of the quality improvement collaborative, which saw 14 pilot wards reduce falls per 1000 bed days by 53%, this work has been handed back to CSUs to continue and own.
3.2.5 Safety Huddles

Background
In partnership with Yorkshire and Humber Improvement Academy and supported by a grant from The Health Foundation we have established ‘Safety Huddles’ across our wards. Leeds Teaching Hospitals and is one of four hospitals scaling up Safety Huddles between 2015 and 2017.

Safety Huddles are team meetings, which take place at a regular time each day for 5 to 15 minutes, and involve all members of the team. Team members can confidently speak up and jointly act on any safety concerns they have, allowing wards to continually learn and improve, as well as to celebrate success. Safety Huddles are focused on one or more agreed patient harms (identified by the team) such as falls, pressure ulcers, or avoidable deterioration, and ownership of ward data is a crucial part of the huddle, for example, monitoring days between falls etc.

Key Achievements in 2017/18
- So far, 91% wards in Leeds are huddling and 45% wards have achieved a statistically significant reduction in patient safety incidents e.g. falls
- We are now seeing the Trust-wide impact of safety huddles, with a significant reduction in cardiac arrests of 25% and a 30% reduction in falls
- Staff surveys have shown that Safety Huddles have led to a positive shift in teamwork and safety culture

The Portering Team at SJUH have established their own Safety Huddles, which have improved inter-departmental working, patient experience and staff satisfaction. As a result, Porter Paul Tobin has won the prestigious award ‘UK Operational Support worker of the Year’ for his work establishing the portering huddles.

- We have showcased work at national conferences and were shortlisted for the Royal College of Physicians Excellence in Patient Safety Award 2017.

Example of a Safety Huddle

Aim for 2018/19
Our ambitions are;
- To provide continued support to all wards huddling; to both sustain huddles and achieve a step reduction in their chosen harm area.
- To continue to support any ward who wishes to start huddles with light touch coaching.
3.2.6 Reducing Pressure Ulcers

Background
It is estimated that 80-95% of all pressure ulcers are avoidable. Pressure ulcers are painful, may lead to chronic wound development and can have a significant impact on a patient’s recovery, their quality of life, as well as increase length of hospital stay.

Our aim is to reduce all avoidable pressure ulcers by 10% through the adoption of the SSKIN framework. This has been widely tested and implemented in a range of acute hospitals and community settings across England, Wales and Scotland.

Key Achievements in 2017/18
- Rollout of the SSKIN Bundle across LTHT for adult services following the successful pilot within a number of CSU’s, in July 2017.
- Launch of the Pressure Ulcer Collaborative on International “Stop the Pressure Day” in November 2017.
- Achievement of a 43% reduction in avoidable pressure ulcers on pilot wards
- Streamlining of the Tissue Viability triage system which has reduced the amount of time spent on patient allocation and more time on patient visits.
- Development and launch of SSKIN weeks for individual CSUs and wards. These have been a proactive way of encouraging wards and CSUs to actively participate in improving pressure ulcer awareness and promote SSKIN in their clinical areas.

Monthly variation in pressure ulcer numbers continues, representing natural variation. The focus on data cleansing, launch of the PU collaborative and the implementation of SSKIN has had a positive impact on the number of incidences reported over recent months. Harm from category 3 pressure ulcers has reduced by 8%. Early re-categorisation of un-gradable pressure ulcers may have contributed to this reduction in severe harm through prompt investigation and learning from incidents.
Aim for 2018/19
Our ambition for 2018/19 is to:

- Reduce all avoidable hospital acquired Pressure Ulcers by 35% in pilot ward areas.
- Scale up the Pressure Ulcer Collaborative initiatives across other wards in the Trust in order to achieve and sustain further reductions in the number of hospital acquired PUs Trust wide.
- Implement an adapted SSKIN bundle across Maternity and Paediatric services.
- Promote Cross-City working with partners in Leeds Community with the re-launch of regular Cross-City meetings.
- Our ambition is to have no category 4 avoidable hospital acquired pressure ulcers and no more than two category 3 avoidable hospital acquired pressure per month as part of a longer term reduction programme.
- Implement a Pressure Ulcer Steering Group to oversee improvement work across the Trust in all CSUs and help in sharing not only lessons learnt from the RCA process and outcomes of Panel meetings but also to spread good practice.

3.2.7 Improving Care for Patients with Parkinson’s

Background
There are approximately 1500 patients with Parkinson’s in the Leeds area, and around 30-40 inpatients in the Trust with Parkinson’s at any time. In 2016, following feedback from patients and carers, we formed our Parkinson’s Quality Improvement Collaborative. Carers and people with Parkinson’s are active members of this collaborative group as well as a multidisciplinary team of staff members.

Ideas for improvement were developed and tested by teams in pilot areas. Our aim is that all people with Parkinson’s receive timely administration of medication and holistic care. The three primary drivers identified to achieve this are:

- Identifying and promptly administering Parkinson’s medications
- Improving culture, teamwork, and accountability
- Identifying and promptly managing patients with swallowing difficulties

Parkinson’s Medications Omitted in 24 Hours, January 2016 - November 2017
**Key Achievements in 2017/18**

By working with patients and carers, we have created a bundle of the successful interventions tested in pilot areas, and initiated scale-up to all adult wards within the Trust.

By raising awareness of the need for timely administration of medication and the role every team member can play, we have seen a reduction in omitted Parkinson’s medications from 15% to less than 4%. There has also been a reduction in the delay in patients receiving their first dose of medication after admission from over 7 hours to 67 minutes.

We have also:

- Established a bi-annual educational Masterclass and educational video for hospital and community-based staff

- Conducted a Patient Experience event with patients and carers to discuss patient-centred approaches to medication administration

- Supported carers and staff members to present our work at regional, national and international conferences, and been shortlisted for the 2018 Parkinson’s Excellence Network Award for Excellence in Parkinson’s Care

- Initiated spread of our work to other Trusts within Yorkshire and the North East

**Aim for 2018/19**

We aim to have completed the scale-up of our interventions to all adult areas within the Trust by August 2018, so all of our patients receive high-quality and safe care as inpatients. We aim to further involve our patients and carers and to pilot novel interventions for self-medication administration in 2018/19.
3.2.8 Maternity Care - Reduction in Harm

Work continues to align the national maternity safety campaign with local implementation through the development of quality improvement schemes and the national maternity Better Births strategy locally.

National Maternal and Neonatal Health Safety Collaborative

In 2017 LTHT was successful in its application to be included within wave 1 of the 3 year programme, to improve safety and quality.

Selection of the four topics of focus: reduction in smoking in pregnancy; improving delays in the induction of labour pathway; learning from excellence, and improving the homebirth referral rate, have been developed using Quality Improvement theory and methodology.

A safety culture survey has been conducted on both delivery suites as part of the collaborative work.

Obstetric Anal Sphincter Injury

The use of clinical dashboards had informed the Women's CSU of being an outlier for 3rd and 4th degree perineal tears. Significant multi-disciplinary work using quality improvement methodology to define areas to focus on, have led to reducing the number of tears by 75%. This work will continue in 2018/19 to ensure it is embedded in all practice.

Stillbirth / Neonatal Deaths

LTHT has seen a reduction in the stillbirth rate by 24.6%. This aligns with the national ambition to reduce stillbirth by 20% by 2020 and 50% by 2030, with regional recommendations for stillbirth review. LTHT have been involved in the piloting of the new MBRRACE national Perinatal Mortality Review Tool (due to be launched late 2018).

LTHT have also been accepted into the second wave of The National Bereavement Care Pathway (NBCP) pilot sites.

In September 2017 LTHT introduced the offer for all women who book to have their baby in Leeds access to Baby Box, which is a platform of educational content for maternity care in Leeds. Women receive a baby box on completion of a short programme which reinforces safe sleep principles.

Development of Elective Caesarean Section Surgical Lists

Both maternity units have been involved in piloting the effectiveness of using identified operating days for elective Caesarean sections. This early work has achieved excellent feedback from clinical teams and most importantly from the women and their families.

Local Maternity Strategy Implementation

Work continues with identifying, developing, and implementing areas of the local maternity strategy which aligns with the national Better Births agenda. Personalisation of service provision remains high on the agenda and working alongside our service users to co-design and produce service models which are effective and sustainable.

Introduction of Birth-rate+ (Workforce Planning Acuity Tool)

We recognise the importance of having the right staff in the right place at the right time. Birth-rate + is the only recognised midwifery workforce planning tool, and has been commissioned for implementation on both delivery suites, followed by roll out to other areas to ensure our patient acuity is matched in need to workforce.

Local Maternity System’s (LMS)

The West Yorkshire and Harrogate LMS is a programme of work which has been set up to make sure all women, their babies and their families receive the care they choose and need, before and after having a baby, as close to home as possible. LTHT are working with colleagues across West Yorkshire and Harrogate to develop a plan that will improve care over the next 5 years and beyond. Information is available at www.wyhpartnership.co.uk
### 3.2.9 Quality Improvement in Surgical Teams

In 2018 LTHT became one of 40 NHS organisations taking part in the Quality Improvement in Surgical Teams (QIST) Patient Safety Collaborative, which aims to improve the quality of care delivered to patients requiring joint replacement surgery, by 2020. The programme is funded by Northumbria Healthcare NHS Foundation Trust, the British Orthopaedic Association, and NHS Improvement.

The collaborative will focus on two main areas;
- Reducing anaemia related transfusion, critical care, length of stay and readmission rates
- Reducing surgical site MSSA related infections

The programme will use a breakthrough serious collaborative model, and the first of seven learning events will take place in May 2018.

### 3.2.10 Reducing Rates of Healthcare Associated Infections (HCAI)

The reduction of HCAI remains a key priority for the Trust, and this is reflected in the key objectives achieved in 2017/18:
- Development of an HCAI Trust-wide Collaborative, supported by a Faculty
- Launching an expanded approach to offering MRSA decolonisation for our “at-risk” patients
- Employing the Leeds Improvement Method to modify the CDI nurse role to attend safety huddles and provide greater education in ward areas
- Utilising social media such as Twitter to run a CDI campaign

#### MRSA

The national ‘Zero Tolerance’ approach to MRSA bacteraemia remains in place and we are firmly committed to achieving this. There will continue to be an emphasis on the interventions that have been shown to work in preventing any / all HCAIs. The days between MRSA bacteraemia graph below shows early indication that we are extending the days between cases.

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**MRSA**

There is now a “national ambition” to reduce healthcare associated bloodstream infections with certain Gram-negative bacteria, namely *Escherichia coli*, *Klebsiella* species and *Pseudomonas aeruginosa*, by 50% by March 2021; with the initial focus on a 10% reduction of *E coli* bacteraemia, across the whole health economy, in 2017-8. These challenging goals are mirrored in the agreed aims of our local HCAI Collaborative. The primary drivers to achieve this are in Figure 12. Members of the Faculty have been meeting fortnightly to review progress and share the results of the “small tests of change” that have been trialled in specific ward areas. Our second “Big Learning Event” will be happening in Spring 2018 where we will be able to share the results more widely, and recruit new areas to try the strategies that have worked.

The IPC leadership team have participated in the Lean for Leaders programme. To further build on the safety culture we have trained all our IPCN and administrative team in lean methodology: one of our projects enabled us to reduce the time taken for staff to undertake mandatory and priority IPC training thus freeing up time for patient care.

### HCAI Driver Diagram

**Aim**

To reduce avoidable LTHT bloodstream infections by 75% by the end of 2018, and by 100% by the end of 2020.

**Primary Drivers**

- “A device (catheter, drain, etc) is everybody’s business at LTHT”
- Culture, teamwork, and accountability: staff, patients, and carers
- Getting the basics right. Identify the risks and act on them.

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**Clinical teams from Oncology celebrating over 3 years since MRSA BSI and 4 months since MSSA BSI**
CDI

The Trust’s nationally-set CDI objective for 2017-18 was the same as in 2016-17, as for all acute trusts in England, which for LTHT was 119. However, our ambition remains to prevent any potentially avoidable cases. We continue with a post-infection review process whereby local commissioners can agree that there were no significant lapses in care during a patient’s pathway in LTHT, and we aim to further increase the proportion of these. A CDI Twitter Campaign was launched to share lessons learnt from root cause analysis investigations.

CDI Cases per 100,000 bed days
2016/17 vs 2017/18

<table>
<thead>
<tr>
<th></th>
<th>LTHT</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>21.82</td>
<td>14.01</td>
</tr>
<tr>
<td>2017/18</td>
<td>23.04</td>
<td>14.84</td>
</tr>
</tbody>
</table>

CDI Rate 100,000 bed days

Days Between MRSA Bacteraemia Cases
The rising prevalence of pathogenic bacteria with the ability to resist multiple different classes of antibiotics is a well-recognised global phenomenon. We need to continue to protect the therapies that we have now so that they will continue to be effective for our future patients. This means that we need to ensure patients receive the most appropriate antibiotic for their clinical condition at the time - i.e. not only starting smart but also that we then focus subsequently. The national CQUIN for Severe Infections in 2017-18, promotes a judicious approach to antibiotic use and we are confident that we will achieve the reductions required.

We also remain watchful for any unanticipated or novel infections emerging in our global village in 2017-18, such as Ebola and Zika viruses in recent years. In the autumn of 2017, measles was circulating in Leeds, as it was in some other English cities, in association with a rise in cases in some other European countries. LTHT IPC team worked closely with the Children’s CSU and others, to prevent onward transmission of this highly contagious infection within LTHT; as well as being closely involved in the successful city-wide campaign to control it.

Antimicrobial Stewardship

Antimicrobial Stewardship is what we are doing to improve the use of antibiotics to treat patients with infections without causing them harm or contributing to the problem of developing resistance to current antibiotics.

In 2017/18, we have focused on reducing potential patient harm this year by:

- Changing from vancomycin (our most commonly used intravenous antibiotic for patients with penicillin allergy) to teicoplanin, which will reduce kidney injury.
- Working with CSUs to improve the review of the antibiotics given within the first three days, to reduce harm from healthcare acquired infections like Clostridium difficile, and to reduce the time patients stay in hospital from extended intravenous antibiotic use.
- Developing a reporting tool to identify which patients are on IV antibiotics within the hospital to help doctors and infection experts to ensure patients receive the safest treatment.

Ensuring the equipment we use on our patients and the environments we work in, are safe and free of infection is also of paramount importance. This year, in conjunction with our Estates colleagues, we are introducing a new specific IT system to record, report and monitor the results we obtain from relevant water samples.
Throughout the year we have also been managing severe antibiotic shortages. Nearly all infection treatment guidance has been revised based on available antibiotics, and our electronic prescribing system that is being rolled out across the Trust has also been updated.

The targets we have been set for 2018/19 are:

- Zero “avoidable” MRSA bacteraemias
- No more than 118 cases of CDI.
- There is now a “national ambition” to reduce healthcare associated bloodstream infections with certain Gram-negative bacteria, namely *Escherichia coli* (E. coli), Klebsiella species and *Pseudomonas aeruginosa*, by 50% by March 2021.

**Aims for 2018/19**

- Participate in the NHS England and NHS Improvement urinary tract collaborative for systems wide improvement, focusing on interventions to reduce healthcare associated UTIs.
- We will identify the successful HCAI interventions from the tests of change completed by the HCAI collaborative, and those ideas will be used to formulate a HCAI care bundle.

The challenge is to deliver this continuous improvement, whist ensuring that the actions already implemented to achieve the tremendous overall reductions witnessed to date are sustained.

### 3.2.11 Medications without Harm

**Comparing safe medication practice in our Trust to other hospitals**

The most recent nationally available figures show our Trust in a favourable position with regard to our peers. The distribution of Medication Related Incidents causing harm among all Trusts nationally to March 2017 is shown below. LTHT is in black and our peers are in grey.

We encourage our staff to report all incidents involving medicines so we can continue to investigate and share learning to minimise harm.
3.2.12 Reducing Harm from Preventable Venous Thromboembolism (VTE)

Venous thromboembolism (VTE) or blood clots can be caused by being in hospital, so reducing the risk of these occurring is an important part of patient care. Assessing adult patients on admission to hospital for their risk of developing blood clots, or their risk of bleeding, helps us decide how best to care for each patient.

Key Achievements in 2017/18

The VTE Prevention Team has worked with the clinical teams to improve VTE assessment rates. They also worked with the electronic prescribing team to develop an alert which reminds doctors to complete a risk assessment and appears whenever a clinician tries to prescribe a medicine. This improved completion rates in December 2017 by over 2% to 93.81%, and work is on-going to improve completion rates further. The table below shows the percentage of patients who have had a VTE risk assessment in 2017/18.

In order to learn how we can prevent VTEs we complete investigations into all patients’ care if they developed a VTE during or within 90 days of their hospital admission. We are now collating the details of the investigations and sharing learning with clinical teams.

Aims for 2018/19

Our plans for the coming year are to improve risk assessment rates and achieve the 95% target while ensuring we continue to investigate HATs and feedback learning to clinical staff.

### Percentage of admitted patients risk-assessed for VTE

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting period</th>
<th>Trust performance</th>
<th>National acute average</th>
<th>National acute range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)¹</td>
<td>Q4 2017/18</td>
<td>91.51%</td>
<td>95.18%</td>
<td>67.04% - 100%</td>
</tr>
<tr>
<td></td>
<td>Q3 2017/18</td>
<td>92.23%</td>
<td>95.36%</td>
<td>76.06% - 100%</td>
</tr>
<tr>
<td></td>
<td>Q2 2017/18</td>
<td>94.96%</td>
<td>95.25%</td>
<td>71.88% - 100%</td>
</tr>
<tr>
<td></td>
<td>Q1 2017/18</td>
<td>93.52%</td>
<td>95.20%</td>
<td>51.38% - 100%</td>
</tr>
</tbody>
</table>

¹ Excludes independent sector providers
3.2.13 Preventing Harm from Misplaced Nasogastric Tubes

Feeding through a misplaced nasogastric (NG) feeding tube is defined by NHS England as a Never Event. In 2017/18 we have continued to improve standards and safety for those who require nasogastric tubes for feeding (NGTs).

Radiographers are empowered to highlight any problems they observe and take action, enabling focused training/feedback to be given to individuals or clinical areas.

All incidents related to NG tubes are reviewed every 2 months at the Enteral and Parenteral Guidelines group meeting, with actions taken.

In the most recent NG tube audit, NG care plans were shown to be used for 94% of patients, with pH used first line in the majority of cases (the gold standard method to check safe placement). X-ray was used as the first line check of safe placement in only two cases and both of these with good reason, reflecting the excellent progress that has been made.

3.2.14 NHS Safety Thermometer

The NHS Safety Thermometer Classic provides a ‘temperature check’ on harms associated with falls, pressure ulcers, catheter associated urine infections (CAUTIs) and venous thromboembolism (VTE). Data is collected nationally on one Wednesday every month. Results are published on the NHS safety thermometer website. This gives a snap shot view of patients in the bed base at the time of the audit.

Harm free care performance for LTHT can be seen in the graph below.

Since December 2016, harm free care performance has been reported at greater than 95% for 8 months. Harm free care was reported to be 96% in November and December 2017. The improvements in our performance over time are due to a reduction in all falls, falls with harm and new pressure ulcers categories 2 to 4.

(NB. The upper and lower control limit is calculated at 3 standard deviation points from the mean)
3.2.15 Safeguarding Vulnerable People

The Trust is committed to safeguarding all children, young people and adults at risk of abuse; we believe that everyone has an equal right to protection from abuse, regardless of their age, race, religion, gender, ability, background or sexual identity.

Leeds Teaching Hospitals NHS Trust continues to work to enhance safeguarding practice and standards across the whole organization to safeguard our most vulnerable patients and to continue to develop and embed a culture that puts safeguarding at the centre of care delivery.

Key Achievements in 2017/18

- We have produced our unique safeguarding Trust logo which helps improve practice and supports the wider awareness of safeguarding across the organisation.

- A full review of mandatory safeguarding training was carried out and new training developed: This training commenced in July 2017. Evaluation from the training is positive and equips all staff with the appropriate competences, skills and knowledge required to meet their individual roles.

- In October 2017 as part of West Yorkshire Safeguarding week, Leeds Teaching Hospitals Trust held our own Safeguarding Week. The week had a programme of various awareness raising events, and learning opportunities, across the Trust. Our campaign focused on ‘What Safeguarding Meant to us?’ which involved staff, patients and members of the public.

- Representatives from the Trust attended and contributed on a National Health Panel as part of intelligence gathering for the Independent Inquiry into Child Sexual Abuse (IICSA). LTHT ensures the important messages from the inquiry are cascaded throughout the organisation and to the citizens of Leeds.

- The specialist midwifery teams at LTHT are now reporting information on to the National web platform for Female Genital Mutilation: this ensures that any vulnerable women or girl is not only identified but ensures they are safeguarded.

- 2017/18 has seen the start of the Trust introduction of the National Child Protection Information System (CP-IS) into unscheduled care pathways. This NHS England sponsored nationwide initiative helps clinicians in unscheduled care settings identify vulnerable children. Data relating to children (including unborn children) with a Child Protection Plan (CPP), or with Looked After Status (LAS) is securely transmitted to and stored in CP-IS on the NHS Spine and is presented as a flag indicating the patient is a vulnerable child. By sharing data across regional boundaries, CP-IS helps health and care professionals build a complete picture of a child’s visits to unscheduled care settings, supporting early detection and intervention in cases of potential or actual abuse.
3.2.16 Serious Incidents

We are committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence: weekly meetings are held within the Trust to ensure these conversations take place.

The Trust Board receives a report in public on new serious incidents and the actions taken to reduce the risk. A more detailed discussion on serious incidents, including the lessons learned takes place at the Quality Assurance Committee, led by the Chief Medical Officer: this Committee provides assurance on the follow up of incidents and the implementation of learning, including undertaking more detailed reviews of any areas of concern identified.

We have made some significant changes to the Trust’s incident management system to improve the experience for users in order to encourage more reporting and improve accuracy of the data captured. This allows us to extract useful theme and trend data to support clinical governance initiatives at local and Trust-wide level.

This year has seen an increase in the total number of serious incidents reported over the previous year but remains less than in the two years prior to that. The overall increase is due to more patient fall incidents leading to serious harm.

Number of serious incidents reported

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trust Performance</th>
<th>Average all Acute Hospitals Performance</th>
<th>All Acute Hospitals Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of patient safety incidents (per 1000 bed days)</td>
<td>41.7</td>
<td>42.8</td>
<td>23.47 - 111.69</td>
</tr>
<tr>
<td>Number of patient safety incidents that resulted in severe harm</td>
<td>10</td>
<td>13.4</td>
<td>0 - 92</td>
</tr>
<tr>
<td>Number of patient safety incidents that resulted in death</td>
<td>2</td>
<td>5</td>
<td>0 - 29</td>
</tr>
<tr>
<td>Percentage of patient safety incidents that resulted in severe harm</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.1%-1.5%</td>
</tr>
<tr>
<td>Percentage of patient safety incidents that results in death</td>
<td>0%</td>
<td>0.1%</td>
<td>0%-0.5%</td>
</tr>
</tbody>
</table>
Beyond Incident Reporting

In June 2017 the Risk Management team hosted a patient safety conference at Leeds General Infirmary; ‘Beyond Incident Reporting’. Delegates from a variety of clinical areas and professions at Leeds Teaching Hospitals, and other NHS organisations in Yorkshire, spent the day learning about what happens to information from the incidents that are reported and how we use the information to improve services and care for patients.

LIST (Leeds Incident Support Team)

In 2017/18 we consolidated the introduction of the LIST with further support sessions for buddies to meet and discuss their experiences of helping colleagues involved in serious incidents.

The Leeds Incident Support Team (LIST) is a voluntary group of LTHT staff who have previously been involved in serious incidents. They have made a commitment to be available to talk to other staff who may become involved in a similar type of incident. They will talk through the process of an investigation and answer questions a staff member may have.

Learning from incidents

The Lessons Learned Group, established in 2014/15, continues to increase the effectiveness of learning lessons from serious incidents. Four learning points’ bulletins have been produced Trust-wide during 2017/18 covering various topics including Never Events, VTE prevention and discharge planning. Videos continue to be made by the Clinical Service Units and uploaded onto the Lessons Learned YouTube Channel, with a local production relating to a serious medication error being viewed nearly 3000 times.

The LTHT intranet site has been updated with a Lessons Learned page where all staff can access all the learning points’ bulletins, videos and resources to assist with learning.

The Trust has continued to publish regular safety briefings for staff, called Quality and Safety Matters. These have focused on a series of topics arising from serious incidents and complaints, to highlight the reasons why it is important that these things are managed appropriately and the actions that need to be taken to help reduce the risk. These have been sent to all wards and departments within the Trust to ensure that all staff are aware of these risks and what they need to do about them. The topics below were included in 2017/18:

### Quality and Safety Matters Briefing Topics

<table>
<thead>
<tr>
<th>Positive Identification of patients</th>
<th>Duty of Candour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted use of open systems for injectable medication</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Hospital Associated Venous Thromboembolism (VTE)</td>
<td>Safeguarding Adults and Children</td>
</tr>
<tr>
<td>Safe Removal of Dressings</td>
<td>Safe removal of surgical drains and catheter tubing</td>
</tr>
<tr>
<td>Safe use of sharps</td>
<td>Safe storage of cleaning products</td>
</tr>
<tr>
<td></td>
<td>Care after death</td>
</tr>
</tbody>
</table>

The topics below were included in 2017/18:

- Positive Identification of patients
- Duty of Candour
- Restricted use of open systems for injectable medication
- Sepsis
- Hospital Associated Venous Thromboembolism (VTE)
- Safeguarding Adults and Children
- Safe Removal of Dressings
- Safe removal of surgical drains and catheter tubing
- Safe use of sharps
- Safe storage of cleaning products
- Care after death
**Never Events**

NHS England revised the list of Never Events in 2017/2018, increasing the number from 14 to 16 (although one of the new category types is currently on hold as a defined Never Event).

The Never Events list provides an opportunity for commissioners, working in conjunction with trusts, to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur. Nationally the most commonly reported Never Events relate to retained surgical items, wrong site surgery, and wrong implants.

We have reported six Never Events during 2017/18 under the following categories:

- Retained foreign object x 2
- Wrong site surgery x 2
- Incorrect implant used x 1
- Administration of medical air instead of oxygen x 1,*New category*

All of these Never Events were reviewed with the Trust’s Chief Medical Officer and Chief Nurse and also with our commissioners at Leeds West CCG. They have also been reviewed with the clinical teams to ensure immediate action has been taken to reduce the risk of recurrence, that Duty of Candour regulations have been followed, and that they have been investigated in line with our serious incident procedure.

**Duty of Candour**

The statutory Duty of Candour regulation came into force on 27 November 2014. The Duty of Candour applies to all incidents that result in moderate harm, severe harm and death, using the National Reporting and Learning System (NRLS) categories for incident reporting.

Every week the Risk Management Department monitors the Datix web incident reporting system to ensure that where incidents have led to moderate harm, severe harm or death the Duty of Candour process has been followed, including offering an apology and an explanation that an investigation will be done to help us understand the cause of the incident so that we can learn from this.
3.2.17 Scan 4 Safety

LTHT is one of six demonstrator sites for a programme that utilises standards to associate: patient, product, place and process.

This brings with it significant safety and efficiency benefits including:

• Tracking product use, eg tracking those used for a surgical procedure in an operating theatre.
• Tracking patients in each location they go to in our hospitals, including which bed they are in on which ward.
• Rapid identification of the location of products that have been recalled.
• Recording which staff are involved in procedures.
• Managing stock more efficiently, reducing stock stored and ensuring all stock is in date.
• December 2017 saw the completion of the 2 year programme phase, however, the work will continue to ensure the maximum benefits are realised.

Key achievements this year include:

• Scanning has been introduced into most theatres for high risk or high cost implantable products, to associate product to patient and lead clinician responsible for the procedure

• Scanning at the bedside has been successfully tested in a contained clinical area covering an inpatient ward, radiology suite and theatre. This associates a patient to a location and provides a detailed timeline of their movement within their electronic health record (EHR).
• We met all the milestones associated with the programme and achieved 98.7% compliance in an audit undertaken by the Department of Health & Social Care.
• There have been significant savings in theatre environments due to more robust stock control and management.
• The development of a mobile app that will facilitate point of care data capture direct into the EHR.

Key areas of work this year include:

• Roll out of scanning to all wards, with the mobile app available on mobile devices within the workplace.
• Maximising the potential of scanning at the bedside, opening the EHR, and completing an e-form direct into the electronic record at the bedside with the patient.
• Maximising the potential of scanning to provide robust information relating to patient flow and location.
• Further product capture across all theatres and moving towards capturing lower risk items
• Initiation of the programme across WYAAT

Scan4Safety Standards

[Image of Scan4Safety Standards]

- Right Patient: Setting standards to make sure we always have the right patient and know what product was used with which patient, when.
- Right Product: Setting standards to make sure our staff have what they need, when they need it.
- Right Place: Setting standards to make sure that patients and products are in the right place.
- Right Process: Setting standards and implementing common ways of working to deliver better and more easily repeatable patient care.
3.3 Patient Experience

3.3.1 Priorities

Last year we continued to introduce a consistent approach to the way we listen to patients and the public. We also recognised the importance of asking people to help us with developments that would make a real difference to the experience of our patients and that some of these would take more than a year to achieve. Finally, we aimed to be able to describe the difference listening to the patient and public voice had made to our services. We have outlined later in this section the great work that has taken place this year towards the achievement of these goals.

Our Aims for 2018/19

This year, we will build on last year’s progress and also demonstrate that patients and the public are included in service changes that are planned across the Trust. Consequently, our key areas of focus for 2018/19 are:

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

3.3.2 Using Feedback to Support Trust Development

Background

One of our quality goals last year was to demonstrate patient and public feedback is used to support service and Trust developments, by capturing the resulting changes.

Key Achievements in 2017/18

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

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

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

Patients said: A leaflet should be available for patients going home in the early stages of labour.
What we did: We developed an information leaflet to support women in the early phase of labour to provide information and reassurance for women who choose to go home.

Patients said: When they have been involved in major trauma incidents they often need ongoing support.
What we did: We worked closely with Day One, a third sector organisation which supports major trauma patients, to provide patients with access to further support.

Patients said: It would be nice to have better facilities for relatives who are on wards for long periods.
What we did: On ward J08 a store cupboard was converted into a facility for relatives to make hot drinks and a dedicated visitor shower/toilet has been put in place.

Aims for 2018/19

We will continue encouraging our clinical service units to report and celebrate the great work they are doing with the feedback they receive from patients.
Our second project is focussing on the experience of patients who attend theatre and have anaesthetics. This work began with undertaking a survey with patients called ‘Before and After You Sleep’ which generated much interesting information. On 15 December 2017, the service then held a very successful patient engagement event which was supported by a graphic illustrator and which expanded on the survey feedback. More than 130 suggestions and ideas were generated from this event which are being used to identify quick service improvements as well as to inform the content of potential ‘Always Events’. Some of the findings of the day are illustrated below.

### Aims for 2018/19

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

### 3.3.3 Always Events

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

### Key Achievements in 2017/18

In 2017/18 we began to work with Trust teams to consider their patient feedback and to identify where to focus an ‘Always Event’ project. During the year, two key areas were identified for this support and both projects are progressing.

The first project is concentrating on improving the patient night time experience on four of our hospital wards. To identify the best way to do this, feedback was sought from 480 patients. A member of the patient experience team also spent time on the wards overnight, to directly experience the environment and contribute to our learning. A number of developments are in the pipeline including an information leaflet for patients, a night time banner to remind staff to be quiet, and comfort packs which provide patients with simple measures to help them sleep, such as eye masks and ear plugs.
3.3.4 What have we done to improve the Experience of Patients

Interpreting Services

In 2017/18 we started working with a new interpreting provider, to provide all face to face and telephone interpreting at the Trust. We worked with them to build a hub of local interpreters which has now been fully operational since August 2017. We have also engaged with the Deaf and Blind Community to ensure they are satisfied the supplier is meeting their needs. Since August 2017, 93.7% of requests for interpreters have been fulfilled. We aim to ensure patients receive the most appropriate access support they need at the right time, and in the right place. We will continue to monitor service provision and check user feedback to ensure our service meets the needs of our patients.

Carers

During 2017/18, we were delighted to receive the ‘Commitment to Carers’ kitemark. This recognised the commitment we had made, as a member of the Leeds Carers Partnership Group, to support Leeds becoming the best city for carers.

Some of our achievements in 2017/18 include; updating our nursing assessment document to ensure carers are better supported when a relative or friend is in hospital, and updating our website to include a Carers page, which provides information about ‘John’s Campaign’, Carers Leeds, and sources of support. We also work closely with Carers Leeds and host two Carers Leeds support workers, who offer practical support to carers of patients with Dementia and carers who require advice on funding additional care. In 2018/19 we will contribute to regional work undertaken by the West Yorkshire and Harrogate (WY&H) Health and Care Partnership, as part of the Sustained Transformation Programme. The aim is to heighten the profile of carers in a more holistic way and to ensure a more consist approach to the way carers are supported across the region.

Think Drink

We know that fasting for longer than is necessary causes unnecessary discomfort and that good hydration can aid recovery and earlier discharge from hospital, so we have been working to improve the experience of patients who are fasting before theatre. Guidelines say that patients can drink some water for up to two hours before they have a procedure which involves general or regional anaesthetic. We launched a campaign in March 2018 to raise awareness amongst staff and to encourage all areas to adopt this new practice. We will also be working on helping our patients understand better what they are allowed to do before surgery, so that they know they are able to drink for longer than they might expect to, when they are admitted to our hospital for planned surgery.

Maternity Services - 15 Step Challenge

The “15 Steps Challenge” is a suite of toolkits that explore healthcare settings through the eyes of patients and relatives, in order to improve their experience. In January 2018, the Trust Maternity Services held a big improvement event using the “15 Steps Challenge, and suggestions from the event included improved signage, updated notice boards, and a more comfortable environment. The service aims to use this feedback to make positive changes, and they will use the comments
to influence meetings that are taking place to agree strategic service changes and redesign. Because the exercise was so useful, we plan to repeat it on a regular basis at both maternity sites across the city, and to feed the findings into senior meetings to bring about change.

**The Power of Patients**

We discovered, by looking at our data, that the Trust performs a high number of tests, like scans and x-rays, when compared to other teaching hospital Trusts, so we decided to explore why this was, and what patients would think about a change in scanning rates, if that was to happen. Patient feedback was collected and shared with clinicians who manage patients with certain conditions. Doctors responded positively to receiving this feedback and are now working on the following:

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

The doctors involved in this work also aim to share this approach with others so that it can be used to support changes in other parts of the Trust.

**Other Examples**

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

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**Sit Up, Get Dressed, Keep Moving**

We know that wearing nightwear in hospital reinforces a ‘sick role’ and that prolonged stays in bed, particularly for older and frail adults can result in serious deteriorations in their health in a short space of time. This can make it difficult for people to get back on their feet and makes it harder for them to get home as quickly as they would like to after they have been ill. This year, we joined a national campaign which aims to raise awareness of the importance of wearing clothes during the day and keeping as active as possible whilst in hospital, as this enhances their well-being and self-esteem, and promotes dignity, independence, normality, and can aid recovery and a quicker discharge home. Patients have reported that this makes them feel better and more like themselves. Winifred, who was 102 years of age, told us that you are never too old to get dressed.

**Matron, General Medicine with our Patient Representative for the Sit Up, Get Dressed, Keep Moving Campaign**

We would like our hospital to become a place where it is normal to see patients on our wards in their own clothes, and are actively raising awareness with patients and families so they help in supporting the campaign. We know that some patients will not have anyone who is able to support them to do this, and we are exploring ways in which we can offer items of clothing to patients who would like to get dressed and don’t have this help available.
outpatient environments. The database was also used to gather feedback on the content of an End of Life Care booklet and the content of the Trust Complaints Policy.

### 3.3.5 Positive Engagement with our Service Users

#### Patient Information

The Trust holds a Patient Information Forum every three months, made up of Trust staff and patient representatives, to improve internal processes for developing and managing patient information at the Trust. Over the last year we have tested a new piece of software which will allow the Trust to offer published patient information leaflets in up to 90 languages, and we aim to roll this out in the coming year. We have also published over 250 leaflets on our Trust website, and begun rolling out an improvement document management system to allow for better management and availability of patient information.

#### New Multi-Cultural Menu

Some of our patients who have specific religious or cultural requirements had told us that the multi-cultural menu we provided could be better, so in August 2017 we asked members of local faith communities to sample available products to decide what should be on the menu. We have updated our menus based on this, and a large number of positive comments have been received. In future, we aim to ensure that all of our patients are aware of the full range of menus available, as some patients have also told us that they didn’t know about all the different menus we provide.

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### Trans Day of Remembrance

In November 2016 we hosted our first Trans-Day of Remembrance event and invited local partner organisations to this. Following this, we worked with local trans-groups to improve and make the event more accessible. This year’s event, in November 2017, was a success and was attended by more than 80 people: it included artwork produced in conjunction with Leeds College of Art.

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### Teaching Future Nurses about Patient Experience

Nursing students have traditionally undertaken placements in clinical areas as part of their training. The Trust Patient Experience Team support a number of key Trust functions that students usually have little training on before they qualify as nurses. In 2017, the Team began to take University of Leeds Nursing Students for two-week placements, in order to provide experience in a number of different departments, such as, Complaints and the Friends and Family Team, Bereavement Services, Volunteering Services, PALS, the Interpreting Team and the Patient, Carer, and Public Involvement Team. In each of these areas they gain knowledge that they can take back to their clinical practice to improve the care they deliver to our patients in the future.
Working with Healthwatch

During 2017/18, we continued to work in partnership with Healthwatch Leeds to plan good ways to seek the views of patients and the public from across Leeds to understand the issues that matter most to patients. This has helped the Outpatient Management Team to plan the improvements such as the upgrade of the Self-Check-In machines, which many patients reported problems and frustrations with.

In February 2018, the Trust also took part in a Leeds-wide workshop, facilitated by Healthwatch, aiming to bring organisations together from across the city to seek the views of patients and the public on a number of different topics. Some of the findings have resulted in the Trust to undertaking longer term projects to improve experiences which are underway.

Engaging with Our Members

The Trust now has over 25,930 members. Over the past year our members have played an important role in the following;

- Developing ‘Always Events’, which have been supported by hearing feedback about the experience of spending time here as a patient
- Sharing views on a proposal to remove payphones from outpatient environments
- Providing feedback on an End of Life Care booklet that supports people to understand the choices available to them at this difficult time
- Providing views on the content of the Trust Complaints policy
- A workshop in February 2018, where Trust plans for a new healthcare building were described.

Looking forward, in February 2018 contact was made with members, asking for their support in the following areas:

- Seeking feedback on the content of the Patient Safety Boards on display in Trust wards and departments.
- Seeking feedback on a proposed cancer pathway
- Seeking patients’ thoughts about researchers having access to information about them, in order to improve wider community health.

Our members are kept informed via two issues of our member magazine per year, called Connect, which provides information on Trust developments and Patient and Public Involvement activities, LTHT Membership events known as ‘Medicine for Members’, of which there were 10 sessions in 2017, and direct contact made via our membership database. They are also able to provide feedback via surveys throughout the year.

3.3.6 National Patient Surveys

The Trust takes part in a number of National Patient Surveys which gives us valuable feedback, and allows us to see whether actions we have put in place in response to previous surveys are having the desired effect and improving our services.

Children and Young Peoples Survey

We take part in the Children and Young People’s Inpatient and Day Case Survey every other year. In the 2014 Survey we scored less well than we would have liked for a number of questions relating to the way we communicate with the parents of our patients. As a result of this feedback we developed an action plan which would help us make the care we give children more family centred. The 2016 survey demonstrated that we had significantly improved on our 2014 survey results for these questions. LTHT also scored significantly better than 70 comparator Trusts for 24 questions resulting in us being the 4th most improved Trust in 2016.

Some of the actions we have taken as a result of the 2016 survey are:

- Working with Charitable Trustees to access funding to improve the parents accommodation on L42
- Improving patient information leaflets for surgical patients (including simplified fasting instructions)
- Working with Clinical Nurse Specialist Teams to ensure patient information is available and accessible in electronic format
- Delivering Motivational Interviewing Training for staff (in response to feedback about the way doctors nurses communicate with young people).
3.3.7 Complaints

In 2017/18, we have continued to work with clinical areas to both reduce the number of complaints received and reduce the length of time we take to formally respond to complainants either in writing or by meeting.

### Number of complaints received (cumulative)

- **2016/17**: 800 complaints
- **2017/18**: 700 complaints

### Number of complaints reopened (cumulative)

- **2016/17**: 100 complaints
- **2017/18**: 90 complaints

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**National Cancer Patient Experience Survey 2016**

The 2016 National Cancer Patient Experience Survey was published in July 2017 and sampled adult patients undergoing cancer treatment as inpatients or day cases between April and June 2016. LTHT scored better than the expected range for 11 questions, worse for only 1. We also improved our performance significantly against our 2015 survey for 2 questions. There were no questions in the survey for which we performed significantly worse. The Trust was ranked 17 out of 147 Trusts in the country and was the 10th most improved Trust of 147 Trusts.

Key actions we have taken following the survey include:

- New patient information packs to help provide the right information at the right time for patients
- Inclusion of information in all clinic letters explaining that patients are able to bring a relative or friend to their appointments, this was following a patient saying they weren’t aware they could bring someone
- We have worked with the cancer charity Breast Cancer Now and undertaken a more detailed survey to further understand some of the issues that were raised
- All MDTs have developed an action plan for any area where the results were 5% or more below the national average, and all ward related issues have been shared with the clinical teams and every relevant triumvirate team.
- We will be undertaking a focus group with some of the haematology patients who responded to the survey to more fully understand some of the issues raised in relation to understanding diagnosis and treatment options

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**Key Achievements in 2017/18**

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

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

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

There has been an increase in complaints resolved through recorded meetings at the Trust which have been found to not only speed up the complaints process but also increase the likelihood of complainants being satisfied with their response on their first contact.

We are aware of fewer complainants contacting the Parliamentary Ombudsman than the previous year, which we believe is due to more complainants being satisfied with the Trust’s handling of and resolution of their complaint.

**Aims for 2018/19**

- We will continue to share lessons learned from complaints across the Trust.
- We will offer all complainants the opportunity to feedback about their experience of making a complaint and will ensure this feedback is used to improve our practices.

**3.3.8 PALS**

During 2017/18, the Trust PALS service has seen a decrease in the number of PALS concerns received. We believe that some of the reduction is a response to our ‘Speak to Sister’ initiative which aims to resolve concerns locally before they become more serious and require formal investigation. The graph below compares the number of PALS concerns received in 2016/17, with those received in the same months in 2017/18.

**Key Achievements in 2017/18**

Some of the lessons learned or actions taken in response to PALS concerns are summarised below:

- A patient raised a concern that Switchboard staff were not very helpful and passed him from department to department. Managers played the voice recordings of the call to staff so they could hear what went wrong and then they discussed how the call could have been handled better.

- A patient had an appointment in Bexley Wing. It was her first appointment and she was expecting bad news. She was waiting a long time and this increased her fear and anxiety to the extent that she became tearful and upset. As a result of her feedback the clinic staff now identify first attenders on the clinic list and extra care is taken to track their progress through the department and their well-being. In addition the team are working with the lady concerned to raise some money.
for patient bleepers so that when delays are expected patients can leave the department without fear of missing their ‘slot’.

- In response to a male patient’s concerns about dignity and clothing storage in Radiotherapy the team are providing hangers and lockers and have sourced a different style of gown to be worn whilst undergoing treatment.

**Aims for 2018/19**

We are looking at ways to establish a mechanism to share good practice more widely, something we already do with improvements that have come about in response to patient surveys and FFT data. In 2018/19 we will be providing CSUs with a live PALS ‘dashboard’ which will enable them to identify any recurring themes in a timely manner so they can focus their improvement work on these areas.

**3.3.9 Friends and Family Test**

The Friends and Family Test (FFT) at Leeds Teaching Hospitals is now available in a number of formats, which allow our patients to have more choice in how they provide feedback to us about their experiences at the Trust.

Some of the achievements this year have included the following:

- A higher number of patients providing feedback, and Trust staff being able to use this feedback in a much more useful way.
- The Trust achieved some of its highest ever response rates in 2017 which demonstrates our staff commitment to ensure every patient has the opportunity to give feedback.
- We have successfully rolled out an electronic survey using hand held tablets: this is now available in every adult inpatient ward across the Trust.
- In collaboration with the Trust’s Youth Forum, we have designed new children and young people’s FFT cards – the design was inspired by our young patients and reflect the diverse families across our communities.

- In summer 2017, we ran a FFT workshop with a team from Maternity Services. This generated lots of innovative ideas about how more women could be encouraged to get involved in FFT, and also resulted in the Women’s CSU now having FFT champions.
- Business cards, which include a QR code have now been made available. These allow patients to feedback from the comfort of their own home rather than feeling pressured to complete a survey on discharge.

![Aims for 2018/19](chart.png)

**Friends and Family Test Trust-wide performance April 2017 - March 2018**

- **Aims for 2018/19**
  - We will support clinical service units to use their feedback more openly by developing a Trust wide ‘You said we did’ ethos.
  - We will share best practice resulting from FFT across the Trust
Aims for 2018/19

- To implement a digital advance care planning platform linked to the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) across all adult CSUs, enabling future care plans and wishes to be shared. To progress the MCN transfer of care work, to enable more patients to achieve their preferred place of care and utilise available hospice beds more efficiently.

- To develop bespoke e-learning priority training modules for use across the trust.

- To develop a sustainable model of best practice for bereavement care for LTHT’s families in order to meet the needs of families who require additional support post bereavement.

- To work with all CSUs and the discharge team to promote wider use of the Rapid Discharge Plan (RDP) to improve the transfer of care for patients to their preferred place of care at the end of life.

Members of our End of Life Care Team

Key Achievements in 2017/18

- Streamlined timely transfer of care for patients from LTHT to the Hospices - average reduction of one day from first visit by palliative care to transfer to the hospice.

- CSU improvement plans - led to wards adapting space to make quiet rooms for families to relax in while visiting their dying relatives.

- Updated care of the dying person (adult) documentation launched November 2017 separated into nursing and medical /MDT booklets with updated prescribing guidance.

- Development and recruitment into new bereavement CNS role.

- Secured charitable funding and volunteers to provide comfort care packs for relatives staying with dying patients and decorative cloth bags to hold syringe pumps.

- Successful quality improvement project as part of the National “Building on the Best project”, improving the care of patients experiencing terminal agitation at the end of their lives, improving access to palliative care services for oncology and cardiac out patients.

- Implementation of nurse verification of death to improve the timeliness of verification of death for families.

3.4 Clinical Effectiveness

3.4.1 End of Life Care

End of life care affects everyone and over recent years there has been a shift in ownership/responsibility leading to this aspect of care becoming everyone’s business.

Ensuring that dying patients and their families receive the best possible care remains a priority within LTHT. Our Trust - wide action plan outlines a programme of improvement work aligned to the National Ambitions for Palliative and end of life care (2015 - 2020), Nice quality standards and guidance for end of life care and feedback received, including from the CQC.

By working collaboratively as part of the Leeds citywide Palliative and EoLC Managed Clinical Network (MCN) we are progressing work, across organisational boundaries to our very best to achieve for everyone what we would want for our own families.
Aims for 2018/19

Our aim in 2018/19 is to reduce the number of patients in medicine and elderly wards who have been assessed as being medically fit for discharge who remain in hospital for longer than 21 days by 50%.

3.4.2 Discharge

Improving the quality of discharge of patients remains a key priority of the Trust. 2017 has been another very productive year in continuing the improvement of service. Listed below are some of the highlights:

- Same day discharge via trusted assessment for Re-ablement services delivered by Leeds City Council
- Implementation of the new Community Care beds Strategy for both rehabilitation of patients (intermediate Care) and Discharge to Assess Pathway, including an increase in overall beds capacity.
- Leeds integrated discharge service (LIDS) successful bid from the Better Care Fund for increased funding to expand the team, including Age UK delivered Hospital to Home Service.

The Leeds City Council re-ablement service completed their review and expansion of service so that patients could be assessed by the LIDS team and go home with support the same day. This service, implemented in June 2018, has seen huge success with an average of 50 patients per week discharged via this route. The patients are supported and assessed in their own home, instead of hospital, until they reach independence or longer term care needs are known.

November 2017 saw the launch of the new Community Care beds (CCB) in 7 intermediate care hubs across all regions of the city. Patients can receive rehabilitation therapy closer to home where possible or, if on a discharge to assess pathway, patients have time to recuperate and recover so that their long term care needs can be better assessed and implemented.

LIDS, including Age UK, were successful in bidding for funds to be able to expand the service across all areas of the Trust, including additional capacity opened for winter pressure. This additional resource will ensure that all patients’ discharges can be progressed in a timely way with expert support and advice for patients and their families.
3.4.3 The Perfect Week and Multi-Agency Discharge Event

In response to the sustained bed pressures that Leeds Teaching Hospitals Trust is experiencing, we worked with system partners to hold a Perfect Week on the St James's site, in October 2017. It was perhaps the biggest system wide Leeds Way initiative that has been conducted so far, with over 700 individuals supporting our teams and working collaboratively to improve patient care.

The aim of the Perfect Week was to engage all health and care providers within Leeds with issues affecting patient flow both within and from LTHT, to:

• Improve our understanding of system issues for all partners
• Improve patient and staff experience
• Improve measurements of performance
• Ultimately improve patient flow across the health and care economy

91% of the delays highlighted during the week related to delays in discharging patients who were Medically Optimised For Discharged (MOFD). Collaborative working with system partners was essential in facilitating the resolution of individual patient delays and by the Friday of the week the number of Delayed Transfer of Care Patients within the hospital bed base was at the lowest it had been since August 2017.

Just 5% of escalated delays relate to operational issues within LTHT, including the late completion of e-DANs and Adult Therapy support for patients staying outside their speciality bed base.

Both internally and across the system teams are working to address the issues highlighted during the Perfect Week and improve information sharing and collaborative working across organisations.

Following on from the Perfect Week, which had highlighted significant difficulties in the discharge processes across Leeds, NHS Improvement invited us to host a Multiagency Discharge Event (MADE).

MADE brought together senior clinical and operational staff from the local health system to support improved patient flow, recognise and unblock delays, while challenging, improving and simplifying complex discharge processes in real time.

24 wards across St James's Hospital hosted MADE teams who looked at each patient individually to understand what needed to happen to improve the patient pathway and reduce any delays. The teams, comprised of individuals who worked for Adult Social Care, Leeds Community Care Trust and LTHT, used their collective knowledge and influence within their organisations to expedite milestones within each patient's journey.

Leeds Teaching Hospitals Trust in collaboration with organisations across the health system is working to implement the recommendations from MADE:

• Set out a system strategy to develop a “Homefirst” approach for discharge planning
• To develop Professional Standards ‘system-wide’ that will be monitored. Allowing the system to develop a clear single version of the truth (one list) of what is causing delays in order actions can be prioritised
• Work to agree and implement a “trusted assessor” model for mainstream care homes and community services
• Address unwarranted variation in the delivery of the SAFER patient flow bundle.
3.4.4 Hospital Mortality

There are two national trust-level mortality indicators:

- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the observed number of deaths following admission to the Trust and the expected number of deaths based on the England average, given the characteristics of the patients treated (risk adjusted). It is produced and published quarterly by NHS Digital.

- The Hospital Standardised Mortality Ratio (HSMR), developed and published by Dr Foster, compares the number of observed deaths at the Trust with a modelled (risk adjusted) expected number.

- The HSMR differs from the SHMI in a number of respects, including:
  - The SHMI includes all deaths, while the HSMR includes a basket of 56 diagnoses (around 80% of deaths).
  - The SHMI includes post-discharge deaths (30 day), while the HSMR focuses on in-hospital deaths.
  - The HSMR is adjusted for more factors than the SHMI, most significantly palliative care and social deprivation.
  - The SHMI is expressed as a rate where 1 is the national average; the HSMR is expressed as a rate where 100 is the national average.

The table below shows the Trust's latest published SHMI, for the period July 2016 to June 2017, also shown is the HSMR for the same period. The Trust continues to fall within the 'as expected' banding for both measures.

### Trust SHMI & HSMR Oct 16 - Sept 17

<table>
<thead>
<tr>
<th>Trust level mortality, Oct 16 - Sept 17</th>
<th>Spells</th>
<th>Value</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHMI</td>
<td>128,491</td>
<td>0.9928</td>
<td>4,136</td>
<td>4,166</td>
<td>0.899-1.112</td>
</tr>
<tr>
<td>HSMR</td>
<td>60,317</td>
<td>100.46</td>
<td>2,467</td>
<td>2,456</td>
<td>93.89-106.36</td>
</tr>
</tbody>
</table>

- Higher than expected
- As expected
- Lower than expected
### SHMI Indicator by rolling 12 month reporting period

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Trust Rate</th>
<th>National Average</th>
<th>National Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHMI</td>
<td>Oct 13 to Sep 14</td>
<td>1.04</td>
<td>1.00</td>
<td>0.597 - 1.120</td>
</tr>
<tr>
<td></td>
<td>Jan 14 to Dec 15</td>
<td>1.03</td>
<td>1.00</td>
<td>0.655 - 1.243</td>
</tr>
<tr>
<td></td>
<td>Apr 14 to Mar 15</td>
<td>1.02</td>
<td>1.00</td>
<td>0.670 - 1.243</td>
</tr>
<tr>
<td></td>
<td>Jul 14 to Jun 15</td>
<td>1.01</td>
<td>1.00</td>
<td>0.661 - 1.209</td>
</tr>
<tr>
<td></td>
<td>Oct 14 to Sep 15</td>
<td>1.01</td>
<td>1.00</td>
<td>0.652 - 1.177</td>
</tr>
<tr>
<td></td>
<td>Jan 15 to Dec 15</td>
<td>1.01</td>
<td>1.00</td>
<td>0.669 - 1.173</td>
</tr>
<tr>
<td></td>
<td>Apr 15 to Mar 16</td>
<td>1.02</td>
<td>1.00</td>
<td>0.678 - 1.178</td>
</tr>
<tr>
<td></td>
<td>Jul 15 to Jun 16</td>
<td>1.00</td>
<td>1.00</td>
<td>0.694 - 1.171</td>
</tr>
<tr>
<td></td>
<td>Oct 15 to Sep 16</td>
<td>0.98</td>
<td>1.00</td>
<td>0.690 - 1.164</td>
</tr>
<tr>
<td></td>
<td>Jan 16 to Dec 16</td>
<td>0.98</td>
<td>1.00</td>
<td>0.691 - 1.189</td>
</tr>
<tr>
<td></td>
<td>Apr 16 to Mar 17</td>
<td>0.97</td>
<td>1.00</td>
<td>0.708 - 1.212</td>
</tr>
<tr>
<td></td>
<td>Jul 16 to Jun 17</td>
<td>0.97</td>
<td>1.00</td>
<td>0.726 - 1.228</td>
</tr>
<tr>
<td></td>
<td>Oct 16 to Sep 17</td>
<td>0.99</td>
<td>1.00</td>
<td>0.899 - 1.112</td>
</tr>
</tbody>
</table>

### Trust level SHMI and HSMR (basket of 56 diagnoses) by rolling 12 month reporting period:

The Trust SHMI and HSMR rates have consistently fallen within the expected range.
The Trust uses tools provided by Dr Foster to review more current mortality rates, as the SHMI is published 9 months in arrears. The table below shows the Trust’s most recent HSMR position which remains within the expected range;

### Trust HSMR Feb-17 to Jan-18

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Trust Percentage</th>
<th>National Average</th>
<th>National Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 16 to Sep 17</td>
<td>29.1%</td>
<td>31.5%</td>
<td>11.5% - 59.8%</td>
</tr>
<tr>
<td>Jul 16 to Jun 17</td>
<td>29.9%</td>
<td>31.1%</td>
<td>11.2% - 58.6%</td>
</tr>
<tr>
<td>Apr 16 to Mar 17</td>
<td>29.6%</td>
<td>30.7%</td>
<td>11.1% - 56.9%</td>
</tr>
<tr>
<td>Jan 16 to Dec 16</td>
<td>28.1%</td>
<td>30.1%</td>
<td>7.3% - 55.9%</td>
</tr>
<tr>
<td>Oct 15 to Sep 16</td>
<td>28.2%</td>
<td>29.7%</td>
<td>0.4% - 53.3%</td>
</tr>
<tr>
<td>Jul 15 to Jun 16</td>
<td>26.0%</td>
<td>29.2%</td>
<td>0.6% - 54.8%</td>
</tr>
<tr>
<td>Apr 15 to Mar 16</td>
<td>24.2%</td>
<td>28.5%</td>
<td>0.6% - 54.6%</td>
</tr>
<tr>
<td>Jan 15 to Dec 15</td>
<td>23.6%</td>
<td>27.6%</td>
<td>0.2% - 54.7%</td>
</tr>
<tr>
<td>Oct 14 to Sep 15</td>
<td>22.4%</td>
<td>26.6%</td>
<td>0.2% - 53.5%</td>
</tr>
</tbody>
</table>

For the reporting period October 2016 to September 2017 LTHT had a crude death rate of 29.1% of deaths reported in the SHMI with a palliative care coding. This figure is less than the National average of 31.5%, and within the National range of 11.5% to 59.8%.

### Weekend Care

#### Weekday and Weekend HSMR - Emergency Admissions

<table>
<thead>
<tr>
<th>Trust HSMR - Emergency Admissions Feb-17 to Jan-18</th>
<th>Spells</th>
<th>Value</th>
<th>Observed deaths</th>
<th>Expected deaths</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekday</td>
<td>27,586</td>
<td>99.9</td>
<td>1,754</td>
<td>1,756</td>
<td>95.3 - 104.7</td>
</tr>
<tr>
<td>Weekend</td>
<td>8,762</td>
<td>102.1</td>
<td>600</td>
<td>600</td>
<td>94.1 - 110.6</td>
</tr>
</tbody>
</table>

The table above shows the Trust HSMR for emergency patients split by weekday (Monday - Friday) and weekend (Saturday & Sunday) day of admission; both are within the expected range and there is no significant variation between the two.
Mortality Reporting and Learning from Deaths

National Guidance on Identifying, Reporting, Investigating and Learning from Deaths in Care was published by the National Quality Board in March 2017. LTHT was well placed to move forward with the immediate changes in view of the work overseen by the Mortality Improvement Group over the previous 18 months. We already had specialty mortality review processes in place including discussion at specialty mortality/governance meetings.

The Trust launched an updated Mortality Review Procedure in June 2017. A new screening tool to be used for all adult deaths was launched in June 2017, and Structure Judgement Review (SJR) is being rolled out as the preferred methodology for use by specialties for reviewing cases (Case Record Review - CRR), where appropriate. In the last quarter of 2017/18, the % of adult deaths screened had reached 83%, and 54% of detailed case record review used the SJR methodology.

In line with the national guidance, we have been discussing how we can report on the number of potentially avoidable deaths. This has been an interesting challenge as there is no clear indicator nationally of how this should be determined. We currently have an escalation process from our specialties’ review of deaths, into a weekly Quality Meeting which includes the Deputy Chief Executive and Chief Nurse, and Chief Medical Officer, where there is cause for concern about the care provided. A decision is then made as to whether an ‘incident investigation’ is needed. We are now reporting each quarter on the number of deaths identified through Datix and the mortality review process as requiring a level 2 or serious incident investigation (level 3), as "potentially avoidable".

The collective learning from our clinical specialties is reviewed at our Mortality Improvement Group quarterly. The key themes identified included: communication, VTE prophylaxis; prompt senior review, and early recognition of end of life, in order to enable advanced planning. These issues had previously been identified through other mechanisms within the Trust and are all the subject of existing improvement programmes.

Our mortality data, and learning from deaths, will continue to be overseen by our Mortality Improvement Group, and reported to the Quality Assurance Committee and Trust Board.

<table>
<thead>
<tr>
<th></th>
<th>Number of Deaths</th>
<th>Number Screened**</th>
<th>%</th>
<th>Number Triggered for Case Record Review (CRR)*</th>
<th>% of those Screened that Triggered for CRR</th>
<th>Total Number of CRRs completed (including SJR)</th>
<th>Number of Structured Judgement Reviews</th>
<th>Number of Potentially Avoidable Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18 Q1</td>
<td>655 (201 from June 2017)</td>
<td>8</td>
<td>43%</td>
<td>22</td>
<td>26%</td>
<td>205</td>
<td>89</td>
<td>3*</td>
</tr>
<tr>
<td>2017/18 Q2</td>
<td>684</td>
<td>412</td>
<td>63%</td>
<td>117</td>
<td>28%</td>
<td>200</td>
<td>65</td>
<td>4*</td>
</tr>
<tr>
<td>2017/18 Q3</td>
<td>804</td>
<td>605</td>
<td>78%</td>
<td>200</td>
<td>33%</td>
<td>258</td>
<td>101</td>
<td>5*</td>
</tr>
<tr>
<td>2017/18 Q4</td>
<td>927</td>
<td>758</td>
<td>84%</td>
<td>206</td>
<td>27%</td>
<td>224</td>
<td>120</td>
<td>6*</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3070</td>
<td>1859</td>
<td>73%</td>
<td>545</td>
<td>29%</td>
<td>887</td>
<td>375</td>
<td>18*</td>
</tr>
</tbody>
</table>

* identified through Datix and the mortality review process as requiring a level 2 or serious incident investigation (level 3)

**Using PPM+ screening tool

***% of deaths screened (of those using the PPM+ screening tool since its introduction in June 2017)
### 3.4.5 Readmissions

The Trust performs better than its peers with lower readmission rates following an elective or non-elective admission. Sometimes, after patients are discharged from hospital, they may need to be re-admitted again for a variety of reasons. Some readmissions are unavoidable, such as for patients returning following cancer treatment or for some cases the relevant care in the community may not be available. Nevertheless, it is important that hospitals closely monitor their readmission rates to ensure that these are as low as possible.

**Readmissions to the Trust within 30 days of discharge: elective spells**

The above show monthly re-admission rates for patients who had originally been in hospital for planned care (elective) and those who had originally been in hospital as an emergency (non-elective). The average performance for our peer hospitals is also shown. Our rates are consistently lower than other teaching hospitals for both categories of patients.

**Readmissions to the Trust within 30 days of discharge: non-elective spells**
3.4.6 Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) aim to measure improvement in health following certain elective (planned) operations. These are: hip replacement, knee replacement, groin hernia and varicose vein. Information is derived from questionnaires completed by patients before and after their operation and the difference in responses is used to calculate the ‘health gain’. It is therefore important that patients participate in this process, so that we can learn whether interventions are successful.

Over the last three years we have worked hard to improve our participation rates, the results of which can be seen in the chart below (please note that the 2016/17 data is still provisional; the final signed-off data will not be available until Summer 2018). Trust participation rates for hip and knee replacement are in line with the national average and for varicose vein are well above average. Groin hernia rates are now closer to National levels than in previous years.

PROMs - Pre-Operative Participation Rates - All procedures

Source: NHS Digital; 2016/17 YTD (January) as at August 2017

The following table shows the average Health Gain for each of the PROMs procedures for each of the scoring systems, for both LTHT and the England average; (note that the condition-specific systems are not applicable to certain procedures). Average Health Gain is measured by comparing the results of the pre-operative questionnaire with the post-operative questionnaire. The outcomes show that LTHT is within with the expected range across the various procedures.

Readmissions Audit

In June 2017 LTHT began joint working with the whole health and care economy to better understand the reasons patients were being readmitted to the hospital.

The purpose of the work was both to identify any further improvements for patient care, and to ensure up to date data was used to establish the financial penalty applied to LTHT.

LTHT consultants reviewed all patients readmitted for one week and identified a number of emerging themes.

Joint Clinical Reviews were conducted for a selection of cases from each theme, with staff members from all relevant sectors. These reviews focused on factors that would have avoided the readmission.

Out of a total of 237 readmissions it was jointly agreed that only 30 could have been avoided. Of these 30 it was agreed that 15 could have been avoided by the services within LTHT and 15 could have been avoided by services outside of hospital. Aside from the impact on patients, financially this would mean a reduction of the current annual penalty paid by LTHT from approx. £8.4m to £1.5m.

A number of potential pathway improvements were identified and an action plan for the Health and Care economy has been developed looking at:

- Improving the communication between LTHT and Neighbourhood teams
- Developing a more joined up approach to Palliative Care
- Implementing a Frailty Unit within LTHT
- Improving collaborative working with the Community Respiratory Team
- Improving the support of addiction services with ED
- Improving services for people with mental health needs who present to A&E
- Improving the quality of data recording in LTHT
The Trust has consistently demonstrated compliance with standards 5 and 6, and more recently with standard 8. Progress against standard 2 has also occurred however at the last survey in September 2017 performance was at 75%, below the expected level of 90%. Improvement has been seen across the Trust as a result of heightened awareness of the standards and improved documentation of ward rounds. In local areas, clinical teams have undertaken improvements in the frequency and timings of ward rounds, the clinical processes when patients are admitted to wards, and in prioritising patients for review on ward rounds who are approaching the 14 hour target. We anticipate that as a result of these improvements the Trust will demonstrate compliance with all 4 standards in the April 2018 survey results.

### 3.4.7 Seven Day Service

The Trust has submitted data to the 6 monthly national Seven Day Services Survey since 2015. This has involved assessments against the four core standards:

- **Standard 2:** All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

- **Standard 5:** Hospital inpatients must have scheduled seven-day access to diagnostic services, typically; ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.

- **Standard 6:** Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet relevant specialty guidelines such as critical care and interventional radiology.

- **Standard 8:** All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least daily, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

### PROMS Scores - Casemix-adjusted average Health Gain - April 2016 to March 2017, provisional data

<table>
<thead>
<tr>
<th></th>
<th>EQ-5D Index</th>
<th>EQ VAS</th>
<th>Oxford Hip Score</th>
<th>Oxford Knee Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Replacement Primary</td>
<td>0.42</td>
<td>11.66</td>
<td>21.37</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>England Average</strong></td>
<td>0.44</td>
<td>13.43</td>
<td>21.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Knee Replacement Surgery</td>
<td>0.28</td>
<td>6.74</td>
<td>N/A</td>
<td>15.66</td>
</tr>
<tr>
<td><strong>England Average</strong></td>
<td>0.32</td>
<td>6.85</td>
<td>N/A</td>
<td>16.36</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>0.11</td>
<td>0.93</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>England Average</strong></td>
<td>0.09</td>
<td>-0.24</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>0.09</td>
<td>-0.79</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>England Average</strong></td>
<td>0.09</td>
<td>0.08</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
3.4.8 Medicines Optimisation

During 2018 we continue to promote our Leeds city wide campaign to encourage everyday conversations about medicines and how to get the best from them. The “me + my medicines” conversation prompt tool compliments our “Your Medicines-Your Health” programme of work in the Hospital.

This year we have supported more patients with chronic conditions, who are well enough and wish to, to continue to manage their own medicines whilst they are in hospital. We have changed our systems to support some patients to learn about the safe administration of specialist intravenous medicines (medicines given by a drip into a vein).

Whenever a patient is transferred from one location to another it is really important that the relevant information about their medicines is shared, as this helps prevent mistakes. An electronic medicines prescribing and administration system is now in use for all adult patients who are cared for in the hospital and information in this system forms part of the single Leeds Care Record. All prescribing and administration of medicines for children in the hospital will be through the electronic system by the end of 2018.
3.5 Staffing

We know that great care is dependent on great staff. Our ambition is to make LTHT one of the best places to work. We have been growing our workforce, from 15,200 in March 2014 to 17,700 in December 2017. In 2017 we recruited 3,240 people, across a range of disciplines.

The right number of staff is an essential precondition to great care but is not enough on its own. We are embedding our values through The Leeds Way to drive staff engagement and use a number of different approaches to build engagement. From the 2017 Staff Survey we are proud to see that we are best performing Trust in England in terms of the number of staff having an appraisal. As a result of the feedback in 2016, we have improved our Health and Wellbeing offer, we have 75 health and wellbeing champions who work with their teams to share information and encourage them to make healthier choices. We have provided access to an Employee Assistance Programme which provides a range of confidential support services to our staff.

In 2017 Staff Survey, we continue to see further improvements in our staff survey results. We have 13 of our 32 key findings in the top 20% of Acute Trusts and 28 of our 32 key findings are average or above.

We have continued to expand our opportunities for apprentices and are on target to have 630 apprentices in post in 2017 across the Trust. We are proud that our programmes have won a range of awards and we have been recognised as the West Yorkshire and Harrogate Centre of Excellence in collaboration with Bradford District Care Trust, by Skills for Health.

3.5.1 Staff Friends and Family Test (Staff FFT)

Following the successful introduction of the Friends and Family Test (FFT), the facility was extended to staff for the first time from April 2014, to provide on-going feedback about the Trust. All staff are invited to participate in quarters 1, 2 and 4. The results of Q4 2016/17 are shown below.

Comparison of Friends and Family Test Results May 2014-March 2017

<table>
<thead>
<tr>
<th>Results</th>
<th>Q1</th>
<th>Q4</th>
<th>Q4</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May 2014</td>
<td>March 2015</td>
<td>Mar 2016</td>
<td>March 2017</td>
</tr>
<tr>
<td>Response Rate (numbers of staff, students and volunteers)</td>
<td>750</td>
<td>1514</td>
<td>1546</td>
<td>3879</td>
</tr>
<tr>
<td>How likely are you to recommend LTHT to Family and Friends if they needed care or treatment?</td>
<td>72.7%</td>
<td>84%</td>
<td>82%</td>
<td>86%</td>
</tr>
<tr>
<td>How likely are you to recommend LTHT to Family and Friends as a place to work?</td>
<td>56.90%</td>
<td>68%</td>
<td>66%</td>
<td>70%</td>
</tr>
</tbody>
</table>

The results from the National Staff Survey for the equivalent question in 2017 are shown in the table below.

Results for Key Finding ‘Staff recommendation of the organisation as a place to work or receive treatment’

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Reporting period</th>
<th>Trust performance</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>2014</td>
<td>3.58</td>
<td>3.67</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>3.72</td>
<td>3.76</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>3.84</td>
<td>3.76</td>
</tr>
<tr>
<td></td>
<td>2017</td>
<td>3.86</td>
<td>3.75</td>
</tr>
</tbody>
</table>

Over the last four years the Trust’s performance on the National Staff Survey for ‘Staff recommendation of the organisation as a place to work or receive treatment’ has improved significantly. We continue to perform better than the national average.
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>LTHT score 2014</th>
<th>LTHT score 2015</th>
<th>LTHT score 2016</th>
<th>LTHT score 2017</th>
<th>National Average for acute trusts 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.</td>
<td>86%</td>
<td>87%</td>
<td>86%</td>
<td>89%</td>
<td>85%</td>
</tr>
</tbody>
</table>

The score for this key finding shows us performing better than the national average.

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

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>LTHT score 2014</th>
<th>LTHT score 2015</th>
<th>LTHT score 2016</th>
<th>LTHT score 2017</th>
<th>National Average for acute trusts 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.</td>
<td>26%</td>
<td>26%</td>
<td>23%</td>
<td>24%</td>
<td>25%</td>
</tr>
</tbody>
</table>

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

Our aim is that volunteer roles in our Trust are truly patient led and are from a wide range of communities. We also aim to provide more opportunities for volunteers in their training and development needs.

Since April 2017, 158 volunteers new have been recruited across the Trust, to both existing and new roles. Some new roles include:

- Hospital Guides - Meet and Greet Volunteers who provide front of house support and signposting for patients around our hospital sites.
- The Children's Hospital - has launched a ‘Scouts and Guides’ play scheme, as well as a ‘Supersibs’ volunteer led créche for siblings of premature babies.
- Model Ward - Acute Surgical wards developed a ‘Model Ward’, aiming to understand how volunteers can be successfully used in a ward. This will continue in 2018/19.
- Emotional Support and Spiritual Care – in our Emergency Departments, providing friendship, emotional support and signposting to support services where required.
- Peer Support and Activities - Volunteer ambassadors, who have experienced a stroke themselves, provide much needed emotional support to patients on our Acute Stroke Unit.

We hold volunteer focus groups every three months, providing more specialised training than ever before and giving every volunteer at the Trust an opportunity to feedback. We have also held two celebration events this year in June 2017 and a special Christmas event that took place in December 2017.

LTHT has signed up to be part of a learning network led by 'Helpforce', a national initiative aimed at harnessing the potential of volunteers to assist the NHS. This national networking opportunity allows the Trust to work in collaboration with other Trusts and continue to build on our successes.
3.5.3 Nursing Workforce

Nurse Staffing
In 2014 the Trust committed to investing £14 million in additional nursing staff. In 2017/18 we continued to recruit across the registered and unregistered workforce to maximise this investment. The Trust has now embedded the new provider of the LTHT Staff Bank to increase financial efficiency and optimise staffing levels.

Ward staffing establishment reviews have been completed for all CSUs to review staffing requirements and to modernise the workforce. This includes changing the workforce model to increase senior nursing numbers to attract experienced staff, integrate allied health professionals or to change skill mix to better reflect the range of skills and roles to deliver high quality care.

Recruitment: Registered Staff – Nurses, Midwives and Operating Department Practitioners (ODPs)
In 2017/18, we attended a number of national recruitment fairs and university engagement events across the country. These are now attended in conjunction with our city partners, promoting Leeds as a first class place to pursue a career in nursing and as a place to live. The feedback on this approach has been positive. We attend local recruitment events at Universities and Higher Education Institutes to recruit both qualified staff and apprentices. Internally, a number of CSU or site-specific recruitment campaigns and events have taken place, for example Theatres, the Children’s Hospital, and the Acute Medicine CSU.

The Trust continues to work with the local universities and healthcare partners and during 2017/18 over 220 newly qualified staff joined the Trust, alongside 433 Band 5 nursing staff.

Recruitment: Support Staff – Clinical Support Workers, Assistant Practitioners and Nursing Associates.
The Trust has a full range of developmental opportunities for support staff aimed at enhancing career progression and retention.

In 2017/18 over 270 apprentices joined the Trust to commence training to become CSWs via the Trust’s apprenticeship initiative, The programme will continue to recruit up to 25 apprentices in each of 10 cohorts into 2018/19.

The Level 3 apprenticeship programme to train Senior CSWs has now been established, with 45 starting the programme in 2017/18. A further 75 places will be available for 2018/19.

The Assistant Practitioner Training Foundation Degree Programme, continues, and is now provided as an apprenticeship. The programme is being adapted to include modules on therapy skills to enhance the transferability of the role.

The Trust, as part of a West Yorkshire Pilot Partnership across Leeds, Bradford and Airedale, is a pilot site for the training of Nursing Associates. This new role will bridge the gap between registered and unregistered nursing staff, with responsibility for all elements of care. The trainees work towards a Foundation Degree and access placements across the whole health economy. Further programmes are being planned for 2018/19.

Recruitment: Advanced Practice
In 2017/18, Health Education Yorkshire & Humber funded 27 advanced practice trainees and continued to support academic programmes for advanced practice. The number of trainees and completed practitioners in the Trust is now over 80, with interest for widespread development of the role across the CSUs.

Temporary Staff
Bank and agency staff continue to provide an essential component of the workforce. In 2017/18 the Trust has worked to recruit to the LTHT Staff Bank, to reduce reliance on agencies. The Trust has seen a reduction in agency spend and a consistent increase in the bank supply. In 2018/19 the Trust aims to further increase temporary shift fill and reduce the agency spend through closer agency management.
3.5.4 Guardians of Safe Working

The Trust’s Guardians of Safe Working are responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. Their role is:

- To address concerns relating to hours worked.
- To support safe care for patients by ensuring doctors do not work excessive hours.
- To use powers to impose financial penalties when safe working hours are breached.

The 2016 TCS requires trainees who work over and above their contracted hours, or are unable to take adequate rest, or attend education or training to complete an exception report, which are reviewed by the Guardians every morning. All trainees have now transitioned to the 2016 TCS and the Trust has received 910 exception reports from 191 trainees, dating from 01 April 2017 to 31 March 2018.

Late finishes are the most common type of exception report, accounting for 63% of reports to date (see pie chart below).

Trust Board and Research, Education, and Training (RET) Committee reports over the last 12 months focused on:

- Exception reporting being currently at 12% of trainees. Approximately 40% are dealt with by Educational supervisors.
- The effect of rota gaps on trainees working hours, leading to late finishes and inability to take breaks.

The interdependence of different rotas in terms of the workforce available each day.

How the quality of handover and the presence of a senior doctor can improve the ability of trainees to prioritise their workload.

With the current number of doctors available in many specialties, there is little capacity for covering sick leave.

In some specialties, work schedules do not reflect the actual hours worked by the junior doctor, and early work schedule reviews have been required.

Qualitative information from exception reports indicate that a trust wide review of how ward rounds are conducted could be beneficial.

In the last 6 months we have had specific challenges in Neurosurgery. Neurosurgery trainees transitioned to the 2016 TCS in October 2017 and make up 38% of exception reports from 01 October 2017 to 31 January 2018, logging 274 hours in excess of their contracted hours.

All exception reports are sent to the appropriate senior managers in each CSU on a monthly basis. On an individual basis we have engaged with junior doctors and their educational supervisors where particular concerns have been highlighted.

A lot of the information and detail we have received from junior doctors who have exception reported indicates a strong desire in those individuals to improve the system for all junior doctors.
3.5.5 Freedom to Speak Up

Since October 2013 the Trust has taken a number of actions to review and strengthen whistleblowing arrangements, including strengthening the previous Whistleblowing Policy, now called the Freedom to Speak Up Policy.

In October 2016 LTHT appointed Joe Cohen and Julia Roper as Trust Freedom to Speak Up Guardians. Our new policy, and Freedom to Speak Up Guardians (FTSUGs) were formally launched by the Chief Executive in June 2017.

We currently also have 19 specially trained Freedom to Speak Up Leads in the Trust (renamed from the previous whistleblowing leads) who are available to listen to concerns raised by staff, and ensure appropriate action is taken. The Trust Guardians are also responsible for providing assurance to the Board and embedding an open and transparent culture. We also have a Non-Executive Director with responsibility and oversight for Raising Concerns.

During the period April 2017 to March 2018 a total of 22 concerns were raised centrally in the organisation compared with 19 in the previous 12 months.

**Broad themes covered by Freedom to Speak Up concerns**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number 2016/17</th>
<th>Number 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour/relationship</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Process</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Patient Safety / Quality</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Leadership</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Please note - the activity as detailed above reflects only cases reported centrally. Concerns raised with local managers are not logged centrally.

All concerns have been followed up and feedback is provided to the individual staff members. Of the concerns raised in 2017/18, 9 remain open, with investigations/action in progress.

Some concerns are followed up through the appropriate HR process e.g. grievance or bullying and harassment.
3.6 Integrated Care Improvement Programme

Building on the work started as part of the Integrated Care Improvement Programme led by the Leeds Institute for Quality Healthcare (LiQH), the Trust’s priorities in 2016/17 were on two pathways linked to CQUINS, in collaboration with Leeds Community Healthcare;

Respiratory Pathway CQUIN

We successfully achieved all elements of the Respiratory Improved Care Pathway CQUIN in 2016/17. This project built upon previous work by the key stakeholders supporting people with respiratory conditions in Leeds. A comprehensive review was undertaken and a plan produced, underpinned by the NICE Quality Standards for Chronic Obstructive Pulmonary Disease and Asthma, to optimise respiratory care in the city.

The Integrated COPD Service focused on improving key points in the patient pathway which traditionally reflect a ‘handover’ of care between LTHT and LCC. A single electronic referral form and triage matrix was developed to streamline the pathway for patients into the COPD service. This is accessible across the hospital and community networks and sits alongside established patient information systems. The roll out was supported by training and support for staff, and patient information about the service.

Staff from LTHT Acute Medicine and Respiratory Services worked with Community Respiratory colleagues to review the processes around discharge from hospital to ensure comprehensive and timely information is available to support seamless care after a hospital admission.

Cardiology Pathway CQUIN

We successfully achieved all elements of the Cardiology Improved Care Pathway CQUIN in 2016/17. Informed by the relevant NICE guidance, a comprehensive review of Acute Coronary Syndrome pathways including post treatment rehabilitation and medication titration was completed. The project also brought into being the first ever integrated review and plan for Heart Failure care across Leeds.

This work has enabled more patients to access cardiac rehabilitation across the Trust and promoted mental wellbeing as a key consideration during heart attack rehabilitation. The introduction of an innovative Consultant Pharmacist led medicines optimisation clinic has ensured more patients receive the maximum benefit from their prescribed medications, take fewer medications overall, and gain a greater understanding of their treatments.

The hospital and community Heart Failure teams have set up the first ever Heart Failure MDT involving a truly multidisciplinary team. The MDT serves as a point of referral and a forum to allow supportive appropriate decision making in complex patients. The hospital Heart Failure team now provide a more informative service for GPs and Primary care through ‘Advice and Guidance’, alongside a virtual, Consultant Cardiologist led clinic, to support Community Cardiac Nurses reviewing increasingly complex patients.

In addition the project has expanded the capability of the community IV diuretic service to include those patients eligible for early discharge whilst on IV diuretics reducing the time spent in hospital for these patients.

3.7 Performance Against National Priority Indicators

The Trust’s performance against the national priority indicators is summarised in Appendix E.
Part 4: Statements of Assurance from the Trust Board

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

4.2 Participation in Clinical Audit

The Trust is committed to improving services and has a systematic clinical audit programme in place which takes account of both national and local priorities. The Trust programme is managed within Clinical Service Units by the Clinical Director and Head of Nursing within each CSU, supported by the Clinical Audit Leads in each specialty.

The Department of Health recommended 81 specific national audits that all hospitals in England should contribute data to, if relevant to the services they provide. The Trust contributed data to 97% (74) of the recommended national clinical audits and 100% (5) of the confidential enquiries that it was eligible to participate in.

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

The Trust did not participate in the Inflammatory Bowel Disease (IBD) audit, the COPD audit, or the National Cardiac Rehabilitation Audit, for the following reasons:

• The Trust has been working to develop its IT system by linking with clinical colleagues to improve data capture and support quality improvement for IBD. Due to a number of technical delays associated with functionality it has not been possible to submit data to the IBD Registry for 2017/18.

• Throughout 2017/18 the Trust has been transitioning its processes and technology for the accurate data capture and quality improvement of COPD. Due to a number of delays associated with the complexity of the work, it has not been possible to submit data for the 2017/18 period. The Trust will be participating 2018/19. Cardiac Rehab have not participated - statement as follows:

• The National Cardiac Rehabilitation Audit requires a unified approach between LTHT and Community Cardiac Rehabilitation

The reports of 33 national clinical audits, and 416 local clinical audits, were reviewed by the Trust in 2017/18. Examples of actions arising from this work that the Trust has implemented or intends to implement to further improve the quality of care are provided on the following pages.
Enhanced Care Audit

Enhanced care is fundamental in ensuring that patients receive the care best suited to their needs, and that it is provided by the best person to ensure safe and effective care. Risk assessments enable staff caring for patients to identify the level of care each patient requires. Two audits were carried out in 2017/18 across LTHT to ensure enhanced care was being utilised appropriately. The results showed that the enhanced care documentation was being used well. The results also highlighted an area that required focus was sign off of extra staff where risk assessments indicated additional support was needed. Sign off of extra staff by Matrons or Heads of Nursing is important as it allows staffing levels to be maintained across other clinical areas. Additional guidance was provided to Matrons and Heads of Nursing in light of these results, and further audits are planned for 2018/19.

Charcot Arthropathy Offloading Audit

Diabetes can involve complications that lead to patients being susceptible to problems with their feet and lower limbs. LTHT’s Diabetic Limb Salvage Service (DLSS) runs a clinic that treats high risk diabetic patients who have ulcerations, or acute Charcot arthropathy. In August 2015, NICE published guidance on the prevention and management of diabetic foot problems. It recommended that if acute Charcot arthropathy is suspected, treatment should be offered with a non-removable offloading device; if a patient’s circumstances mean a non-removable device is not advisable, a removable offloading device should be considered. The DLSS aims to provide treatment in line with NICE’s recommendations within two weeks of patients being referred. An audit was carried out on all patients seen in 2017 to ensure the NICE guidance and local standards were being met, and the findings showed that all patients with suspected acute Charcot arthropathy were treated within two weeks with an appropriate non-removable or removable offloading device.

National Vascular Registry

The National Vascular Registry 2017 Annual Report (published in November 2017) looked at the care provided to, and clinical outcomes of, patients undergoing major vascular interventions. The report allowed Trusts to compare their performance across these interventions. The results showed that patients with carotid disease had a relatively short waiting time between vascular assessment and surgery in LTHT, and that mortality for patients undergoing vascular surgery was within the expected range. The results also showed that the length of treatment pathways for vascular conditions was a concern nationally, and that LTHT waits were generally within the centre of the national distribution, being neither poor nor exemplary. In order to shorten waits for surgery, LTHT’s Vascular Service is streamlining outpatient investigation pathways, increasing vascular specialist nurse capacity, and introducing “hot clinics” for rapid investigation of urgent patients. These clinics will have the additional benefit of avoiding unnecessary admissions.

Re-Audit of Paediatric Cardiology Discharge Letters

Discharge letters form a vital part of effective and safe sharing of information with healthcare professionals continuing to care for patients after they are discharged from LTHT. An audit of discharge letters from Paediatric Cardiology was carried out at the end of 2016. The findings showed that 36% of patients had a discharge letter, that on average it took six days for the discharge letter to be completed, and that 61% of letters were sent to all the relevant healthcare professionals. To improve these results, a new discharge letter pathway was introduced to Paediatric Cardiology in June 2017. A re-audit between September and November 2017 showed that discharge letters were completed for 85% of patients, and that 72% of the letters were sent to all the relevant healthcare professionals. It was also noted that letters were taking slightly longer to be produced under the new pathway. Alterations to the pathway were therefore agreed to improve the results, and a further re-audit is planned in April 2018.
4.3 Information Governance and Data Quality

Statement on relevance of Information Quality and actions to improve

Information Governance is a framework for handling information in a confidential and secure manner.

The Trust ensures that it holds accurate, reliable, and complete information about the care and treatment provided to patients. Clear processes and procedures need to be in place to give assurance that information is of the highest quality. High quality information is important for the following reasons:

- It helps staff provide the best possible care and advice to patients based on accurate, up-to-date and comprehensive information.
- It ensures efficient service delivery, performance management and the planning of future services.
- It ensures the quality and effectiveness of clinical services are accurately reflected.
- It ensures the Trust is fairly paid for the services we provide and care we deliver.

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

The Trust is fully committed to ensuring that personal information is protected and used appropriately. It is constantly reviewing its existing processes to significantly reduce the likelihood of data loss.

NHS Number and General Medical Practice Code Validity

We continue to use the national data quality dashboard tool to support a review of the accuracy and quality of data submitted, and benchmark against the rest of the NHS. As with previous years, we submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are published nationally.

The percentage of records in the published SUS Data Quality Dashboard for the period April 2017 to March 2018 which included a valid NHS number can be seen in the table below.

<table>
<thead>
<tr>
<th>Type of care in the NHS</th>
<th>% of records</th>
<th>% above the national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patient</td>
<td>99.8%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>99.9%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Accident and emergency</td>
<td>95.8%</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

The percentage of records in the published SUS Data Quality Dashboard for the period April 2017 to March 2018, which included a valid General Medical Practice Code can be seen in the table below:

<table>
<thead>
<tr>
<th>Type of care in the NHS</th>
<th>% of records</th>
<th>% above the national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patient</td>
<td>100%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>99.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Accident and emergency</td>
<td>99.8%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Clinical Coding

It is the responsibility of the Clinical Coding team to ensure that the clinical information recorded for our patients is complete, accurate and reflective of the care and treatment. High quality Clinical Coding is important for the management of our clinical services and the recovery correct reimbursement of income for the care we deliver.

The Trust has a continuous programme of audit and training in place to ensure high standards of Clinical Coding are delivered. The programme involves audits by CSU to ensure a general overview of all areas.

In line with the IG Toolkit, a 200 FCE (Finished Consultant Episode) Clinical Coding audit was undertaken. This was a general audit of 19 specialties.
In order to achieve Level 2 accreditation for the IG Toolkit, coding accuracy needs to be 90% on primary diagnosis and primary procedures, and 85% on secondary diagnosis and procedures.

Recommendations from this audit include:

- The Trust is reviewing its internal clinical coding training capacity, and the overall resources in the coding department.

The timeliness of accurately coded data is of particular importance to the Trust in terms of income recovery via the National Payment by Results (PbR) process. There is sustained improvement in the timeliness of the coded information.

### Clinical Coding Audit Findings

**Overall percentage of correct coding:**

<table>
<thead>
<tr>
<th></th>
<th>Total from episodes audited</th>
<th>Total correct</th>
<th>% correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>200</td>
<td>182</td>
<td>91.0%</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>1250</td>
<td>1164</td>
<td>93.1%</td>
</tr>
<tr>
<td>Primary procedure</td>
<td>90</td>
<td>81</td>
<td>90.0%</td>
</tr>
<tr>
<td>Secondary procedure</td>
<td>230</td>
<td>220</td>
<td>95.7%</td>
</tr>
<tr>
<td>Overall</td>
<td>1770</td>
<td>1647</td>
<td>93.1%</td>
</tr>
<tr>
<td>HRG derived (episode level)</td>
<td>200</td>
<td>168</td>
<td>84.0%</td>
</tr>
</tbody>
</table>

### Timeliness of accurately coded data in LTHT 2014-2018

<table>
<thead>
<tr>
<th></th>
<th>Jan 2014</th>
<th>Jan 2015</th>
<th>Jan 2016</th>
<th>Jan 2017</th>
<th>Jan 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month End</td>
<td>76.2 %</td>
<td>86.95%</td>
<td>94.9%</td>
<td>96.2%</td>
<td>98.1%</td>
</tr>
<tr>
<td>5th Working day (after month end)</td>
<td>89.3%</td>
<td>98.6%</td>
<td>97.6%</td>
<td>98.89%</td>
<td>100%</td>
</tr>
<tr>
<td>Payment by Results Flex Date</td>
<td>95.5%</td>
<td>100%</td>
<td>98.7%</td>
<td>99.96%</td>
<td>100%</td>
</tr>
<tr>
<td>Payment by Results Freeze Date</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
The IG toolkit is self-assessed by the organisation and, in 2017/18 the Trust maintained its overall level 2 rating. This demonstrates to patients and service users that the Trust has robust controls in place to ensure the security of patient and staff information.

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.

### IG Toolkit Final Ratings

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Total Req's</th>
<th>Overall Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14.1 (2017-2018)</td>
<td>0</td>
<td>0</td>
<td>27</td>
<td>18</td>
<td>45</td>
<td>80%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Version 14 (2016-2017)</td>
<td>0</td>
<td>0</td>
<td>29</td>
<td>16</td>
<td>45</td>
<td>78%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Version 13 (2015-2016)</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>21</td>
<td>45</td>
<td>82%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Version 12 (2014-2015)</td>
<td>0</td>
<td>0</td>
<td>25</td>
<td>20</td>
<td>45</td>
<td>81%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Version 11 (2013-2014)</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>22</td>
<td>45</td>
<td>82%</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>
### 4.4 Goals agreed with Commissioners (CQUINS)

#### 2017/19 CQUIN

<table>
<thead>
<tr>
<th>Quarter Requirements</th>
<th>Q1 Signed off Performance</th>
<th>Q2 Signed off Performance</th>
<th>Q3 Signed off Performance</th>
<th>Q4 Signed off Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Staff Health &amp; Wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a. Staff Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: Achieve a 5% point improvement in two of the three NHS annual staff questions.</td>
<td></td>
<td></td>
<td></td>
<td>Achieved required improvement on 1 of 3 questions</td>
</tr>
<tr>
<td>Improving Staff Health &amp; Wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b. Healthy food for NHS staff, visitors and patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: Maintain 4 changes from 2016/17 &amp; Introduce 3 new changes 2017/18 (re sugar content)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Staff Health &amp; Wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1c. Improving the uptake of flu vaccinations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target &gt; 70%</td>
<td></td>
<td></td>
<td></td>
<td>Achieved 80.3%</td>
</tr>
<tr>
<td>Reducing the impact of serious infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings</td>
<td>82%</td>
<td>90%</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>Target &gt; 90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing the impact of serious infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b. Timely treatment of sepsis in emergency departments and acute inpatient settings</td>
<td>61%</td>
<td>72%</td>
<td>74%</td>
<td>77%</td>
</tr>
<tr>
<td>Target &gt; 90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing the impact of serious infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2c. Assessment of clinical antibiotic review between 24-72 hrs of patients with sepsis who are still inpatients at 72 hrs</td>
<td>82%</td>
<td>90%</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>Targets are: Q1 &gt; 25%, Q2 &gt; 50%, Q3 &gt; 75%, Q4 &gt; 90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing the impact of serious infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2d. Reduction in antibiotic consumption per 1,000 admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 2% reduction for each category</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Improving services for people with mental health needs who present to A&amp;E (Joint CQUIN with LYPFT and other partners, primary care, police, ambulance, substance misuse etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 20% reduction in attendances at A&amp;E for specified cohort of patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved</td>
<td></td>
<td></td>
<td></td>
<td>Achieved 31% reduction in attendances for cohort</td>
</tr>
<tr>
<td>4. Offering Advice &amp; Guidance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providers to have A&amp;G services for non-urgent GP referrals, allowing GPs to access Consultant advice prior to referring patients to secondary care. Target A&amp;G operational for 35% of total GP referrals by 1 Jan 2018</td>
<td>Approved</td>
<td>Approved</td>
<td>Approved</td>
<td></td>
</tr>
<tr>
<td>5. NHS e-Referrals (1 year CQUIN - 2017/18)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP referrals to consultant led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service Target All 1st OP appointment slots to be available on NHS e-Referrals by 31 Mar 2018</td>
<td>Approved</td>
<td>Approved</td>
<td>Approved</td>
<td></td>
</tr>
</tbody>
</table>
### 6. Supporting Proactive and Safe Discharge

Part a) Increasing % patients admitted via non-elective route discharged to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3/Q4 16/17) OR an increase to 47.5% across Q3 & Q4 17/18.

<table>
<thead>
<tr>
<th></th>
<th>Not applicable</th>
<th>Joint report approved</th>
<th>Not applicable</th>
<th>Achieved 47.6%</th>
</tr>
</thead>
</table>

Part b) Implement new Emergency Care Dataset (ECDS) on 1 October 2017

<table>
<thead>
<tr>
<th></th>
<th>Approved</th>
<th>Not applicable</th>
<th>Position statement submitted outlining mitigating factors</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

### 7. Risky behaviours Alcohol & Tobacco

(1 year CQUIN 2018/19)

<table>
<thead>
<tr>
<th></th>
<th>Not applicable in 2017/18</th>
</tr>
</thead>
</table>

### NHS England Spec Comm

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Description</th>
<th>Apr-Sept Target</th>
<th>Oct-Mar Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>ODN MDT decisions aligned to NHS England published run-rate</td>
<td>Trigger B1, B2 &amp; B3 Assessed bi-annually</td>
<td>Not applicable</td>
</tr>
<tr>
<td>B2</td>
<td>ODN Treatment cost per patient relative to lowest acquisition cost</td>
<td>Target: 789 treatment initiations as at Oct 2017; (previously 849)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>B3</td>
<td>ODN Prioritisation of patients with highest clinical need. Includes setting up data flows from labs and reporting on the % of those offered an assessment within 3 months</td>
<td>Trigger B4 Assessed at year-end</td>
<td>Not applicable</td>
</tr>
<tr>
<td>B4</td>
<td>ODN Effectiveness in sustaining benefits of treatment, including signed agreement with partners on opt-out testing (months 7-12)</td>
<td>Target: 85% of patients followed up 12 months post treatment</td>
<td>Not applicable</td>
</tr>
<tr>
<td>B5</td>
<td>ODN ‘registry’</td>
<td>To be assessed on 22 Dec</td>
<td>Achieved requirements</td>
</tr>
<tr>
<td>C</td>
<td>Governance &amp; Partnership working</td>
<td>Approved</td>
<td>Report submitted</td>
</tr>
</tbody>
</table>

| | Approved | Approved | Approved |
| B4 Improving Haemoglobinopathy Pathways through ODN Networks | Approved | Approved | Approved |
| TR3 Spinal Surgery: Networks, Data, MDT Oversight | Approved | Approved | Approved |
| IM3 Auto-immune Management | Approved | Approved | Approved |
| WC3 CAMHS Screening | | Value of CQUIN is less than resource required to deliver it | CQUIN income foregone |
| GE3: Medicines Optimisation | Approved | Approved | Approved |
| CA2 Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) | Approved | Approved | Approved |
| WC4 Paediatric Networked Care | Approved | Not applicable | Approved |
| IM2 Cystic Fibrosis Patient Adherence (Adult) | Value of CQUIN is less than resource required to deliver it | CQUIN income foregone |

Local QIPP Incentivisation scheme

| | Approved | Approved | Approved |

- **Not achieved**
- **Partial achievement**
- **Local assessment - partial achievement to be signed off**
- **Achieved**

2.5% contract income was allocated to the CQUIN scheme in 2017/18; payment agreed with commissioners following quarterly submission.
The Trust has an ambitious strategy for research and innovation, aimed at harnessing the significant advances in clinical science for the benefit of Trust patients by improving access to world-leading research studies.

In 2017 we opened the new Research and Innovation Centre on the St. James’s University Hospital Campus which brings together the core Research and Innovation team together with a number of the Trust’s other core research functions under one roof.

One of our strategic goals is to ensure that all our specialist services are research-intensive. Working in partnership with the University, the Trust has strengthened its research programmes, with a number of key national programmes being re-funded, and it has also managed to win funding for participation in a number of new national initiatives.

The **NIHR Leeds Clinical Research Facility** received a significant uplift in its funding from NIHR for the next 5 year period and continues its impressive trajectory of work. The Leeds Clinical Research Facility is amongst the top 5 performing NIHR Clinical Research Facilities nationally (of 18 CRF’s) in almost all metrics assessed. The Facility conducts early phase research with leading-edge medicines and technologies across a range of diseases, with cancer particularly prominent.

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

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

Leeds was awarded funding for the **NIHR Leeds Bioresource Centre** in December 2017. Part of a national network, the Bioresource centre aims to create a national register of patients (particularly those with “rare diseases”) who can be recalled for participation in future clinical trials. This will give patients at the Trust an opportunity to participate in more trials in the future.

The **Innovate UK Northern Alliance Advanced Therapies Treatment Centre** is a consortium which includes 6 NHS bodies across the North of England and Scotland and 11 private sector companies from across the UK. The purpose of the centre is to increase the number and scale of Advanced Therapy (cell and gene therapies) trials across the UK and to work through some of the challenges which face these therapies becoming routinely commissioned by the NHS in the future. Funding for the centre comes from the Life Sciences Industrial Strategy Challenge Fund, and the centre was one of three funded by Innovate UK across the UK.

**Research Performance**

The Trust conducts a large number of clinical trials and other research studies across all specialties. This portfolio of studies is kept under active review to ensure a balance between delivering large simple studies and the Trust’s leading role in delivering complex studies which involve smaller numbers of patients.

During 2017/18, the Trust was the 2nd highest performing trust in England for recruiting into...
clinical research projects recognised by the National Institute for Health Research (NIHR). This year we involved 19,179 patients in 451 research studies - the most patients that the Trust has ever involved in studies in a single year.

The Trust also continues to lead the way nationally against NIHR initiation and delivery targets for clinical trials. This demonstrates that we are recruiting patients into trials in a fast and effective manner. During 2017/18 we exceeded both the 70 day initiation target (84.6% - 7th in England) and the recruitment to time and target metric for commercial studies (83.1% - 2nd in England) set by NIHR.

Research and Innovation Ambassadors

Patient Research Ambassadors (PRAs) are Trust volunteers who help R&I ensure the patient experience of participating in research is clear and simple. There are currently 12 PRAs and they are part of the public-facing team for research to help raise awareness of research taking place within research active departments. This means attending outpatient clinics and talking to patients about the studies that are currently open and hosting study specific stands in the main reception areas across the Trust. The PRAs assisted in celebrating International Clinical Trials day on 19 May 2017 by hosting stands alongside research teams in the main reception areas in the Trust to promote the diversity of research taking place in the Trust.
Part 6: What Others Say -
Engagement with our Regulators 2017/18

6.1 Care Quality Commission

We continued to work with partners, including commissioners at NHS England and NHS Leeds CCG and with regulators at NHS Improvement and the Care Quality Commission.

The Leeds Teaching Hospitals NHS Trust was required to register with the Care Quality Commission (CQC) under Section 10 of The Health and Social Care Act 2008 from 1 April 2010.

The Trust is required to be compliant with the fundamental standards of quality and safety. The Trust's current registration status is registered with the CQC without conditions (compliant).

The CQC last undertook a planned inspection in May 2016. This was a follow up visit following the comprehensive inspection that had been undertaken in March 2014. The CQC published their final reports on 27 September 2016, and we were delighted to have been rated as Good.

<table>
<thead>
<tr>
<th>Key Question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Effective</td>
<td>Good</td>
</tr>
<tr>
<td>Caring</td>
<td>Good</td>
</tr>
<tr>
<td>Responsive</td>
<td>Good</td>
</tr>
<tr>
<td>Well led</td>
<td>Good</td>
</tr>
<tr>
<td>Overall rating</td>
<td>Good</td>
</tr>
</tbody>
</table>

An action plan was developed to address the recommendations from the CQC reports.

Progress on implementation of the actions was overseen by NHS Improvement and reported to the Quality Assurance Committee and Trust Board. The plan was also monitored in conjunction with our local CQC Inspection Manager through routine engagement meetings with the Trust, and through routine joint quality meetings with the CCG.

The CQC undertook an unannounced inspection visit at St James's Hospital on 20 December 2017. The focus of their inspection was on the care of patients in non-designated areas, specifically medical and elderly patients in the Emergency and Specialty Medicine (ESM) CSU. This has been a shared concern across the NHS and related directly to the flow of patients across the healthcare system, both locally and nationally. A risk assessment framework has been developed by the corporate nursing team and implemented through CSUs to ensure that patients are assessed before being identified to be cared for in non-designated areas and this is subject to a programme of audit led by the corporate nursing team.

The draft report was received by the trust on 8 May 2018, which included 7 areas for improvement linked to 5 Regulations (Requirement Notices). This has been reviewed and checked for factual accuracy and returned to the CQC. The trust will produce an action plan in response to the recommendations when the final report is published by the CQC. The report will be publicly available on the CQC website. The action plan will be monitored through the Quality Assurance Committee, joint quality meeting with commissioners and engagement meetings with the CQC.

During 2017/18 the Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008.
Appendices

Appendix A:  
Statement of Directors’ Responsibilities in Respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care issued guidance on the form and content of annual Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017. These added new mandatory disclosure requirements relating to ‘Learning From Deaths’ to quality accounts from 2017/18 onwards.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

• the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
• the performance information reported in the Quality Account is reliable and accurate;
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
• the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
• the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

.......................... Date                  ................................................ Chair
.......................... Date                  ................................................ Chief Executive
Appendix B: Statements from Local Stakeholders

Joint comments from Healthwatch Leeds, and the Overview and Scrutiny Committee for Health, Public Health and Social Care in Leeds

Was the patient, service user, carer and public involvement clear?
Good involvement of patients, service users, carers and the public was clearly demonstrated. It is evident that LTHT are using a variety of approaches including use of friends and family feedback, involving patients in staff triaging and work with Healthwatch. The patient experience sub group is used to demonstrate the outcomes of service user involvement.

Did we understand how the engagement has influenced the priorities and actions in the QA?
We felt that this was very clearly explained with examples of how patient engagement has made a difference. It is clear that LTHT is committed to listening to people and acting on what people say.

Are there plans for accessible versions?
It seems that this is proving to be a challenge, given the size of LTHT. Although they have a new member of staff working on an easy read document it is proving difficult to get range of info into simpler document.
Thank you for providing the opportunity to feedback on the Quality Account for Leeds Teaching Hospitals NHS Trust for 2017-18. This account has been shared with key individuals across the newly formed Leeds Clinical Commissioning Group (formerly Leeds West CCG, North CCG and South & East CCG) and this response is on behalf of the new organisation.

We acknowledge that the report you provided for review and comment is in draft form and additional information will be added and amendments made before final publication, so please accept our observations on that basis.

The account is presented in an easily readable style with a good mix of real life examples, local improvements with the mandatory national elements. It provides a good representation of the Trust’s achievements and its commitment to delivering high quality care.

The Leeds Improvement Method has continued to grow and gather momentum from its development last year. The inclusion of patients, carers and families, facilitation of a co-production methodology and the ethos that everybody is empowered to make improvements is laudable. The number of patients attending ‘Making Quality Count’ sessions and completing the full QI training is impressive and demonstrates a real commitment to involving patients in quality improvement. The programme is clearly having a positive impact and the evidence presented of successes within the different Value Streams is powerful. We are pleased to see that quality improvement is given such a high profile in the Trust and is at the heart of Trust activity.

We note the continued work in Acute Kidney Injury and Sepsis, and are particularly pleased to hear of the intention to appoint a sepsis nurse to support the ongoing work of the sepsis team. It will be important to see the impact of this over the coming year.
The work to address the deteriorating patient is admirable and the subsequent 25% reduction in cardiac arrest calls shows the effect of the work done. We are similarly encouraged to see the dedicated approach to reducing in-patient falls is paying off with an impressive 62% reduction in falls resulting in harm.

Safety huddles are crucial to supporting all of the work described above and their introduction is commendable. We hope the measurable improvements in patient safety help to further engage staff and embed the importance of ‘huddling’ across the organisation. The work by the portering team to introduce safety huddles to support services is excellent and well deserving of the national recognition gained.

The continued drive to reduce avoidable pressure ulcers is welcomed, especially the focus on more prompt investigating and learning and the collaboration with the community trust. We feel the steering group is well set up to support the reduction ambitions for category 3 and 4 pressure ulcers over the next twelve months.

We congratulate the Trust on being shortlisted for an award for excellence in Parkinson’s care. The collaboration with patients and carers is admirable and the reduction in delay for patients receiving their first dose of medication achieved is a great success.

The Trust’s Maternity work shows a proactive stance being taken with involvement in national initiatives to improve safety. The reduction in stillbirth rate is worthy of note, however it would be useful to also identify progress against the Saving Babies Lives Stillbirth Care Bundle or Each Baby Counts national priorities. We are particularly pleased to see a significant improvement in number of perineal tears by 75%, as this is an area that the Trust had previously seen slow progress.

Healthcare Associated Infection remains a challenging area. It is good to see the collaborative approach to the challenge of the national gram-ve bacteria reduction ambitions whilst continuing work to further reduce MRSA and Clostridium difficile infections.

The Trust’s position in relation to national and peer performance for medication related incidents causing harm is very impressive and reassuring, and we look forward to the Trust sustaining this position.

There appear to be a lot of initiatives in improving safeguarding education and the approach to raising and maintaining awareness of safeguarding is commendable.

The approach to sharing learning from serious incidents and complaints is welcomed. The use of Quality and Safety Matters briefings and a staff conference are good examples of investment in collaboration and sharing. It is also good to note the use of a variety of different media to engage staff and support widespread learning. The LIST initiative is
evidence of a supportive approach to staff involved in incidents. It would be useful to see some evaluation from this including the uptake and what the feedback and experience is from staff who have accessed it.

The Trust demonstrates an open and honest approach to incidents and never events, and it is reassuring to see significant assurance given by the internal audit on the Duty of Candour process.

The account describes a wide range of initiatives to involve and improve the experience of patients which is impressive and shows an inclusive approach to all groups. It demonstrates the importance of engagement to improve services and we are pleased to acknowledge the achievement of the Trust receiving the ‘Commitment to Carers’ kitemark. It is also notable that nursing students are now undergoing placements with the Patient Experience Team. This is an excellent way of raising the profile of experience and embedding this vital component of care into the perspectives of future clinicians.

The introduction of two ‘Always Events’, particularly in improving the night time experience for patients which has traditionally been an issue for many people staying in hospital, is highly commendable and we will be keen to see the progress and impact made.

It is pleasing to hear that fewer complaints are going to the ombudsman and to see the work being done on improving the complaints handling process and experience for complainants. There are also some good examples of PALS queries and how these have been addressed. However, it would have been helpful if the Trust had provided some explanation on why numbers of re-opened complaints have increased despite the improvement work undertaken and whether there are any themes to look at in 2018/19.

It is particularly good to note the introduction of children’s and young people’s FFT cards and the improvements in response rates overall. We hope that having FFT champions in some areas to raise the profile is beneficial and can be spread to other areas. The drive for continuous improvement is evident in work to improve in areas where performance is already good compared to peers, namely the work on readmissions.

Trust’s performance in the staff Friends and Family Test results show an impressive improvement since 2014 and continues to be above national average performance. This is testament to the Trust’s focus on involving, valuing and understanding staff.

The commitment to recruiting staff and developing new roles to support career progression is welcomed. It is unclear whether turnover rates are challenging but recruitment appears to be successful overall. The expansion of the range of volunteer roles is also good to see and the support they provide the Trust and receive is a good example of community engagement.
The wellbeing of staff is also an evident priority and we welcome the Guardians of Safe Working initiative which shows a supportive approach and is key to understanding the challenges faced by staff that could lead to disillusionment and burn out. We hope this helps to support the health, wellbeing and retention of staff.

It is encouraging to see the Freedom To Speak Up Guardians in place in the organisation, but it would be useful to understand if any actions have been implemented in response to the increase in concerns raised, particularly those relating to patient safety and quality.

We are supportive of the 2018/19 quality priorities which have a strong focus on key improvements in patient safety, effectiveness and experience. We appreciate the opportunity to review the account and hope that this is accepted as a fair reflection. We commend the Trust on its commitment to working with the CCG in a collaborative and transparent manner, and we look forward to continuing to work in partnership over the coming year.

Yours sincerely,

Jo Harding
Executive Director of Quality and Safety/Governing Body Nurse
## Appendix C: Glossary of Terms

<table>
<thead>
<tr>
<th><strong>Acute Hospital Trust</strong></th>
<th>an NHS organisation responsible for providing healthcare services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Always Events</strong></td>
<td>aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time.</td>
</tr>
<tr>
<td><strong>Antimicrobial Stewardship</strong></td>
<td>antibiotic stewardship refers to a set of coordinated strategies to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs.</td>
</tr>
<tr>
<td><strong>Birth-rate+</strong></td>
<td>a midwifery workforce planning tool, which allows midwives to assess their “real time” workload in the delivery suite.</td>
</tr>
<tr>
<td><strong>Board (of Trust)</strong></td>
<td>the role of the Trust’s Board is to take corporate responsibility for the organisation’s strategies and actions.</td>
</tr>
<tr>
<td><strong>Breakthrough Series Improvement Collaborative</strong></td>
<td>a model for achieving improvements in the quality of healthcare.</td>
</tr>
<tr>
<td><strong>BUFALO</strong></td>
<td>blood cultures and septic screen, Urine output, Fluid Resuscitation, Antibiotics IV, Lactate measurement, Oxygen.</td>
</tr>
<tr>
<td><strong>Care Quality Commission (CQC)</strong></td>
<td>the independent regulator of health and social care in England.</td>
</tr>
<tr>
<td><strong>Clinical Commissioning Group (CCG)</strong></td>
<td>clinically led NHS bodies responsible for the planning and commissioning of health care services for their local area.</td>
</tr>
<tr>
<td><strong>Clinical Audit</strong></td>
<td>clinical audit measures the quality of care and services against agreed standards, and suggests or makes improvements where necessary.</td>
</tr>
<tr>
<td><strong>Clinical Service Unit/Clinical Support Unit (CSU)</strong></td>
<td>the Trust is made up of 19 CSUs, which are groups of specialties that deliver the clinical services the Trust provides.</td>
</tr>
<tr>
<td><strong>Clostridium Difficile Infection (CDI)</strong></td>
<td>a type of bacteria which causes diarrhoea and abdominal pain, and can be more serious in some patients.</td>
</tr>
<tr>
<td><strong>Commissioning for Quality and Innovation (CQUIN) payment framework</strong></td>
<td>a framework which makes a proportion of providers’ income conditional on quality and innovation.</td>
</tr>
<tr>
<td><strong>Critical Care Step-Down</strong></td>
<td>an intermediate level of care between the Intensive Care Unit (ICU) and general medical-surgical wards.</td>
</tr>
<tr>
<td><strong>Datix</strong></td>
<td>patient safety and risk management software for healthcare incident reporting and adverse events.</td>
</tr>
<tr>
<td><strong>Department of Health (DoH)</strong></td>
<td>a department of the UK Government with responsibility for Government Policy for health, social care and NHS in England.</td>
</tr>
<tr>
<td><strong>Dr Foster Hospital Guide</strong></td>
<td>annual national publication from Dr Foster containing data from all NHS Trusts in England &amp; Wales highlighting potential areas of good and poor performance. The Guide’s focus changes each year but consistently contains measures of hospital mortality.</td>
</tr>
<tr>
<td><strong>e-DAN</strong></td>
<td>an electronic discharge advice note.</td>
</tr>
<tr>
<td><strong>eMeds</strong></td>
<td>an electronic system for prescribing and administration of medicines.</td>
</tr>
<tr>
<td><strong>e-Obs</strong></td>
<td>a digital method of recording the observations of patients’ vital signs.</td>
</tr>
<tr>
<td><strong>Employee Assistance Programme</strong></td>
<td>staff advice, information &amp; counselling service able to assist with financial, legal, family and personal issues.</td>
</tr>
<tr>
<td><strong>Enhanced care</strong></td>
<td>additional support provided to patients who require an extra level of care to ensure safety.</td>
</tr>
</tbody>
</table>
**Friends and Family Test:** a national NHS tool allowing patients to provide feedback on the care and treatment they receive and to improve services. It asks patients whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment.

**Gram-negative bacteria:** a class of bacteria that includes those that can cause, amongst others, pneumonia, bloodstream infections and surgical site infections in healthcare settings. Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics.

**HDU:** High Dependency Unit; a level of care between intensive care and general wards.

**Healthwatch Leeds:** Healthwatch is the independent consumer champion that gathers and represents the public’s views on health and social care services in England. It ensures that the views of the public and people who use the services are taken into account.

**Hospital Standardised Mortality Ratio (HSMR):** an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

**Hospital Episode Statistics (HES):** a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

**IHI Model for Improvement:** Institute for Healthcare Improvement. Combines with Lean Methodology to form the Leeds Improvement Method.

**Information Governance Toolkit:** the NHS Information Governance Toolkit ensures necessary safeguards for, and appropriate use of, patient and personal information.

**Kaizen Promotion Office (KPO):** established to drive the improvement work of the organisation in collaboration with the Virginia Mason Institute.

**Lean methodology:** a methodology to ensure we provide the highest quality care for patients, whilst reducing inefficiencies and getting the best value for public money.

**Leeds Care Record:** the Leeds Care Record gives health and social care professionals directly in charge of your care access to the most up-to-date information about you by sharing certain information from your records between health and social care services across Leeds.

**Leeds Improvement Method (LIM):** the method focusses on improving efficiency and flow of our services under the three key concepts: value, waste, and respect for people.

**Leeds Involving People:** an organisation that represents the independent voice of people through the promotion of effective involvement. It involves the community in the development of health and social care services by ensuring their opinions and concerns are at the centre of decision making processes.

**MBRRACE:** Maternal, Newborn and Infant Clinical Outcome Review Programme. Aims to study to collect data on patient care to inform service improvements in maternity services nationally.

**Medically Optimised For Discharged (MOFD):** a patient who is medically fit for discharge, after a clinical decision has been made that the patient is ready to transfer.

**Methicillin Resistant Staphylococcus Aureus bacteraemia (MRSA):** a bacterial infection.

**MSSA related infections:** infections as a result of methicillin-susceptible S. aureus (bacteria).

**National Child Protection Information System (CP-IS):** a project to help health and social care staff to share information securely to better protect vulnerable children.

**National Confidential Enquiry into Patient Outcome and Death (NCEPOD):** reviews clinical practice across England and Wales, and makes recommendations for improvement.

**National Institute for Health and Care Excellence (NICE):** an independent organisation responsible for providing national guidance on promoting good health, and preventing and treating ill health. It produces guidance for health care professionals, patients and carers, to help them make decisions about treatment and health care.
<table>
<thead>
<tr>
<th><strong>National Institute for Health Research (NIHR):</strong></th>
<th>an organisation which aims to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National maternity Better Births</strong></td>
<td>a nationwide initiative to improve outcomes of maternity services in England.</td>
</tr>
<tr>
<td><strong>National Payment by Results (PBR):</strong></td>
<td>the payment system in England under which commissioners pay healthcare providers for each patient seen or treated.</td>
</tr>
<tr>
<td><strong>National Reporting and Learning System (NRLS):</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Never Events:</strong></td>
<td>serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.</td>
</tr>
<tr>
<td><strong>Patient Advice and Liaison Service (PALS):</strong></td>
<td>offers support, advice and information on NHS services to patients, their carers, the general public and hospital staff.</td>
</tr>
<tr>
<td><strong>Patient Reported Outcome Measures (PROMs):</strong></td>
<td>a measure of quality from the patient’s perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre and post-operative surveys.</td>
</tr>
<tr>
<td><strong>Perfect Week</strong></td>
<td>a national initiative designed by the Emergency Care Intensive Support Team (ECIST) to help improve Patient Flow and Patient Experience.</td>
</tr>
<tr>
<td><strong>Perinatal Mortality Review Tool:</strong></td>
<td>a data collection tool which aims to support standardised perinatal mortality reviews across NHS maternity and neonatal units.</td>
</tr>
<tr>
<td><strong>Rapid Discharge Plan (RDP):</strong></td>
<td>a patient-specific plan to facilitate safe, urgent transfer of care for patients expressing a wish to die at home.</td>
</tr>
<tr>
<td><strong>RCA process:</strong></td>
<td>Root Cause Analysis. A method of problem solving used for identifying the root causes of faults or problems.</td>
</tr>
<tr>
<td><strong>RESPECT:</strong></td>
<td>A Recommended Summary Plan for Emergency Care and Treatment, that is agreed by a patient and their healthcare professional. It includes recommendations about the care an individual would like to receive in future emergencies if they are unable to make a choice at that time.</td>
</tr>
<tr>
<td><strong>Safety Thermometer data collection tool:</strong></td>
<td>a local improvement tool for measuring, monitoring and analysing patient harms and harm free care.</td>
</tr>
<tr>
<td><strong>Secondary Uses Service:</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Seven Day Hospital Services:</strong></td>
<td>the ambition of the initiative is for patients to be able to access hospital services which meet four priority standards every day of the week.</td>
</tr>
<tr>
<td><strong>SPC chart:</strong></td>
<td>Statistical Process Control chart. Data is plotted chronologically to see changes over time.</td>
</tr>
<tr>
<td><strong>Summary Hospital-level Mortality Indicator (SHMI):</strong></td>
<td>an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital.</td>
</tr>
<tr>
<td><strong>The Leeds Way:</strong></td>
<td>The ‘Leeds Way’ is the Values of Leeds Teaching Hospitals Trust created by staff. It defines who we are, what we believe and how we will work to deliver the best outcomes for our patients. The Values are Fair, Patient Centred, Collaborative, Accountable and Empowered.</td>
</tr>
</tbody>
</table>
**The National Bereavement Care Pathway (NBCP):** a project to help professionals support families in their bereavement after any pregnancy or baby loss.

**Trust Members:** Trust Members have a say in the services the Trust offers and help us understand the needs of our patients, carers and local population, in order to improve our services. Anyone aged 16 years or over living in England or Wales can become a member.

**Trust’s Youth Forum:** designed to allow young people to put across their points of view about the Trust and share their experiences and opinions of hospital in general.

**Venous thromboembolism (VTE):** a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vein can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT).

**WYAAAT:** West Yorkshire Association of Acute Trusts.
### Appendix D: Trust Participation in NCEPOD and National Audits

#### Summary tables of participation in NCEPOD Studies and DoH recommended national audits

<table>
<thead>
<tr>
<th>National Confidential Enquiry</th>
<th>Participation Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Heart Failure</td>
<td>77.9%</td>
</tr>
<tr>
<td>Cancer in Children, Teens and Young Adults</td>
<td>100%</td>
</tr>
<tr>
<td>Chronic Neurodisability</td>
<td>93%</td>
</tr>
<tr>
<td>Young People’s Mental Health</td>
<td>75%</td>
</tr>
<tr>
<td>Perioperative Diabetes</td>
<td>NYA **</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Participation Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Cardiac Surgery</td>
<td>100% ***</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>99%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management</td>
<td>100% ***</td>
</tr>
<tr>
<td>Case Mix Programme</td>
<td>100%</td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric Cardiac Surgery)</td>
<td>100%</td>
</tr>
<tr>
<td>Cystectomy Audit</td>
<td>98%</td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit</td>
<td>NYA</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database</td>
<td>93.6%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Inpatient Falls</td>
<td>100%</td>
</tr>
<tr>
<td>Fractured Neck of Femur</td>
<td>93%</td>
</tr>
<tr>
<td>Female Stress Urinary Incontinence</td>
<td>19%</td>
</tr>
<tr>
<td>Head and Neck Oncology Audit</td>
<td>NYA</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Registry Biologics Audit</td>
<td>Non-Participation 17/18</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme</td>
<td>NYA</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>94%</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>100%</td>
</tr>
<tr>
<td>Myocardial Ischaemia National Audit Project</td>
<td>100% ***</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients</td>
<td>NYA</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Dementia: Spotlight Audit on Delirium</td>
<td>NYA</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry (NBSR)</td>
<td>NYA</td>
</tr>
<tr>
<td>Audit/Observed</td>
<td>Participation Status</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>100%</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Non-Participation 17/18</td>
</tr>
<tr>
<td>National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme: Transfusion Associated Circulatory Overload Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme: Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme: Audit of O Negative Red Cells</td>
<td>**</td>
</tr>
<tr>
<td>National Diabetes Core Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit</td>
<td>Participated Denominator unknown</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Transition Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit</td>
<td>99%</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>NYA</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>95% ***</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>NYA</td>
</tr>
<tr>
<td>National Maternal and Perinatal Audit (NMPA)</td>
<td>98%</td>
</tr>
<tr>
<td>National Neonatal Audit Programme (NNAP)</td>
<td>100%</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>100% (HES data)</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>100%</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
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</tr>
<tr>
<td>National Vascular Registry</td>
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<tr>
<td>Nephrectomy Audit</td>
<td>111%</td>
</tr>
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<td>Neurosurgical National Audit Programme</td>
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<td>Oesophago-gastric Cancer (NAOGC)</td>
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<tr>
<td>Pediatric Intensive Care (PICANet)</td>
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<tr>
<td>Pain in Children</td>
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<tr>
<td>Patient Reported Outcomes Measures - Hernia</td>
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<td>Patient Reported Outcomes Measures - Hip replacements</td>
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<td>Patient Reported Outcomes Measures - Knee Replacements</td>
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</tr>
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<td>National Audit</td>
<td>Participation Rate*</td>
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<td>---------------------</td>
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<tr>
<td>Adult Bronchiectasis</td>
<td>NYA</td>
</tr>
<tr>
<td>Breast and Cosmetic Implant Registry (BCIR)</td>
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<td>Bronchoscopy</td>
<td>NYA</td>
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<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP): Physiotherapy Hip Fracture Sprint Audit</td>
<td>Participated Denominator unknown</td>
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<tr>
<td>Female Genital Mutilation</td>
<td>Participated Denominator unknown</td>
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<tr>
<td>Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection</td>
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<tr>
<td>National 2017 Survey and Audit of Psychological Wellbeing and Support and Use of Alcohol and Other Drugs</td>
<td>NYA</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>NYA</td>
</tr>
<tr>
<td>National Audit of Small Bowel Obstruction</td>
<td>NYA</td>
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<tr>
<td>National Psoriasis Re-audit</td>
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<tr>
<td>Paediatric Bronchiectasis</td>
<td>100%</td>
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<tr>
<td>Programme</td>
<td>Participation</td>
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<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------</td>
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<tr>
<td>Perioperative Quality Improvement Programme</td>
<td>NYA</td>
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<tr>
<td>Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Antibiotic Consumption</td>
<td>NYA</td>
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<tr>
<td>Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Antimicrobial Stewardship</td>
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<td>Seven Day Hospital Services Self-Assessment Survey</td>
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</tr>
<tr>
<td></td>
<td>Denominator Unknown</td>
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<tr>
<td>Society for Acute Medicine's Benchmarking Audit (SAMBA)</td>
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<tr>
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<tr>
<td></td>
<td>Denominator Unknown</td>
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<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>100%</td>
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<tr>
<td>UK Renal Registry</td>
<td>100%</td>
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### Appendix E: CQUINS 2017-19

#### National CQUINS

| **1. Improving Staff Health and Wellbeing** | **1a. Improving staff health and wellbeing - Staff Survey**  
| | **1b. Healthy food for NHS staff, visitors and patients**  
| | **1c. Improving the uptake of flu vaccinations**  
| **2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)** | **2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings**  
| | **2b. Timely treatment of sepsis in emergency departments and acute inpatient settings**  
| | **2c. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours**  
| | **2d. Reduction in antibiotic consumption (per 1,000 admissions)**  
| **3. Improve services - mental health needs who present to A&E** | **3. Improving services - people with mental health needs presenting to A&E**  
| **4. Offering advice and guidance** | **4. Advice and guidance (NHSE to provide guide to support scheme)**  
| **5. NHS e-Referrals** | **5. NHS e-Referrals (1 year CQUIN - 2017/18)**  
| **6. Supporting proactive and safe discharge** | **6. Supporting proactive and safe discharge**  
| **7. Risky behaviours, alcohol and tobacco (1 year CQUIN 2018/19)** | Tobacco screening, brief advice, referral and medication offer  
| | Alcohol screening, brief advice or referral  

#### NHS England Specialist Commissioning CQUINS

| **BI1 Improving HCV Treatment Pathways through ODNs** | Providers participation in ODN & HCV patient access to treatment to accord with ODN guidelines  
| **BI4 Improving Haemoglobinopathy Pathways through ODN Networks** | Improve access by developing ODN and ensuring compliance with guidelines  
| **TR3 Spinal Surgery: Networks, Data, MDT oversight** | Setting up regional MDT; entering data into British Spinal Registry or Spine Tango: no surgery without MDT sanction  
| **IM3 Auto-immune Management** | Review specialised patient cases across Networks by MDTs, with data flowing to registries  
| **WC3 CAMHS Screening** | SDQ screening for paed inpatients with listed LTCs  
| **GE3 Medicines Optimisation** | To support procedural and cultural changes required fully to optimise use of medicines commissioned by specialist services  
| **CA2 Nationally Standardised Dose Banding for Adult Intravenous Anticancer Therapy (SACT)** | Standardisation of chemotherapy doses through a nationally consistent approach  
| **WC4 Paediatric Networked Care** | This scheme aims to align to the national PIC service review  
| **IM2 Cystic Fibrosis Patient Adherence (Adult)** | Improved adherence and self-management by patients etc  
| **Local QIPP Incentivisation Scheme** | Engagement with NHSE local QIPP proposals and delivery of agreed savings |
### Appendix F: Performance against National Priority Indicators

<table>
<thead>
<tr>
<th>Section A - National Operational Standards</th>
<th>Target</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
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<tbody>
<tr>
<td>RTT Incomplete</td>
<td>&gt;=92</td>
<td>87.87</td>
<td>88.72</td>
<td>88.72</td>
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<td>A&amp;E Performance</td>
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<td>88.29</td>
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<td>74.69</td>
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<td>59</td>
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<tr>
<td>Cancer: 62 Day: GP/Dentist Referrals</td>
<td>&gt;=85</td>
<td>72.8</td>
<td>78.5</td>
<td>77.1</td>
<td>78.9</td>
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<td>75.2</td>
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<td>Cancer: 62 Day: Screening</td>
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<td>95.0</td>
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<td>Cancer: 31 Day: 1st Treatment</td>
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<td>96.4</td>
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<td>95.7</td>
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<tr>
<td>Cancer: 31 Day: Sub Radiotherapy</td>
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<td>100.0</td>
<td>100.0</td>
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<td>Cancer: 14 Day: Urgent GP Referrals</td>
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<th>Section B - National Quality Contract Requirements</th>
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<td>HCAI: MRSA</td>
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<td>HCAI: CDiff</td>
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<td>VTE Risk Assessment</td>
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<tr>
<td>VTE RCA Completion Rate</td>
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<tr>
<td>RTT Incomplete 52+ Week Waiters</td>
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<tr>
<td>Cancelled Ops: Urgent Cancels 2nd/Sub</td>
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<tr>
<td>Ambulance Handovers: 30 - 60 mins</td>
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<tr>
<td>Ambulance Handovers: Over 60 mins</td>
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<tr>
<td>A&amp;E 12 Hour Trolley Waits</td>
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<td>Friends and Family Test: Response Rate - Inpatients</td>
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<td>Friends and Family Test: Response Rate - A&amp;E</td>
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<td>eDAN: Completed</td>
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<tr>
<td>eDAN: Sent to GP within 24 hrs</td>
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<tr>
<td>Complaints: Total</td>
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<td>Complaints: % Responded to within target time</td>
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### Section C - NHSE Quality and Contract Requirements

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<th>Serious Incidents (SUs)</th>
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<th>7</th>
<th>6</th>
<th>7</th>
<th>6</th>
<th>3</th>
<th>7</th>
<th>10</th>
<th>13</th>
<th>4</th>
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<th>9</th>
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<tr>
<td>Gynae Cytology 14 Day TATs</td>
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<td>94.72</td>
<td>94.40</td>
<td>95.06</td>
<td>95.35</td>
<td>95.40</td>
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<td>94.64</td>
<td>94.90</td>
<td>94.97</td>
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<td>Harm Free Care</td>
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<td>94.72</td>
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<td>95.06</td>
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### Section D - Local Quality and Contract Requirements

<table>
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<th>Cancer: 62 Day: Consultant Upgrade</th>
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<th>77.8</th>
<th>89.5</th>
<th>91.3</th>
<th>93.9</th>
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<th>59.3</th>
<th>70.9</th>
<th>81.0</th>
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<tbody>
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<td>OP FUP Backlog: More than 3 months overdue</td>
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<td>6,956</td>
<td>7,148</td>
<td>8,219</td>
<td>6,237</td>
<td>5,926</td>
<td>5,849</td>
<td>6,592</td>
<td>5,832</td>
<td>5,796</td>
<td>5,529</td>
<td>5,432</td>
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<tr>
<td>OP FUP Backlog: More than 12 months overdue</td>
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<td>36</td>
<td>36</td>
<td>31</td>
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<td>32</td>
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<td>28</td>
<td>29</td>
<td>31</td>
<td>31</td>
</tr>
</tbody>
</table>

### Section E - Internal Monitoring

| Dementia Performance: Stage 1 | >=90 | 99.91 | 100.00 | 99.81 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |
| Dementia Performance: Stage 2 | >=90 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |
| Dementia Performance: Stage 3 | >=90 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |
| Pressure Ulcers (Grade 3) (developed) | -    | 6    | 2    | 6    | 5    | 1    | 5    | 4    | 4    | 5    | 1    | 3    | 4    |
| Pressure Ulcers (Grade 4) (developed) | -    | 1    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 1    | 0    | 0    | 0    |
| Urgent Biopsies and Non Gynae Cytology - 7 Day Target | >=45 | 63.95| 69.58| 69.31| 71.79| 70.04| 75.24| 70.70| 53.81| 67.05| 65.65| 57.48| 64.98 |
| All Histo and Gynae Cytology - 14 Day Target | >=80 | 78.72| 78.56| 83.51| 84.03| 82.56| 78.56| 77.60| 72.06| 79.55| 74.83| 66.72| 76.63 |
| OP Appts Cancelled 2 or More Times (Total) | -    | 2,387| 2,503| 2,558| 2,390| 2,680| 2,530| 2,625| 2,337| 2,944| 2,582| 3,111| 2,633 |
| OP Appts Cancelled 2 or More Times (By Hospital) | -    | 977  | 1,051| 1,162| 981  | 1,077| 996  | 1,025| 961  | 1,163| 926  | 1,114| 1,064 |
| Research Studies Recruited to Time and Target | >=80 | 78.72| 78.56| 83.51| 84.03| 82.56| 78.56| 77.60| 72.06| 79.55| 74.83| 66.72| 76.63 |
| Research Studies First Patient Recruited Within 70 Days | >=80 | 78.72| 78.56| 83.51| 84.03| 82.56| 78.56| 77.60| 72.06| 79.55| 74.83| 66.72| 76.63 |