Quality Account
2016-17
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Part 1: Chief Executive’s Statement from the Board

1.1 Introducing the Trust

The Leeds Teaching Hospitals NHS Trust is one of the largest and busiest NHS acute health providers in Europe, a regional and national centre for specialist treatment, a world renowned biomedical research facility, a leading clinical trials research unit, and also the local hospital for the Leeds community. This means we have access to some of the country’s leading clinical expertise and the most advanced medical technology in the world. Each year around 10,000 babies are born in our hospitals; we see around 100,000 day cases, 125,000 inpatients, 200,000 patients attending A&E and 1,050,000 in our outpatient departments, 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 2016/17 has been developed with our staff, stakeholders and partner organisations, including clinicians and senior managers, commissioners at NHS Leeds West Clinical Commissioning Group (CCG), and Healthwatch Leeds. It has been approved by the Trust Board.

1.3 Chief Executive’s Statement on Quality

On behalf of the Trust Board and staff working at Leeds Teaching Hospitals NHS Trust, I am pleased to introduce you to our Quality Account for the year 2016/17.

We had much to be proud of in our achievements through 2016/17. We have continued to make improvements in quality and safety whilst facing a significant financial challenge. We have also continued to experience pressures relating to emergency admissions and capacity within our hospitals throughout the year, which has affected all NHS trusts. We have worked with our partners in health and social care to improve the flow of patients and facilitate timely discharge, opening two new wards at Wharfedale hospital to help with this, supported by Villa Care.
In May 2016 the Care Quality Commission (CQC) returned to do a follow-up inspection; they undertook their first comprehensive inspection of our hospitals in March 2014 and judged the Trust as “Requires Improvement”. We were therefore delighted to be rated “Good” in the most recent inspection, reflecting the significant progress we have made in improving our culture of quality and safety across the Trust.

Leeds Teaching Hospitals NHS Trust was chosen to be one of only five Trusts in the UK to work with the prestigious Virginia Mason Institute on a programme known locally as the Leeds Improvement Method, providing a framework for improving quality and efficiency across the organisation. It has brought together staff with a range of skills and experience to review how they work to improve the experience of patients in our care and staff who work in our hospitals. This work began in Elective Orthopaedics at Chapel Allerton Hospital and we have introduced new workstreams in our surgical services, critical care and outpatients. We have trained a wide range of staff in lean methodology and this continues to be embedded in our safety culture.

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

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

Signed

Date: 30 June 2017

Julian Hartley, Chief Executive

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

2.1 Our Priority Improvement Areas for 2017/18

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

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

Clinical Effectiveness
Leeds Improvement Method Value Streams

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

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

2.1.1 Quality Improvement Strategy and Programme

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

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

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

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

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

The programme involves formal training and certification in lean methodology that will provide the Trust with the opportunity to bring about sustainable and lasting culture change. Over the next three years it includes intensive support through coaching and mentoring for our Leeds Improvement Method Team, leaders and staff across the Trust, in how Virginia Mason have applied lean methodology and continuous improvement successfully in a healthcare setting.

Launched in Elective Orthopaedics in Chapel Allerton Hospital in 2015, it has brought together staff with a range of skills and experience to review and adjust how they work to increase their efficiency and improve patients’ experience of our care. It has already helped to reduce waiting times and theatre setup times.

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

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

A fifth and final workstream has been agreed for launch in 2017/18 in the Acute Medicine CSU.
In summary, the Leeds Improvement Method:

- Is patient focused.
- Is the application of observation and data analysis tools, to describe how patients experience our services.
- Supports staff to systematically remove waste.
- Promotes zero defects and zero harm for patients.
- Uses a disciplined timeframe.
- Encourages participation and respect for each other as equals.

At the core of the method are local leadership, forensic analysis of our processes focussing on the patients’ experience of our care, and a team approach to improvement directly where the work is done. This, in turn, encourages participation and respect for each other as equals for the work we do.

A video to describe this work here at Leeds Teaching Hospitals can be found here: www.leedsth.nhs.uk/assets/Uploads/NHS-Leeds-VMI-Final2.mp4
2.2 Progress against our Quality Goals 2016/17

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

Patient Safety
- Improvement in the care of patients with acute kidney injury (see section 3.2.1)
- Improvement in the care of patients with sepsis (see section 3.2.2)
- Reduction in number of hospital acquired pressure ulcers and the incidence of category 3 and category 4 pressure ulcers (see section 3.2.5)
- Best use of antibiotic medicines (antimicrobial stewardship) (see section 3.2.12)

Clinical Effectiveness
Leeds Improvement Method Value Streams (see section 3.4):
- Chapel Allerton Orthopedic Centre - total hip and knee replacement patients
- Discharge - Abdominal Medicine & Surgery, specifically focusing on prostate surgery patients
- Critical Care step down
- Outpatient Services

Patient Experience
- Making it easier to hear the patient voice - establishing a Patient Reference Group and Patient Leader Programme (see section 3.1.2)
- Improving understanding of our feedback - improving monitoring of Friends and Family Test (FFT) percentage recommended, by ward area (see section 3.1.5)
- Learning and improving from what patients and families tell us:
  - Implementing method of capturing actions arising from FFT data and Patient Advice & Liaison Service (PALS) concerns (see sections 3.1.4 and 3.1.11)
  - Responding to patient feedback in Outpatients through delivery of programmes to address concerns (see section 3.1.7)

These remain part of our overall Quality Improvement Programme and span more than one year.
Part 3: Review of Quality Programme

3.1 Patient Experience

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

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

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

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

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

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

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

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

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

What We Did in 2016/17
A ‘Big Event’ was held on 25th November 2016 with the objective of encouraging the public to sign up to become members of a new Trust Patient Reference Group. The aim of the Reference Group is to provide a mechanism for Trust-wide strategy, services, and projects, to have access to the patient voice, in their development.
The first meeting of the Group was held in January 2017 and generated much interest and enthusiasm. The Group agreed to support the development of a Trust Patient Experience Strategy as one of their first pieces of work. Much of the second PRG meeting held in March 2017 was spent in hearing the Group’s ideas and views about the form and content of that strategy.

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

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

**Our Ongoing Aim**

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

### 3.1.3 Staff Friends and Family Test (Staff FFT)

Following the successful introduction of the Friends and Family Test (FFT), the facility was extended to staff for the first time from April 2014, to provide on-going feedback about the Trust. All staff are invited to participate in quarters 1, 2 and 4. The results of Q2 2016/17 are shown below.

*Table 1: Comparison of Friends and Family Test Results May 2014-September 2016*

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 4</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 4</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Rate</td>
<td>750</td>
<td>1507</td>
<td>1514</td>
<td>1644</td>
<td>1671</td>
<td>1546</td>
<td>1053*</td>
<td>1976</td>
</tr>
<tr>
<td>(numbers of staff, students and volunteers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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% 81% 84% 86%</td>
<td>82%</td>
<td>86%</td>
<td>87%</td>
<td></td>
<td></td>
<td></td>
<td></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>65%</td>
<td>68%</td>
<td>68%</td>
<td>67%</td>
<td>66%</td>
<td>73%</td>
<td>73%</td>
</tr>
</tbody>
</table>

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

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

Table 2: Percentage of staff who would recommend the Trust as a provider of care to their family or friends

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

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

Table 3: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

<table>
<thead>
<tr>
<th>LTHT score 2014</th>
<th>LTHT score 2015</th>
<th>LTHT score 2016</th>
<th>National Average for acute trusts</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>
</tr>
</tbody>
</table>

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

Table 4: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

<table>
<thead>
<tr>
<th>LTHT score 2014</th>
<th>LTHT score 2015</th>
<th>LTHT score 2016</th>
<th>National Average for acute trusts</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>
</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.
3.1.4 Friends and Family Test

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

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

What We Did in 2016/17

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

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

Our Ongoing Aims

We aim to:

- Offer more patients a variety of methods to provide feedback using options such as:
  - Tablets
  - Text messaging
  - Instant voice messaging
  - Paper feedback cards
  - On-line FFT links

- Support clinical service units to make FFT accessible to all patients.
- Support clinical services to let patients know what actions have been taken when issues are identified through the FFT process.

Figure 5: Julian Hartley, Chief Executive and Suzanne Hinchliffe, Chief Nurse, at the re-launch of FFT with FFT Team and staff from J21
3.1.5 Friends and Family Test Early Warning System

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

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

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

What we did

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

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

Our Ongoing Aim

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

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

3.1.6 National Patient Surveys

We believe it is important that we listen and respond to the feedback that we receive from patients. The Trust takes part in a number of National Patient Surveys so we can check what patients think about their experiences with us to allow us to see whether actions we have put in place in response to previous surveys are having the desired effect and improving our services.
What we did
In the 2015 National Inpatient survey we scored poorly on questions relating to patients being asked to give views on the quality of care and on receiving information about how to complain. The Patient Experience Team undertook an audit of inpatient areas to ensure that posters and current leaflets were available to advise patients on how to provide feedback, raise concerns or complain. The 2016 survey demonstrated that we had improved in both these areas.

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

Table 5: Inpatient Survey: significant changes since last year’s survey (lower scores are better)

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

<table>
<thead>
<tr>
<th>Areas in which we have got significantly worse since last year (survey question)</th>
<th>2015</th>
<th>2016</th>
<th>National Trust Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Department: not given enough privacy when being examined or treated</td>
<td>19%</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>Discharge: did not always get enough support from health or social care professionals</td>
<td>43%</td>
<td>51%</td>
<td>46%</td>
</tr>
<tr>
<td>Care: not always enough emotional support from hospital staff</td>
<td>45%</td>
<td>51%</td>
<td>43%</td>
</tr>
<tr>
<td>Care: staff did not always work well together</td>
<td>22%</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

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

Emergency Department Survey 2016
The 2016 bi-annual National Emergency Department survey was published in May 2016. This survey demonstrated significant improvements in patients’ experiences of the doctors and nurses involved in their care since the 2014 survey.
Table 6: Emergency Department Survey: significant changes since 2014 survey (lower scores are better)

<table>
<thead>
<tr>
<th>Areas in which we have got significantly better since last survey (survey question)</th>
<th>2014</th>
<th>2016</th>
<th>National Trust Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care: wanted to be more involved in decisions</td>
<td>44%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Tests: results not fully explained</td>
<td>31%</td>
<td>19%</td>
<td>20%</td>
</tr>
<tr>
<td>Doctors / nurses did not fully explain condition and treatment</td>
<td>39%</td>
<td>32%</td>
<td>30%</td>
</tr>
<tr>
<td>Doctors / nurses did not fully discuss patient anxieties or fears</td>
<td>46%</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td>Doctors / nurses did not have complete confidence and trust</td>
<td>26%</td>
<td>21%</td>
<td>21%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Areas in which we have got significantly worse since last survey (survey question)</th>
<th>2014</th>
<th>2016</th>
<th>National Trust Average</th>
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</thead>
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<tr>
<td>Waiting: waited more than 15 minutes before speaking to a doctor or nurse</td>
<td>56%</td>
<td>68%</td>
<td>61%</td>
</tr>
<tr>
<td>Hospital: emergency department not very or not at all clean</td>
<td>1%</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Our Aim

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

3.1.7 Learning from What Patients Tell Us

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

What We Did in 2016/17

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

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

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

Our Ongoing Aim

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

3.1.8 Patient Experience Toolkit

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

What We Did

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

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

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

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

Our Aim

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

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

**Figure 9: Number of complaints received in Trust (cumulative) 2015/16 and 2016/17**

**Figure 10: Number of reopened Trust complaints (cumulative) 2015/16 and 2016/17**

**What We Did**

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

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

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

**Our Ongoing Aim**

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

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

**What We Did**

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

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

*Figure 11: Speak to Sister Posters*

**Our Aims**

In 2017/18 we aim to:

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

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

![Figure 12: Number of PALS received 2015/16 and 2016/17](image)

**What We Did**

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

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

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

![Figure 13: PALS Staff Visiting the Gipton Community Hub](image)

**Our Aim**

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

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

**What We Did in 2016/17**

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

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

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

The Trust has agreed two objectives to date:

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

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

**Our Aim**

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

3.1.13 Learning Disability

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

The Champions and the Learning Disability Team have been such a success they won The Yorkshire Evening Post’s Healthcare Team of the Year in December 2016. The Team are
continuing with their great work to ensure all patients who require reasonable adjustments receive support and to ensure that Leeds Teaching Hospitals provides fair access to all.

**What We Did in 2016/17**

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

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

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

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

**Our Aims**

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

**3.1.14 Calm at Night**

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

**What We Did**

We surveyed over 400 inpatients and 35 members of staff to find out what they thought about our hospital environment at night. 45% of patients surveyed said they slept badly or very badly. The results indicated that some improvements could be made not only in terms of noise, but also in terms of activity, environmental temperature, and excessive light.
A member of the Patient Experience Team observed the ward environment first hand at night on the SJUH and LGI sites. Some immediate actions were taken as a result of these observations, including recommending the repair or maintenance of noisy doors and equipment, and adjusting the timings of stock deliveries to delivery bays on the LGI site.

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

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

What We Did in 2016/17
We implemented a Family Integrated Care project at St. James’s University Hospital. A discharge co-ordinator for the Children’s Hospital has now been introduced as a result, to ensure successful discharge of babies from the neonatal units. The project overall has resulted in increased breast feeding rates and reduced lengths of stay on the unit.

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

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

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

Our Aim in 2017/18
- We will implement the model of Family Integrated Care in the Transitional Care Unit at the Leeds General Infirmary. This will also be rolled out to the Neonatal Intensive Care Unit (NICU) and the Neonatal High Dependency Unit at LGI.
- We will also support the Neonatal Unit’s development of its information pages on the Trust internet site. In addition, we will ensure patient stories are filmed and made available through the Leeds Children’s Hospital TV Channel. This work will ensure families have access to information and advice through a number of different sources.
3.1.16 Bereavement Service

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

What We Did in 2016/17

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

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

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

Our Aim for 2017/18

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

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

What We Did

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

This has enabled our local patients to continue to receive services they are familiar with; delivered by people they have existing relationships with.

Our Ongoing Aim

• To continue to provide patients of Leeds Teaching Hospital high quality access to healthcare through the provision of appropriate interpreters.

• To ensure patients receive the most appropriate access support they need at the right time, and in the right place.

• Continue to monitor service provision and check user feedback to ensure our service meets the needs of our patients.

3.1.18 Volunteering

The Voluntary Services Team has been through a period of review in 2016 with a new management structure now in place. Since August 2016, a full review of Trust processes for the attraction, recruitment, selection and allocation of volunteers at LTHT has taken place and new ways of working have been developed.

What We Did in 2016/17

Since September 2016, 126 volunteers have been recruited to a variety of existing and new roles designed to meet the needs of the patients we care for. A greater focus on collaboration with clinical colleagues has been adopted, which the Voluntary Services Team hope will increase the number of volunteers in the Trust over the coming years.

We trialled the collaborative model of working in Children’s Services, Neurosciences and the Liver Unit. This has produced 3 schemes so far:

• Bedside buddies (Children's Services). These volunteers read stories to children.

• Peer Support Volunteers (Neurosciences). These volunteers have previously experienced a stroke and support patients with this condition.

• Infection Control Support (Liver Unit). These volunteers support and promote hand hygiene on the unit.
We also developed a focus group where volunteers are asked to feedback their experience of working in the Trust to drive future improvements. This takes place every three months.

Finally, we organised a celebration event for our volunteers in June 2016 that was attended by Trust Chair Linda Pollard and Chief Nurse Suzanne Hinchliffe.

**Our Ongoing Aims**

- To continue to support recruitment that provides volunteer roles which add value to the needs of our patients and the Trust.
- To engage with our volunteers to encourage more people to join the service and to help us to understand what we should do to support our volunteers to stay with us.
- To show volunteers our appreciation for their commitment and dedication to the Trust and its patients.

**3.1.19 Engaging with our Members**

In 2016/17, the Trust continued to engage with Trust Members, now totalling over 26,000.

Members receive two member magazines per year, called Connect, which provide information on Trust developments and Patient and Public Involvement activities.

To date, the Trust has collected just over 7,600 responses to the Public and Patient Involvement (PPI) Questionnaire. The PPI Questionnaire identifies members who have had experiences within services at LTHT within the last two years. Responses are stored on a database and can be viewed and selected, using search criteria, so the information can be used for improvement projects.

In the latter part of 2016, the Patient Experience Team began using this feedback for a small number of projects and also extended the use to CSUs through a workshop in December. Feedback provided by members was used to influence service changes and improvements in a range of areas, including Theatres & Anaesthetics, Outpatient discharge letters and the rebranding of the Leeds Cancer Centre. The Research and Innovation Team also sent a communication to members who had registered an interest in becoming part of a patient forum, in an attempt to recruit 10 Patient Research Ambassadors. This advertisement received over 130 member responses.

Connect also gives information regarding Leeds Teaching Hospitals NHS Trust (LTHT) Membership events, Medicine for Members. In 2016, the Trust held 22 sessions, inviting members to learn about the exciting and innovative work undertaken at LTHT. The events are presented mainly by clinical staff giving an overview of their professional area of expertise. Almost 900 members attended the 2016 programmes overall, which is an increase of around 300 more members than the sessions presented in 2015. The Osteoarthritis session, held on 3rd October 2016, was one of the most popular events, with 82 members attending the session. The CQC Inspection Event in April 2016 was also very well attended, with 122 members attending.
3.2 Patient Safety

3.2.1 Improvement in the care of patients with acute kidney injury (AKI)

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

The Tackling Acute Kidney Injury (AKI) project was launched in April 2016 as part of a Health Foundation ‘Scaling up Improvement Programme’, across five NHS Trusts. Improvements will be achieved through awareness, education, an electronic alert, and use of the STOP AKI care bundle.

Key Achievements in 2016/17
• The AKI electronic alert and care bundle has been successfully piloted across eight wards within the Trust.
• The AKI alert is now visible on all wards within the Trust, allowing staff from all areas to complete the care bundle when the patient is identified as having AKI.
• The Trust observation charts have been updated to improve the awareness of AKI.
• There have been a number of targeted AKI education sessions for medical and nursing teams.
• The AKI staging is included on the Electronic Discharge Advice Notice (EDAN).
• Patient information leaflets have been developed to increase patient awareness.
• There is continued shared learning with other organisations in the project through peer assist events.

Aim for 2017/18
Our ambition is to continue to implement the AKI STOP care bundle across all our wards. Education and training will be a key focus in 2017/18 to ensure that all staff are aware of AKI diagnoses and management, and the importance of including information on the EDAN: this will ensure continuity of care and treatment throughout the patient pathway.
3.2.2 Improvement in the care of patients with Sepsis

**Background**

NHS hospitals treat around 150,000 cases of severe sepsis each year and many more with uncomplicated sepsis. It is one of the biggest causes of death in the UK but with early recognition and treatment, it is thought that mortality can be cut significantly.

In 2015 we tested and developed an intervention package for clinical areas to provide reliable and effective sepsis care: this consists of a screening tool and the interventions, collectively known as ‘BUFALO’.

**Key Achievements in 2016/17**

The Emergency Departments (EDs) and admission areas have implemented the sepsis protocols and are now embedding the use of the sepsis screening tool and BUFALO interventions.

Sepsis has also been incorporated into an e-learning package as part of our Acute Kidney Injury programme, which is coordinated by the Sepsis Operational Group.

The Sepsis Screening Tool has been introduced to pilot wards at both SJUH and LGI. We have seen consistent improvements in the proportion of patients attending the ED with Red Flag Sepsis features receiving appropriate antimicrobial therapy within one hour. We continue to have a low mortality in this group of patients for acute admissions through the ED (approx 10%) in line with published data for this group of patients. We have successfully achieved the targets agreed with the CCG for completion of the 2016/17 Sepsis CQUIN.

In order to further support staff education regarding sepsis, a training video has been produced that followed a patient admitted with sepsis through from ED to the ward, to HDU and successfully back to the ward after treatment.

A Paediatric Sepsis group has been formed to adapt the current NICE Sepsis Guidelines and Fever in Child guidelines into a safe and workable policy within LTHT that will apply across all areas of Leeds Children’s Hospital. An adapted screening tool is currently being piloted in the Children’s Assessment & Treatment Unit (CAT) and Paediatric ED.

**Aim for 2017/18**

Our ambition is to improve the identification of high risk sepsis patients, across LTHT, and reduce delays to their management.

In 2017/18 we aim to build on the foundations of the pilot wards, and implement the Sepsis Screening Tool and BUFALO interventions Trust-wide (including Leeds Children’s Hospital). Scale-up will commence in April 2017, ensuring timely identification and treatment for Sepsis in all acute inpatient settings.

We are integrating the sepsis work with other key projects across LTHT, such as the deteriorating patient work, AKI project, and the roll out of e-obs and eMeds.
3.2.3 Deteriorating Patients - Improvement in the Care of Patients When Their Condition Deteriorates on our Wards

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

In July 2014 we started a breakthrough series improvement collaborative with 14 wards trialling small scale tests of change, to reduce avoidable deterioration, including escalation of care stickers to alert clinical teams to deterioration and a brief guide for staff for recording observations. Following testing, an intervention bundle of the most successful changes was created, and tested across all pilot wards, from June 2015, before beginning to scale up to other Trust areas.

Achievements in 2016/17

Scale up of the intervention bundle began in three full CSUs in 2016/17; Acute Medicine, Abdominal Medicine and Surgery, and Cardio-Respiratory.

In July 2016 the pilot wards achieved their aim of a 50% reduction in cardiac arrest calls and following scale up to the Abdominal Medicine & Surgery, and Acute Medicine CSUs, there has been a Trust-wide step reduction in cardiac arrest calls, of over 25%.

Figure 21: Trust-wide Cardiac Arrest Calls January 2014 - March 2017

Aims for 2017/18

There are plans for the Trauma and Related Services CSU to begin further scale up later in 2017, followed by the Centre for Neurosciences, Oncology, and Women’s CSUs.

3.2.4 Reducing Patient Falls

Background

The most common patient safety incident causing harm reported by NHS Trusts relates to patients who fall whilst in hospital.

In July 2014, LTHT started a breakthrough series collaborative improvement programme with 14 pilot wards, and our aim was to reduce inpatient falls by 50%. A Falls Intervention Bundle was created and successful changes were then tested across all pilot wards.
Key Achievements in 2016/17

There has been a sustained decrease in the number of patients suffering a fall for the fourth year in a row, and by March 2017 the number of falls per 1000 bed days had decreased by 18.1% when comparing the inpatient fall rate to date in 2016/17 (3.86) to the previous financial year (4.72).

May 2016 saw the 14 pilot wards involved in the collaborative project reach their aim of 50% falls reduction compared to the start of the programme.

The intervention bundle has already been scaled up across four clinical service units (CSUs); Abdominal Medicine & Surgery (AMS) and Oncology have organised their own learning and celebration events to analyse their falls data and share learning between wards. The AMS CSU has been working on learning from the incidents that have occurred, as well as improving staff training. Between April 2016 and the end of March 2017 it has seen a 9.3% reduction in the total number of falls compared to the same time period in the previous financial year, and seen an 8.3% reduction in their falls rate per 1000 bed days compared to the previous year.

The Oncology CSU has also improved its nursing staff’s falls prevention competency training by running twice weekly training sessions. Safety huddles are now embedded in all wards and the CSU is using the Falls Intervention Bundle. It noticed that a number of the falls on its wards were suffered by patients who did not wish to bother the nursing staff. This led to the development of a
sticker which the nurses have started to wear that says “Don’t risk a FALL, give us a CALL”, as well as using patient stories on the wards. This is a great example of a CSU responding to the themes of their own incidents and developing their own intervention. They have seen a 17% reduction in the total number of falls in 2016/17 compared to the previous financial year.

![Figure 24: Falls Per 1000 Bed Days in Oncology, April 2015 - March 2017](image)

**Aim for 2017/18**

Our ambition for 2017/18 is to scale up further the implementation of the Falls Intervention Bundle across all wards in the Trust and achieve and sustain a further reduction in the number of falls Trust-wide. The Trust Inpatient Falls Prevention group will oversee the improvement work across the CSUs and help to spread good practice and lessons learnt from falls that result in serious harm.

### 3.2.5 Reduction in the Number of Hospital Acquired Pressure Ulcers, and the Incidence of Category 3 and Category 4 Pressure Ulcers

Pressure ulcers can be painful, affect quality of life, lengthen hospital stay, and may even be life threatening. It is estimated that 80-95% of all pressure ulcers are avoidable.

Our commitment is to reduce by 50% all avoidable pressure ulcers through the Trusts QI programme launched in November 2015, based around the ‘Stop the Pressure’ initiative from Midlands & East Region. As part of this initiative we are testing a range of interventions that sit under a SSKIN acronym:

- **S**urface - appropriate mattress/cushion
- **S**kin Inspection
- **K**eep Moving
- **I**ncontinence/Moisture
- **N**utrition/Hydration

This framework has been widely tested and implemented in a range of acute hospitals.
Key Achievements in 2016/17

- Following successful testing of the SSKIN Bundle within a number of CSUs, scale up started in 2016 and is currently focussed in the Abdominal Medicine & Surgery, and Trauma & Related Services CSUs, supported by the Tissue Viability Team and a Clinical Leadership Fellow for Nursing.

- There has been a reduction in the incidence of all hospital acquired pressure ulcers (PU) by 4% over the year 2016/17.

- Incidence of all hospital acquired PUs per 1000 bed days has reduced by 5%.

- Category 3 hospital acquired PUs have decreased by 13% in 2016/7.

![Figure 25: Number of New Pressure Ulcers](image)

Aim for 2017/18

- Our ambition in the first instance is to reduce by 50% all avoidable hospital acquired Pressure Ulcers by April 2018 through scale up and spread of the SSKIN interventions across the Trust.

- Our longer term ambition is to have no category 3 or 4 avoidable hospital acquired pressure ulcers.

3.2.6 Scaling up Improvement: Reducing Harm and Improving Patient Safety Culture by Integrating Daily Patient Safety Huddles on Wards

Background

Ward led Safety Huddles were first tested on four wards at LTHT in 2013, with evidence of reduction in patient harm, and improved teamwork and safety culture. Our Trust was one of four acute trusts awarded a ‘Scaling up Improvement’ grant, worth £500,000 from the Health Foundation in 2014.

Safety Huddles are a ward patient safety meeting focused on one or more agreed patient harm. They follow some general principles; staff review how many days it is since the last fall, cardiac arrest, or other agreed harm; look at who may be at risk of the harm today and what actions need to be implemented by the team to reduce the risk. Patient and public engagement events have been held where safety huddles are demonstrated. Suggestions from attendees as to how patient and carer views and concerns can brought into the daily huddle are currently being tested on several wards.
Key Achievements in 2016/17
So far, huddles have been adapted and embedded to 63% of wards at LTHT, and 81% of wards are using huddles. This has been associated with reductions in harm including falls, pressure ulcers, cardiac arrests, and improvements in safety culture. As a result many other organisations nationally are taking an interest in our learning and improvement.

Aim for 2017/18
Our ambition is to embed safety huddles on all our wards by the end of 2017.

3.2.7 Improving Care for Patients with Parkinson’s

Background
There are approximately 1500 patients with Parkinson’s in the Leeds Teaching Hospitals Trust catchment area, and around 30-40 inpatients in the Trust with Parkinson’s at any time. In August 2016 we launched our improvement collaborative, with 16 clinical areas from across the Trust, to improve the care of patients with Parkinson’s. This was in response to feedback from patients’ families and, in this collaborative, patients and carers are actively involved. Our ward areas are testing small scale tests of change, using the breakthrough series collaborative model, with the support of a multi-disciplinary team, including a patient representative.

Our aim is that all patients with Parkinson’s receive timely administration of medication and holistic care by;
- Identifying and promptly administering Parkinson’s medications.
- Improving culture, teamwork, and accountability.
- Identifying and promptly managing patients with swallowing difficulties.

Key Achievements in 2016/17
Working with carers, our faculty and front line teams have already:
- Raised awareness across the wards and through a launch event and Parkinson’s Masterclasses for staff
- Created a real time list of current inpatients with Parkinson’s Disease
- Developed educational material
- Developed tools to support collection of data to highlight good practice and areas for improvement
- Seen a reduction in omitted Parkinson’s medications, and a reduction in the delay in patients receiving their first dose of medication after admission

**Figure 26: Parkinson’s Medications Omitted in 24 Hours, January 2016 - April 2017**

**Figure 27: Delay in first dose of Parkinson’s Medication after admission, January 2016 - April 2017**

**Aim for 2017/18**
Our ambition is that all our patients in pilot areas with Parkinson’s receive timely administration of medication and holistic care by June 2017. We aim to further involve our patients and carers, to work in partnership with us to improve the quality of care we provide.
3.2.8 Maternity Care - Reduction in Harm

The publication of the Maternity Strategy in 2015 provided a focus for the top priorities for the service over a 5 year period, and is aligned closely with the National Maternity Review “Better Births - Improving outcomes of maternity services in England” 2016. Within the Maternity Service in Leeds we have identified several key work streams to progress this work further including:

**Safety Huddles**

Safety Huddles have been introduced on the postnatal ward to review high risk women i.e. readmissions, women on IV antibiotics and medication for blood pressure, or women who a midwife is concerned about. The safety huddle consists of a consultant obstetrician, junior doctors, midwives, and maternity support workers. It ensures that women are reviewed by senior members of staff, and placed on the appropriate treatment, required investigations are requested, and discharge is safe and timely.

**EROS (Enhanced Recovery in Obstetric Surgery)**

The Service has introduced EROS on both sites. This approach is a bundle of the best evidence based practices delivered by a multidisciplinary team with the intention of helping patients to recover faster after surgery.

**Sepsis**

Through national audit, sepsis has been identified as one of the leading causes of maternal morbidity and mortality. Within the Maternity service we have taken steps to address this by including a sepsis module in the new electronic patient record system that is to be introduced in 2017/18 - the aim being to improve the identification of women at risk of developing sepsis so that treatment can be commenced in a timely manner.

**Stillbirths**

In 2016 NHS England published the Saving Babies’ Lives Care Bundle - designed to tackle stillbirths by bringing four elements of care together, namely by;

1. Reducing smoking in pregnancy - Carbon Monoxide monitoring of all pregnant women has been introduced across the antenatal care pathway and targeted support for women who smoke to be referred to stop smoking services. Women who continue to smoke during pregnancy are offered additional growth scans.

2. Risk assessment and surveillance for fetal growth restriction - 6 midwives have been trained to undertake 3rd trimester ultrasound scanning, including fetal growth assessment.

3. Raising awareness of reduced fetal movement - Staff have been trained to discuss with women the monitoring of fetal movements in pregnancy and clear referral pathways have been introduced.

4. Effective fetal monitoring in labour - An enhanced multidisciplinary training package has been introduced which incorporates human factors and situational awareness training in relation to fetal monitoring in labour. In addition, the purchase of new cardiotocograph fetal monitoring machines has improved the quality of recordings obtained.

We are working closely with other units in the Yorkshire region to develop a consistent regional process for stillbirth review and sharing learning to reduce harm.

**Training**

The maternity service has recently been awarded £80,000 to spend on training for staff; the focus of this will be around developing further training in relation to recognising the role of human factors in incidents, the development of the labour ward teams, and resilience training.
3.2.9 Staffing

We know that great care is dependent on great staff. Our ambition is to make LTHT one of the best places to work. We have been growing our workforce, from 15,200 in March 2014 to 17,200 in December 2016.

The right number of staff is an essential precondition to great care but is not enough on its own. We are embedding our values through The Leeds Way to drive staff engagement and use a number of different approaches to build engagement. From the 2016 Staff Survey we are proud to see that we are best performing Trust in England in terms of the number of staff having an appraisal. In 2016 the Trust also launched an Employee Assistance Programme which provides a range of confidential support services to our staff.

In 2015 we were the most improved Trust on the national staff survey, improving our results in 17 key result areas and the 2016 Staff Survey shows further improvements: we now have results in the top 20% of Trusts and 25 of our 32 key findings are average or above. In 2016 we have seen improvement in 21 of the 32 key findings and maintained performance in the other 11.

We have continued to expand our opportunities for apprentices and have recruited around 400 people since April 2015 across a range of disciplines, including nursing, business administration and other clinical areas. We are proud that our programmes have won a range of awards over the past 12 months and we have been recognised as the West Yorkshire Centre of Excellence in collaboration with Bradford District Care Trust, by Skills for Health.

**Nurse Staffing**

In 2014 the Trust committed to investing £14 million in additional nursing staff enabling clinical teams to increase their establishments. In 2016-17 we continued to recruit across the registered and unregistered workforce to maximise this investment. The Trust has also changed the provider of the internal Bank to increase financial efficiency and optimise staffing levels.

Ward rosters are now fully electronic to reduce variation, increase transparency and to ensure the effective deployment of substantive and temporary staff.

Ward establishment reviews have been completed for all CSUs to explore opportunities to modernise the workforce. This includes changing the workforce model to increase senior nursing numbers (to attract experienced staff) or a shift in skill mix to better reflect the range of skills and roles now available to deliver high quality care.

**Recruitment: Registered Staff – Nurses, Midwives and Operating Department Practitioners (ODPs)**

In 2016/17, we attended four national recruitment fairs, the Royal College of Nursing Congress and a number of university events across the country. These are now attended in conjunction with our city partners, promoting Leeds as a first class place to pursue a career in nursing and as a place to live. Internally, a number of CSU or site-specific recruitment campaigns and events have taken place, for example LGI-site specific, the Children’s Hospital and the Acute Medicine CSU.
The Trust continues to work with the local universities and healthcare partners to attract graduating nurses, midwives and ODPs, and in 2016/17 over 200 newly qualified staff joined the Trust through this process. In 2016/17, 566 new Band 5 nursing staff started in the Trust.

**Recruitment: Support Staff – Clinical Support Workers, Assistant Practitioners and Nursing Associates.**

The Trust has now got a full range of developmental opportunities for support staff, enhancing career progression and, hopefully, retention.

Clinical Support Workers are now primarily recruited and trained through the Trust's apprenticeship initiative. In 2016/17 over 250 apprentices joined the Trust to commence training to become CSWs. The programme will continue to recruit up to 30 apprentices in each of 10 cohorts in 2017/18. A second apprenticeship programme has been established to train Senior CSWs, providing a Level 3 qualification.

The Assistant Practitioner Training Programme, supported by Health Education Yorkshire & Humber, has continued with a further cohort starting in September 2016. The programme moved to a Foundation Degree award, taught over two years with the first group of 15 qualifying in July 2017.

The Trust, as part of a West Yorkshire Pilot Partnership across Leeds, Bradford and Airedale, succeeded in becoming one of only eleven pilot sites for the training of Nursing Associates. This new role will bridge the gap between registered and unregistered nursing staff, with responsibility for all elements of care.

The trainees are employed by and work in the Trust whilst studying at local universities and attending placements. The Trust has 29 trainees, mainly recruited internally, who will work towards a Foundation Degree and access placements across the whole health economy.

**Recruitment: Advanced Practice**

In 2016/17, Health Education Yorkshire & Humber funded 25 advanced practice trainees and continued to support academic programmes for advanced practice. The number of trainees and completed practitioners in the Trust is now over 80, with interest for widespread development of the role across the CSUs.

**Temporary Staff**

Bank and agency staff continue to provide an essential component of the workforce. In 2016/17 further pay rate caps were introduced for agency staff to try to reduce agency expenditure overall. The Trust has seen a reduction in agency spend, and work continues to improve Bank recruitment to reduce reliance on agency workers.

In October 2016, the bank provider moved from NHS Professionals to LTHT Staff Bank, supplied by Reed. Shift fill rates continue to improve since implementation despite some delays to recruitment to the service.
3.2.10 Ward Healthcheck

Background

The Ward Healthcheck and metric programme has been in place since December 2013 for all adult wards, March 2014 for maternity and paediatric wards, and September 2014 for the Emergency Departments (ED), Theatres and Outpatients.

The programme audits the assessment, identification of risks, delivery, and evaluation of care against agreed standards for each patient. We have modified the standards and their content to reflect changing practice and recommendations. The individual standard scores are collated to give an overall score which is RAG rated; 79.9% or below is Red, 80-89.9% is Amber and 90% and above is Green.

The chart below sets out by percentage the number of areas that are Red, Amber and Green. 85% of wards were Green by the end of 2016/17, and this has been achieved with only 5% of wards rated red. This is as a result of all the focused hard work clinical areas have delivered.

![Figure 30: RAG Rated % of Clinical Areas Relating to Metrics Scores](image)

| Red | 5% | 2% | 11% | 13% | 4% | 5% | 6% | 9% | 4% | 2% | 5% | 6% |
| Amber | 25% | 19% | 38% | 28% | 36% | 23% | 24% | 26% | 29% | 25% | 22% | 16% |
| Green | 69% | 80% | 52% | 59% | 60% | 72% | 70% | 65% | 67% | 73% | 73% | 79% |

Table 7: Ward Metric results (March 2016 and March 2017)

<table>
<thead>
<tr>
<th>Question Group</th>
<th>Total Mar ’16</th>
<th>Total Mar ’17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>91.50%</td>
<td>96.10%</td>
</tr>
<tr>
<td>Patient Observations</td>
<td>91.10%</td>
<td>93.50%</td>
</tr>
<tr>
<td>Falls Assessment</td>
<td>94.50%</td>
<td>91.70%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85.90%</td>
<td>91.30%</td>
</tr>
<tr>
<td>Pressure Area Care</td>
<td>90.40%</td>
<td>90.30%</td>
</tr>
<tr>
<td>Continence</td>
<td>95.90%</td>
<td>96.00%</td>
</tr>
<tr>
<td>Nutrition Assessment</td>
<td>92.90%</td>
<td>93.90%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>96.60%</td>
<td>97.00%</td>
</tr>
<tr>
<td>Patient Dignity</td>
<td>97.50%</td>
<td>97.80%</td>
</tr>
<tr>
<td>Discharge</td>
<td>87.00%</td>
<td>91.70%</td>
</tr>
<tr>
<td>Documentation</td>
<td></td>
<td>90.50%</td>
</tr>
<tr>
<td>Resuscitation Equipment</td>
<td>87.80%</td>
<td>93.50%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>92.80%</strong></td>
<td><strong>93.60%</strong></td>
</tr>
</tbody>
</table>
The information generated from the Ward Healthcheck audits are produced in a dial and spider diagram displayed on each ward on the Patient Safety Boards. Other key ward information displayed is the 10 Keys Steps (improvements the wards are working on), staffing levels, Open and Honest Care, Friends and Family results, and cleaning and infection prevention audits.

**Figure 31: Patient Safety Board**

**Aim for 2017/18**

Following on from the progress that has been made, we will continue to develop the ward metrics and pilot its use in specialist assessment and day case areas, the Dental Institute and renal satellite units, and review and further develop the outpatients metrics. We will progress the work on the ward accreditation programme and will start to test this with our high achieving wards as a means to recognise their success.

**3.2.11 NHS Safety Thermometer**

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

Harm free care performance for LTHT can be seen in Figure 32. Since April 2016 this has been above 95% for 8 months. The improvements in our performance over time are due to reduction of falls with harm and new VTE, both of which are following a downward trend.

*Figure 32: Harm Free Care Data, Sept 2014-March 2017*
3.2.12 Reducing Rates of Healthcare Associated Infections (HCAI)

Preventing avoidable hospital acquired infection is a key priority for the Trust. Although this has remained challenging in 2016/17, we have seen a number of improvements, noticeably the substantial reduction in the number of patients who developed Clostridium difficile infections (CDI) whilst in our care.

The key objectives achieved in 2016/17 included:

- Providing a robust approach to MRSA screening, to ensure all high risk patients received the appropriate antibiotic treatment prior to surgery.
- Review of all patients with CDI daily, to provide specialist advice and optimise treatment.
- Review of key antimicrobial guidelines, to promote the use of antibiotics which have been shown to be less likely to be associated with CDI, and reduce the use of very broad-spectrum antimicrobials, where clinically appropriate.
- Further promoting the use of safe working practices for all our staff by integration of lessons learnt from inoculation injuries throughout the Trust.
- Introduction of a vessel health and preservation group to develop pathways for safe placement of vascular devices.
- Participation in the 2016 national point prevalence survey on HCAI and antimicrobial usage, for Critical Care, and Abdominal Medicine & Surgery.

**MRSA**

MRSA is a type of bacteria that is resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

In 2016/17, 11 patients developed an MRSA bacteraemia whilst in our care, plus one where the MRSA isolate was a sample contaminant. This total is an absolute rise on the number that we had last year (7), and nationally each NHS Acute Trust continues to have an MRSA bacteraemia annual target set at zero, which a handful of our peers have achieved. The circumstances of each event were thoroughly reviewed. The patients involved had a number of medical co-morbidities, necessitating complex medical and nursing care. In the light of lessons learnt, the LTHT guidance for preventing and controlling MRSA has been refreshed and will be implemented in 2017-8 along with the HCAI Collaborative as outlined below. However, whilst the absolute total has risen, we are not currently a significant outlier nationally.

Figure 33: MRSA Bacteraemia cases March 2016 - March 2017

Trusts

Source: Public Health England

42 Trust(s) reported no MRSA cases for the period.

Rates calculated using 2014/15 bed day data
**CDI**

Clostridium difficile is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, and the condition can usually be treated with another course of different antibiotics.

In 2016/17, 110 patients developed CDI in our hospitals compared to the nationally-set trajectory of 119 for the Trust, which is a significant reduction compared to last year when 139 patients were diagnosed with CDI whilst in our care. The CDI rate per 100,000 bed days has fallen for 2016-7 as illustrated below; and our recent performance in the setting of all England acute trusts is demonstrated in Table 6, courtesy of Public Health England.

**Table 8: CDI rate per 100,000 bed days**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Trust Performance</th>
<th>National Average</th>
<th>National Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI Rate per 100,000 bed days (Patients 2+)</td>
<td>2016/17</td>
<td>19.3</td>
<td>14.4</td>
<td>0.0 to 81.6</td>
</tr>
<tr>
<td></td>
<td>2015/16</td>
<td>24.8</td>
<td>16.1</td>
<td>0.0 to 69.7</td>
</tr>
<tr>
<td></td>
<td>2014/15</td>
<td>21.6</td>
<td>15.1</td>
<td>0.0 to 62.2</td>
</tr>
<tr>
<td></td>
<td>2013/14</td>
<td>25.6</td>
<td>14.7</td>
<td>0.0 to 37.1</td>
</tr>
<tr>
<td></td>
<td>2012/13</td>
<td>26.1</td>
<td>17.3</td>
<td>0.0 to 30.8</td>
</tr>
</tbody>
</table>

**Antimicrobial Stewardship**

Antimicrobial Stewardship is a phrase that describes our work to improve the selection and use of antimicrobial medicines to treat a patient’s condition so their use does not contribute to the problem of developing resistance to our current antimicrobial medicines.

The Trust Antimicrobial Stewardship Committee met with most of the bed-holding CSUs in 2016-17 to review and support their work. This has helped to deliver the four elements of the Antimicrobial Stewardship CQUIN on reducing antibiotic consumption compared to the baseline from 2013/14 and improving the review of “best-guess/empiric” antibiotics within the first three days.

We have built our antibiotic treatment guidelines into the electronic prescribing system that is being rolled out across the Trust. It has been set up to drive day 3 review. We have reviewed our Antimicrobial Stewardship systems against the NICE guidance and quality standards on systems and processes for effective antimicrobial use (NG15 & QS121) and NICE drug allergy quality standards QS97. Our monthly audit programme is now reported on the Trust Ward Healthcheck dashboard.

**Aims for 2017/18**

The targets we have been set for 2017/18 are:

- Zero “avoidable” MRSA bacteraemias
- No more than 119 cases of CDI.

During 2017/18 we will launch a Collaborative for HCAI as part of the quality improvement programme to address the question ‘How can we prevent HCAI blood stream infections?’. The Collaborative will utilise the Model for Improvement as a framework for testing new interventions and making changes to their areas. Ward teams will identify small tests of change that they believe will lead to improvements. Our ambition is to go at least 200 days without an MRSA bacteraemia. The efforts of the Collaborative should also help prevent blood-stream infections with other organisms,
including Escherichia coli and other Gram-negative bacteria; which will be addressed as a whole health care economy approach in accordance with the drive for reduced rates nationally.

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

### 3.2.13 Reducing Harm from Preventable Venous Thromboembolism (VTE)

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

**Key Achievements in 2016/17**

In 2016/17 quarters 1 - 3 the Trust continued to achieve the target of ensuring that at least 95% of adult patients admitted to the Trust are risk assessed for VTE rapidly within 24 hours of admission. Unfortunately the implementation of eMeds had a negative effect on risk assessment rates in quarter 4 and we failed to achieve the 95% target. The Trust is currently looking into this and deciding on an action plan.

The table below shows the percentage of patients who have had a VTE risk assessment in 2016/17.

<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)</td>
<td>Q4 2016/17</td>
<td>94.7%</td>
<td>98.5%</td>
<td>63.0% - 100%</td>
</tr>
<tr>
<td></td>
<td>Q3 2016/17</td>
<td>96.0%</td>
<td>98.2%</td>
<td>76.5% - 100%</td>
</tr>
<tr>
<td></td>
<td>Q2 2016/17</td>
<td>96.0%</td>
<td>97.7%</td>
<td>72.1% - 100%</td>
</tr>
<tr>
<td></td>
<td>Q1 2016/17</td>
<td>96.2%</td>
<td>95.6%</td>
<td>80.6% - 100%</td>
</tr>
</tbody>
</table>

1Excludes independent sector providers

Since April 2013 we have completed an investigation into all patients’ care if they develop a VTE during or within 90 days of their hospital admission. We are committed to learning how we can try to prevent VTEs and so continue to make sure we complete an investigation for 100% of all such events.

We have been incorporating what we have learnt from our investigations into the training we regularly provide to staff. On World Thrombosis Day in October 2016 we organised a Trust-wide study session which was extremely well attended by LTHT healthcare professionals who wanted to increase their knowledge and awareness of VTE, and what they can do to help our patients reduce their risk.

We want to make sure all patients receive general information about what they can do to help reduce the likelihood of developing a VTE, both as an inpatient and when they leave the hospital. This year, to help increase our patients and carers awareness of VTE prevention we have developed more detailed leaflets about VTE prevention for pregnant patients and for patients with cancer.

**Aims for 2017/18**

Our plans for the coming year are to develop a new e-learning package to support staff to learn more about VTE prevention in Leeds.
3.2.14 Preventing Harm from Misplaced Nasogastric Tubes

Feeding through a misplaced nasogastric (NG) feeding tube is defined by NHS England as a Never Event. In 2016/17 we have seen further improvements within our hospitals to improve standards and safety for those who require nasogastric tubes for feeding (NGTs). These include:

- Revising NG care plans to improve safety aspects such as assessing risk of patients feeding overnight.
- Radiographers empowered to highlight any problems they observe and take action, enabling focused training/feedback to be given to individuals or clinical areas.
- Review of all incidents related to NG tubes every two months at the Enteral and Parenteral Guidelines group meeting, with actions taken.

In the most recent NG tube audit, NG care plans were used for 96% of patients, with pH used first line in 93% of cases (the gold standard method to check safe placement). X-ray was used as the first line check of safe placement in only one case, reflecting the good progress that has been made.

3.2.15 Safeguarding Vulnerable People

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

Leeds Teaching Hospitals NHS Trust continues to work to enhance safeguarding practice and standards across the whole 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 2016/17*

- In November 2016 the Trust participated in the Safer Leeds and National White Ribbon Campaign raising awareness about domestic violence.
- Leeds Teaching Hospitals Trust continues to embed the “Think Family” agenda to improve outcomes for children and families.
- In December 2016 our Children’s Hospital, and Safeguarding Team successfully launched the ‘Alternatives to Physical Chastisement’ Campaign.
In our response to valuing mental health equally with physical health or “Parity of Esteem”, the Trust has undertaken collaborative work with all our partners and stakeholders to:

- Roll out a robust procedure and risk tool to better support patients presenting with mental health needs when they need safe transfer to a psychiatric setting.

- Implement an improved suite of procedures focussed on patients who require enhanced levels of care and supervision. This helps front line staff to identify patients early in their admission and to identify person centred responses to keep people safe and still engaged in meaningful interactions with staff providing one to one care.

### 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.

This year has seen a reduction in the total number of serious incidents reported. There has been a reduction in reporting of Category 3 pressure ulcers, because all Category 3 pressure ulcers are now reviewed locally to consider whether each one was avoidable and led to longer-term or permanent harm. This was introduced following the recommendation made in the revised Serious Incident Framework by NHS England in 2015.
**Table 10: Patient safety Incidents (NRLS) October 2015 - March 2016**

<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>40.89</td>
<td>39.31</td>
<td>14.77-75.91</td>
</tr>
<tr>
<td>Number of patient safety incidents that resulted in severe harm</td>
<td>12</td>
<td>Not specified</td>
<td>0-85</td>
</tr>
<tr>
<td>Number of patient safety incidents that resulted in death</td>
<td>8</td>
<td>Not specified</td>
<td>0-37</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%-1.7%</td>
</tr>
<tr>
<td>Percentage of patient safety incidents that resulted in death</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0%-1.1%</td>
</tr>
</tbody>
</table>

**Learning from Incidents**

The Lessons Learned Group, established in 2014/15, continues to increase the effectiveness of learning lessons from serious incidents. Six learning points bulletins have been produced Trust-wide during 2016/17 covering various topics. Videos continue to be made by the Clinical Service Units and uploaded onto the Lessons Learned YouTube Channel. The Group are in the process of developing a Lessons Learned App for Android/Smart phones for staff to download and instantly receive lessons learned from incidents.

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

The Trust has continued to publish fortnightly safety briefings for staff, called Quality and Safety Matters. These have focused on a series of topics arising from serious incidents and complaints, to highlight the reasons why it is important that these things are managed appropriately and the actions that need to be taken to help reduce the risk. These have been sent to all wards and departments within the Trust to ensure that all staff are aware of these risks and what they need to do about them. The topics below were included in 2016/17:

**Table 11: Quality and Safety Matters Briefing Topics**

<table>
<thead>
<tr>
<th>Assessing Mental Capacity</th>
<th>Omission of medicines</th>
<th>Transferring patients with mental health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>McKinley T34 syringe pump</td>
<td>Incident Reporting</td>
<td>Antimicrobial review</td>
</tr>
<tr>
<td>Use of restraint</td>
<td>Preventing incidents involving medicines and allergies</td>
<td>Prescribing strong opioids to adult palliative care patients</td>
</tr>
<tr>
<td>Pre-operative fasting guidelines</td>
<td>Mental Health Act Detention - Sectioning</td>
<td>Investigation and management of VTE</td>
</tr>
<tr>
<td>Patient Blood Management</td>
<td>Stop the Pressure</td>
<td>Stop before you block</td>
</tr>
<tr>
<td>Keeping patient information safe</td>
<td>Insulin</td>
<td>Acute Kidney Injury (AKI) management</td>
</tr>
</tbody>
</table>
LIST (Leeds Incident Support Team)

September 2016 saw the Trust-wide launch of the Leeds Incident Support Team (LIST). The LIST is a voluntary group of LTHT staff who have previously been involved in serious incidents. They have made a commitment to be available to talk to other staff who may become involved in a similar type of incident. They will talk through the process of an investigation and should be able to answer any questions a staff member may have. The ‘buddies’ on the LIST have received training for their role which has just expanded to include supporting staff involved in PALS and Complaints.

Never Events

NHS England revised the list of Never Events in 2015/2016, reducing the number from 25 to 14.

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

We have reported four Never Events during 2016/17 under the following categories:
• Wrong tooth extraction x 1
• Wrong site surgery x 2
• Wrong site block x 1

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

Duty of Candour

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

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

We have supported clinical teams and staff to ensure the Duty of Candour regulation is complied with. We have published an electronic learning tool for staff and Quality & Safety matters bulletins, which have been shared with clinical teams across the Trust.
3.2.17 Scan 4 Safety

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

This brings with it significant safety and efficiency benefits including:

- Tracking product use, eg tracking those used for a surgical procedure in an operating theatre.
- Tracking patients in each location they go to in our hospitals, including which bed they are in on which ward.
- Rapid identification of the location of products that have been recalled.
- Recording which staff are involved in procedures.
- Managing stock more efficiently, reducing stock stored and ensuring all stock is in date.

We are 14 months into a 24 month project and are on schedule to meet all the milestones agreed. We are working to integrate all the information gathered by different systems into our Electronic Patient Record, and link to electronic scanning and documentation using mobile devices at the bedside.

3.2.18 Guardians of Safe Working

As part of the May 2016 junior doctors’ contract, Guardians have been appointed in NHS Trusts to ensure fair and safe delivery of the new contract. The Trust appointed two Guardians to take up this role, who are consultants in Emergency Medicine and Renal Medicine.

The Guardians’ role is to oversee the work schedule review process for junior doctors:-

- To address concerns relating to hours worked and access to training opportunities.
- To support safe care for patients by ensuring doctors do not work excessive hours.
- To use powers to impose financial penalties when safe working hours are breached.
Trainees on the new contract who work over and above their contracted hours, or are unable to take adequate rest, or attend education and training are required to complete an Exception Report (ER), which are reviewed by the Guardians every morning. It is encouraging to note that there have been very few patient safety concerns included in ERs. Robust systems have been put in place to escalate serious concerns to senior colleagues in CSUs, following the daily reviews.

Specific interventions have been made as a direct result of the feedback received from Exception Reports, including:

- A senior doctor now being present at the late afternoon handover in Trauma & Orthopaedics, potentially facilitating juniors leaving on time.
- Work in General Surgery to review the medical and clinical workforce ahead of the August rotation, to create a longer-term solution to the problems of late working.
- Work with the Rostering Team to redesign rotas to accommodate gaps in the Paediatric Intensive Care Unit (PICU) rota.

The Guardians updated the Trust Board in November 2016, and reported to the Research, Education & Training (RET) Committee in March and May 2017. In the latest report, they focused on the lessons learned, and what they are doing alongside colleagues in Human Resources and the Medical Education Team to improve rotas, and better engage with trainees.

The review processes are working effectively and so far the roll-out of the contract is going well. We have noted a significant reduction in the number of reports coming in over this period, particularly from our most junior (FY1) trainees. Where problems have been identified the Guardians are working collaboratively with colleagues across the Trust to deal with them.

The Corporate Medical Directorate is leading a programme of work to improve communication, engagement and morale amongst junior doctors, supported by the appointment of a Chief Registrar, the work of the Junior Doctor Body, and plans to create a Professional Support Unit, which is key to safe working.
3.3 Clinical Effectiveness

3.3.1 Hospital Mortality

There are two national trust-level mortality indicators:

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

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

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

The table below shows the Trust’s latest published SHMI, for the period October 2015 to September 2016, also shown is the HSMR for the same period. The Trust continues to fall within the ‘as expected’ banding for both measures.

Table 12: Trust SHMI & HSMR Oct 15 to Sept 16

<table>
<thead>
<tr>
<th>Trust level mortality, Oct 15 - Sept 16</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>134,133</td>
<td>0.9836</td>
<td>4,130</td>
<td>4,199</td>
<td>0.894-1.119</td>
</tr>
<tr>
<td>HSMR</td>
<td>62,449</td>
<td>100.28</td>
<td>2,556</td>
<td>2,549</td>
<td>96.43-104.24</td>
</tr>
</tbody>
</table>

Table 13: 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 15 to Sep 16</td>
<td>0.98</td>
<td>1.00</td>
<td>0.690 - 1.164</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>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>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>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>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>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>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>Oct 13 to Sep 14</td>
<td>1.04</td>
<td>1.00</td>
<td>0.597 - 1.120</td>
</tr>
</tbody>
</table>
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;

Table 14: Trust HSMR Feb-16 to Jan-17

<table>
<thead>
<tr>
<th>February 2016 to January 2017</th>
<th>HSMR (basket of 56 diagnoses)</th>
<th>HSMR (all diagnoses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed deaths</td>
<td>2,621</td>
<td>3,132</td>
</tr>
<tr>
<td>Expected Deaths</td>
<td>2,645</td>
<td>3,216</td>
</tr>
<tr>
<td>HSMR</td>
<td>99.1</td>
<td>97.4</td>
</tr>
</tbody>
</table>

For the reporting period October 2015 to September 2016 LTHT had a crude death rate of 28.2% of deaths reported in the SHMI with a palliative care coding. This figure is less than the National average of 29.7%, and within the National range of 0.4% to 53.3%.

Table 15: The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust

<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 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>

LTHT Investigation into Intracranial Injury Mortality Outlier Alert

In June 2016 the Trust received a letter from the Dr Foster Unit at Imperial College containing analysis which highlighted a higher than average mortality rate for intracranial injury. This analysis was also shared with the Care Quality Commission. A Trust investigation into the mortality outlier alert was conducted in four parts;

i. An analysis of outcome and activity data, sourced from Dr Foster, NHS Digital, Trauma Audit & Research Network (TARN) and Intensive Care National Audit & Research Centre (ICNARC).
Data was reviewed at the Trust Mortality Improvement Group, including clinician representation from related services.

ii. An audit of clinical coding in 45 cases across 5 services (Neurosurgery, Stroke, Acute Medicine, Children’s, and Trauma services) during the period Apr-15 to Mar-16.

iii. A combined review by the Lead Clinician in Neurosurgery and the Clinical Coding Manager of clinical documentation, covering paper case notes and electronic records.

iv. A case note review of 27 cases by senior clinicians across 5 services.

When compared to other Major Trauma Centres nationally, it can be demonstrated that for intracranial injury, mortality at LTHT is broadly comparable to other MTCs, and the Trust is within expected range compared with its peers.

The Trust Investigation highlighted both clinical coding training needs and clinical documentation issues, both of which are being addressed. Detailed case note reviews did not identify any cases where the death was considered avoidable, however there was valuable learning which is being shared through the Trust Mortality Improvement Group. The investigation provided assurance that there was no cause for concern regarding our level of intracranial injury related deaths.

**Learning from Deaths**

The Trust Mortality Improvement Group has overseen work to review the NHS England’s recommendations for mortality review published in December 2016: this showed the Trust to be in a good position against the guidance in terms of Trust-wide and specialty specific mortality review processes, and actions to strengthen those processes were already well underway.

Subsequent work was undertaken to review the Mazar’s 2015 report into Southern Health which had found shortcomings in adequately reviewing deaths of patients with learning disabilities. In view of this, the Trust carried out an in-depth review of deaths in LTHT of patients with learning disability from February 2015 to February 2016 which demonstrated that all these patients had received appropriate care with regard to their learning disability and that their deaths were unavoidable. The Trust has subsequently become involved in the Yorkshire and Humber pilot of the National Learning Disability Mortality Review (LeDeR) established in November 2016 to support local reviews of deaths of people with learning disabilities aged 4-74 across England.

The Trust has also been actively involved in piloting the Structured Judgement Review tool, which was launched by the Royal College of Physicians in November 2016, and we currently have 167 members of staff trained in the use of this tool. Our specialties are being actively encouraged to use it as a core part of their mortality review process.

Throughout the above period the Trust has been developing an updated Mortality Review Procedure to take into account the learning from the above reviews and incorporating the Structured Judgement Review methodology. This will also take into account aspects of the national guidance was issued by the National Quality Board in March 2017.

**Weekend Care**

*Table 16: Weekday and Weekend HSMR - Emergency Admissions*

<table>
<thead>
<tr>
<th>Trust HSMR - Emergency Admissions Dec 15 - Nov 16</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>27,668</td>
<td>97.32</td>
<td>1,792</td>
<td>1,841</td>
<td>92.87 - 101.94</td>
</tr>
<tr>
<td>Weekend</td>
<td>9,026</td>
<td>97.94</td>
<td>602</td>
<td>615</td>
<td>90.27 - 106.08</td>
</tr>
</tbody>
</table>

| Higher than expected | As expected | Lower than expected |

<table>
<thead>
<tr>
<th></th>
<th>Weekday</th>
<th>Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

3.3.2 Readmissions

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

Figure 42: Readmissions to the Trust within 30 days of discharge: elective spells

Figure 43: Readmissions to the Trust within 30 days of discharge: non-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.
3.3.3 Patient Reported Outcome Measures

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

Over the last two years we have worked hard to improve our participation rates, the results of which can be seen in the chart below (please note that the 2015/16 and 2016/17 data is still provisional; the final signed-off data will not be available until Summer 2017 and Summer 2018 respectively). Trust participation rates for hip and knee replacement are in line with the national average and for varicose vein are well above average. Work is on-going to bring groin hernia rates up to a similar level.

![Figure 44: PROMs - Pre-Operative Participation Rates - All procedures](image)

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

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>EQ-5D Index</th>
<th>EQ VAS</th>
<th>Oxford Hip Score</th>
<th>Oxford Knee Score</th>
<th>Aberdeen Varicose Vein</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin Hernia</td>
<td>0.10</td>
<td>1.41</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>England Average</td>
<td>0.09</td>
<td>-0.18</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Varicose Vein Surgery</td>
<td>0.08</td>
<td>0.13</td>
<td>N/A</td>
<td>N/A</td>
<td>-10.24</td>
</tr>
<tr>
<td>England Average</td>
<td>0.09</td>
<td>0.66</td>
<td>N/A</td>
<td>N/A</td>
<td>-8.61</td>
</tr>
</tbody>
</table>
### 3.3.4 Medicines Optimisation

Involving people in decisions about their medicines is important as this means treatments are more likely to be taken and used correctly. Good communication can help patients and their carers to have a more active role in dealing with their own medicines, which can in turn help to reduce problems.

The number of patients who were offered a copy of a printed patient information sheet about their specific medicines from the tool called MaPPs - ‘Medicines: a Patient Profile Summary’, has increased during this year. We found that different patient groups wanted different information and also wanted to access information about medicines in different ways. We also heard from conversations with patients, their family members and carers, that all too often patients still leave consultations with unresolved medicines related issues. We have been working with a small sub-group of the Leeds Area Prescribing Committee, led by a lay patient advocate, to help develop something called a medicines communication charter. This is an approach that can support patients, carers and health professionals when they are involved in conversations about the choice and use of medicines. The medicines communication charter group has developed tools, with a consistent image, which aim to support everyday conversations about medicines - me and my medicines “It’s ok to ask….”.

In 2017/18 we will be using the “me + my medicines” approach in some of our hospital areas, alongside our continuing “Your Medicines-Your Health” programme of work. We will be using this to support patients with chronic conditions who wish to take responsibility for managing their own medicines whilst they are in hospital.

More patients are telling us they would like to continue to look after their medicines, just like they do at home, if they have to be in hospital and remain well enough to do this safely.

Together with our specialist heart team, Cardiology, we started a new outpatient service in 2016 which helps patients who have suffered a heart attack. After having a heart attack patients are prescribed multiple medicines: the new service offers patients support to help them get the best out of the different medicines and gives patients time to talk about and find ways to resolve medicines related concerns or problems with medicine experts. Patients who have completed our survey about the clinic tell us this service has really helped them to understand their medicines and they feel involved in the decisions about their on-going medicines needs and preferences.

Whenever a patient is transferred from one location to another it is really important that the relevant information about the patient’s medicines is shared so that everyone involved in caring for the patient has the information they need to help prevent mistakes with medicines wherever possible.
Last year we had just started implementing a new electronic medicines prescribing and administration system, and now over 50 wards are using this eMeds system.

Some of the benefits already seen are clearer information about medicine changes, reduced duplication and more easily produced up-to-date medicines lists which share electronically. Throughout 2017/18 we will continue to implement this electronic system, which integrates with the Leeds Care Record.

Children, and some adult patients, told us about their difficulties with swallowing tablet medicines, so this year we worked with patients in the Children’s Hospital, parents, play leaders, nurses, pharmacists and doctors, to try to find out what techniques might help. We identified seven different techniques and, in our survey, everyone found that at least one of the techniques actually worked for them; for many meant that they could start using tablets or capsules instead of inconvenient bulky liquid medicines which are often also more expensive. We plan to use this tool more widely during 2017/18. Some of the things patients told us are: “I’m happier taking tablets as it’s less obvious to my friends”, “Liquids taste awful, tablets are much better”, “I feel more grown up being able to take tablets”, “Putting your head back makes you feel like there is no pill”, “It’s much quicker”.

The parents of the children that this helped told us: “It is not a fight to take medicines any longer”, “We don’t have to come back to clinic as often”, “It’s much easier for school to manage”, “My child no longer dreads taking their medicines”.

Medicines optimisation improvement will continue throughout 2017/18 based on the issues our patients, their carers and our staff tell us about.

### 3.3.5 End of Life Care

Ensuring that we provide excellent end of life care at all times is a priority within LTHT. Our Palliative Care Team lead a large portfolio of quality improvement projects across the Trust, working collaboratively with clinical teams and city wide partners. We are committed to sharing good practice locally, regionally and nationally, thereby informing national strategy and guidance for the benefit of our patients.

**Key Achievements in 2016/17**

- End of life care being rated “Good” by the CQC - May 2016.
- Individualised care plans for dying patients highlighted as an area of outstanding practice by the CQC - May 2016.
- One of 10 hospitals selected to be part of the National Building on the Best (BoTB) project in collaboration with NHS England (NHSE), the National Council for Palliative Care and Macmillan.
• Priority training in place for senior medical staff nurses and AHPs - highlighted as an example of good practice by NHSE.

• Rapid discharge plan (RDP) implemented within the Emergency Department to enable patients to be transferred to their preferred place of care in the final days and hours of life - Best collaborative project at the LTHT Time to Shine awards.

• Agreement with all adult CSUs to have a bespoke end of life care improvement plan in place to be monitored through their governance meetings and reporting progress to the End of Life Care Steering Group.

• Enhanced integrated city-wide working within the new Leeds Managed Clinical Network (MCN) for Palliative and End of Life Care to lead service improvements for palliative care patients in Leeds.

• Improvements made to support for relatives of dying patients - extension of free car parking permits and comfort care packs.

• Palliative care patient information resources promoting choice accessible and visible across adult wards - Best educational / promotional campaign at the LTHT Time to Shine awards.

• Comprehensive opioid guidance implemented Trust wide.

• Successful collaborative projects with the Deteriorating Patient Group, and Liver and Respiratory teams to improve future care planning for palliative care patients.

**Aims for 2017/18**

• Working within the MCN, to streamline processes to facilitate timely transfer of care for patients from the Trust to the Hospices.

• Promoting wider use of RDP to enable patients to be discharged to their preferred place of care at the end of life.

• Improving the quality of prescribing palliative care drugs with a focus on reducing waste and streamlining practice across Leeds.

• Rolling out the end of life / advance care plan in PPM+ to enable sharing and recording of patient preferences with health care professionals across all providers.

• Building on the individual CSU improvement plans to ensure service improvements continue at a local level, and embedding ownership and accountability of end of life care provision with clinical teams.

• Rolling out new care of the dying person care plans across all adult wards.

• Supporting the implementation of the RESPECT documentation and approach.

• Further rolling out and evaluation of the BoTB project workstreams: symptom management and outpatient working.

• Continuing cross city working to build a robust data reporting system that includes patient clinical outcomes.
3.3.6 Discharge

**Discharge Team**

Improving the quality of discharge of patients and their families remains a key priority for the Trust. Building on the work started in the previous year, 2016 has seen the implementation of further improvements to the discharge process:

- Implementation of the Leeds Integrated Discharge Service
- Introduction of a discharge lounge at St James’s University Hospital
- Improvements to the electronic systems
- Collaborative working with care homes

October 2016 saw the launch of the multidisciplinary Leeds Integrated Discharge Service (LIDS) in the Acute Medicine CSU. The team consists of nursing and allied health professional staff from LTHT and Leeds Community Health (LCH). The staff have specialist knowledge and understanding of the discharge process, helping to improve speed and quality of a patient’s discharge from hospital. Early results show a reduction in length of stay on the acute medical wards of 0.6 days.

Improving links into the community is an important part of the discharge process; the Discharge Team is continuing to develop networks with the care homes of Leeds to build relationships and share learning to improve discharge for patients.

**Discharge Lounge**

The Discharge Lounge at St James’s University Hospital was launched in October 2016. The lounge is a dedicated area in Lincoln Wing and can take up to 40 patients per day, with a team of staff who are able to visit wards to collect the patients. Since the opening, the Discharge Lounge has significantly improved the flow of our patients through the hospital, and has now seen over 1000 patients successfully discharged from this area.

Due to the success of the project, the Discharge Lounge is being re-located to a larger area in Lincoln Wing that will enable it to accept more patients and include those patients who require a greater level of care whilst their discharge arrangements are made. This development has been supported by the West Yorkshire Accelerator Zone.

3.4 Leeds Improvement Method

In October 2015 four work areas, known as Valustreams, were chosen for developing the Leeds Improvement Method continuing into 2017/18; a fifth Valustream was added during late 2016 which will launch in May 2017, looking at the time to first consultant review in Acute Medicine, at St James’s University Hospital.

**Valustream 1 - Total Hip and Knee Replacement Surgery Patients**

Since April 2016, there has been two week-long workshops called Rapid Process Improvement Workshops (RPIWs). These are specifically focussed on teams understanding the contribution and impact they have within a single work area and/or process. These two events take the total RPIWs
in this Valuestream to four in total and focussed on:

**RPIW3 - Elective Orthopaedic Pre Assessment**

As a result of our first RPIW most patients have agreed a date for their surgery with the Consultant in their final outpatient clinic appointment. At this point patients require a surgical pre-assessment appointment to ensure they are fit and well for surgery.

*Table 18: Achievements - Elective Orthopaedic Pre Assessment*

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>114 hours to have a clinical administration pack ready for the patient’s surgery</td>
<td>64 hours and 55 minutes, with still more work ongoing</td>
</tr>
<tr>
<td>66% of patients required a repeat pre-assessment appointment</td>
<td>32% of patients currently require a repeat pre-assessment appointment</td>
</tr>
<tr>
<td>Administration clerk had to ask for input to decipher consultant handwriting on a patient booking form for 45% of booking forms</td>
<td>Administration clerk has to ask for input to decipher consultant handwriting on a patient booking form for 7% of booking forms</td>
</tr>
<tr>
<td>0.5 WTE nurse time spent re-preassessing patients</td>
<td>0.13 WTE nurse time spent re-preassessing patients</td>
</tr>
</tbody>
</table>

**RPIW4 - Early Mobilisation**

Research evidence tells us that early mobilisation following a hip or knee joint replacement improves patient outcomes, however we observe variation in our ability to provide this opportunity to every patient.

*Table 19: Achievements - Elective Orthopaedic Early Mobilisation*

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy staff had to walk on average 304 steps to find a patient for early mobilisation on the day of their surgery</td>
<td>Physiotherapy now walk on average 152 steps as patients are clearly identified as requiring early mobilisation with a green card at the end of their bed</td>
</tr>
<tr>
<td>51% of patients were not supported to mobilise at Day Zero</td>
<td>17% of patients were not supported to mobilise at Day Zero</td>
</tr>
<tr>
<td>Only 56% of patients were aware that they would be mobilised on the day of surgery at between 4-6 hours after their operation</td>
<td>80% of patients aware that they would be mobilised on the day of surgery at between 4-6 hours after their operation</td>
</tr>
<tr>
<td>0.3 wte of nursing time supported a handover between two stages of recovery</td>
<td>This process has been eliminated as the same nurse supports the patient through their recovery phase before being moved to the ward</td>
</tr>
</tbody>
</table>

**Valuestream 2 - Transurethral Resection of the Prostate (TURPs) Patients**

After launching in March 2016 there have been three week-long Rapid Process Improvement Workshops (RPIWs). These specifically focussed on:

**RPIW1 - Clinical Checkpoints**

There is significant variation in patients’ experience of their TURP pathway from their arrival on the ward through to their discharge. The theatre suite in which the patient’s surgery takes place, has a significant impact on their length of stay post operatively, between 19 hours to just under 40 hours.
### Table 20: Achievements - Clinical Checkpoints

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients stay post TURP Surgery up to 40 hours</td>
<td>Rapid discharge process with 6 hour discharge pathway and 23 hour pathway</td>
</tr>
<tr>
<td>Bladder scanner not available 75% of the time</td>
<td>Bladder scanner available 100% of the time</td>
</tr>
<tr>
<td>11 individual forms for nurse to complete on patient arrival with no guidance on discharge.</td>
<td>TURP rapid discharge booklet with clinical checkpoints built in to enable a standardised process</td>
</tr>
<tr>
<td>Typical language: “Stop irrigation when the urine colour is rosé”</td>
<td>New irrigation chart with visual control chart</td>
</tr>
</tbody>
</table>

### RPIW2 - Effective preparation for TURP Patients

Patients attending the Urology Outpatients who choose TURPs surgery can experience a frustrating and lengthy journey to their day of surgery.

### Table 21: Achievements - Preparing the Patient

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>64% of patients required a second pre-assessment</td>
<td>7% of patients currently have a second pre-assessment</td>
</tr>
<tr>
<td>Insufficiently prepared patients for clinic appointments resulting in an average appointment time of 64 minutes</td>
<td>New patient information leaflet that lets a patient know they should arrive with a full bladder, and that they would have their flow rate test immediately. Average appointment time reduced to 21 minutes.</td>
</tr>
<tr>
<td>Lower urinary tract patients mixed with all other outpatients in clinic</td>
<td>New Lower Urinary Tract Clinic, specialising in rapid triage and consultation of patients</td>
</tr>
</tbody>
</table>

### RPIW3 - Electronic Discharge Advice Notes (eDANs)

There is significant variation in patients being discharged in a timely way in receipt of a formal record of their care, including medications where applicable. This formal record of their care is called an Electronic Discharge Advice Note or eDAN. A patient is told on the ward round that they can go home that day but can regularly be left waiting significant periods of time before that actually happens.

### Table 22: Achievements - Electronic Discharge Advice Note

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients waited on average 349 minutes once they had been told they could go home to actually having the eDAN ready for them to go</td>
<td>20 minutes nurse authorised discharge, with pre-prepared eDan</td>
</tr>
<tr>
<td>29% of patients left hospital without eDAN being ready</td>
<td>0% of patients leave without an eDAN</td>
</tr>
<tr>
<td>10% of patients had medication sent in a taxi after discharge</td>
<td>All patients leave hospital with all medication they need.</td>
</tr>
<tr>
<td>155 minutes was the average time spent preparing the eDAN on the day of discharge</td>
<td>3 minutes on average is spent preparing the eDAN on day of discharge</td>
</tr>
</tbody>
</table>

### Next Steps for 2017/18

Implementation of the Leeds Improvement Method will continue in Orthopaedics at Chapel Allerton and TURPs at St James’s University Hospital.

Valuestreams 3 and 4 had their launch events during the last quarter of 2016/17 and are planning their first RPIWs during the first quarter (April to June) of 2017/18.
3.5 Integrated Care Improvement Programme

Over the last two years, the Trust has been actively involved in the Integrated Care Improvement Programme led by the Leeds Institute for Quality Healthcare (LIQH).

The programme promotes a cross-city approach to improving quality of care by:

• enabling clinicians to develop shared expertise, and
• developing a rigorous approach to professional accountability using data to review variation and decision-making.

Each Professional Leadership & Change Programme is a 13 day educational and change programme with six additional days to support embedding ideas into practice. The programme is designed for health and social care (public and third sector) professionals in Leeds, who wish to actively improve the quality of care provided to those using services by working collaboratively with colleagues across the city on a shared ambition.

The Trust has been actively involved in six change programme workstreams;

• Chronic Obstructive Pulmonary Disease (COPD)
• Cardiovascular Disease
• Fracture Neck of Femur
• Improving Diabetes Care
• Improving Dementia Care
• Improving Cancer Care

Our priorities moving forward will be on the following two pathways with were linked to CQUINS in 2016/17;

• Respiratory Pathway Review
• Cardiology Pathway Review

**Examples**

**Cardiac Rehabilitation** data collected as part of the LIQH Cardiovascular Disease Programme showed that over an 11 month period, 340 patients who had had a myocardial infarction had been discharged from specialties other than Cardiology; consequently the majority would not have received hospital based cardiac rehabilitation or any community based support. Work has been undertaken to promote the Cardiac Rehabilitation service using posters across the Trust, and the service strengthened with an ‘in reach service’ on the SJUH site, link nurses on wards, and information booklets available for patients. This initiative is already ensuring more patients receive the cardiac rehabilitation they need to improve their outcomes.

The **Fracture Neck of Femur** work stream used a multidisciplinary team approach to develop a community falls clinic for frail patients who were screened as high risk on the basis of their electronic frailty assessment score. 90% of patients who attended clinic went on to have one or more interventions to reduce their risk of falls.

3.6 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.

4.1 Review of Services

During 2016/17 the Leeds Teaching Hospitals NHS Trust provided NHS services across 120 specialist areas, known as “Treatment Functions”, and/or sub-contracted NHS services to a core population of around 780,000, and provided specialist services for 5.3 million people.

The income generated by the NHS services reviewed in 2016/17 represents all of the total income generated from the provision of NHS services by the Leeds Teaching Hospitals NHS Trust for this period.

Leeds Teaching Hospitals NHS Trust has reviewed all of the data available to it on the quality of care in all of these NHS services. We have reviewed the quality of care across these services through the monthly Trust Board Quality and Performance Report (QPR) and internally through the performance review process. The Trust’s quality governance meeting structure also routinely reviews quality and performance measures to gain assurance on quality improvements.

4.2 Participation in Clinical Audit

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

The Department of Health recommended 53 specific national audits that all hospitals in England should contribute data to, if relevant to the services they provide. The Trust contributed data to 98% (47) of the recommended national clinical audits and 100% (5) of the confidential enquiries that it was eligible to participate in.

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

The Trust did not participate in the following Department of Health recommended national clinical audit for the reason given in the table below.

Table 23: Reasons for Non-Participation

<table>
<thead>
<tr>
<th>National Clinical Audit Title</th>
<th>Reason for Non Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>The UK IBD audit transitioned to and merged with the IBD Registry, moving towards an improved system for data capture and quality improvement in IBD. The Trust is developing its IT system and database to support this transition. This work is in progress to enable the Trust to submit data to the IBD Registry in 2017/18.</td>
</tr>
</tbody>
</table>
The reports of 33 national clinical audits, and 677 local clinical audits, were reviewed by the Trust in 2016/17. Examples of actions arising from this work that the Trust has implemented or intends to implement to further improve the quality of care are provided below.

**Patient Property & Valuables**

In 2015 the Trust updated its procedures for looking after patient’s property, money and valuables when they are admitted to hospital. Some changes made as part of this update included redesigning the patient property and valuables record book, and the introduction of sealable patient valuables bags. An audit was carried out in 2015 to see how well these changes had been adopted, and was repeated in 2016 as part of the Trust’s 2016/17 Clinical Audit Programme. The aim of the audit was to ensure staff were following the processes in place to keep patient’s property safe. The results showed there had been improvements in the use of the patient property and valuables record book, availability of sealable valuables bags, and improvements in the storage of patient property on the wards. The audit highlighted that more wards could have bereavement bags available. The findings from the audit will be included in a newsletter, including information about how wards can make sure they have a supply of bereavement bags.

**Audit of Advanced Hepatitis C Therapies**

Hepatitis C infection can lead to disease of the liver if left untreated. Before 2016, the treatment options available in the UK were medications that required long term weekly injections, and had severe side-effects. In February 2016, NICE approved new therapies for the hepatitis C virus (HCV), which require use for a shorter duration and do not have as severe side-effects. Other medications a patient is taking can reduce how well the new hepatitis C therapies work, or increase the risk of side-effects. An audit was carried out in LTHT to ensure patients with hepatitis C were receiving the advanced hepatitis C therapies in line with the national guidance, and that their other medications were appropriate to use alongside the therapies. The findings showed that 99% of patients audited were receiving the correct therapy for their disease type, and in line with the national recommendations. The 1st line treatment was appropriately not being used for the other 1% of patients because of other medical conditions they had. The findings also showed that 85% of the patients audited were using at least one other medication regularly; the audit findings showed the Pharmacy Team had assessed these medications in line with national guidance, and identified 18% that could have potential drug interactions with the hepatitis C medications. The Pharmacy Team had then worked with each patient’s clinician to identify alternative treatments. The audit findings highlighted the importance of ensuring the right medications are used for each patient with hepatitis C: one of the recommendations following the audit was that a process should be established to ensure a patient’s medication history is detailed and accurate prior to the multidisciplinary team (MDT) meeting to discuss their care. A specialist pharmacy technician working in the Hepatology Team now prepares a full documented medication history that is checked for interacting medicines prior to the MDT, allowing any concerns to be raised at the meeting so appropriate action can be taken if necessary.
**National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis**

The 2016 National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (published in July 2016) looked at whether the care patients with inflammatory arthritis received was in line with the quality standard published by the National Institute for Health and Clinical Excellence (NICE). The results showed that patients of the Trust’s rheumatology service had access to urgent advice, and when diagnosed were offered education about their condition, as well how to self-manage it. The results showed patients referred to the service were seen within four to six weeks; NICE’s standard is that patients should be seen within 3 weeks of referral. The service has since reviewed the process for assessing referrals to ensure appointments for appropriate patients are fast-tracked, as well as establishing a dedicated fast-track clinic.

**Audit of the Management of Giant Cell Arteritis (GCA)**

Giant cell arteritis is an inflammatory disease of medium and large arteries, normally those in the head. Treatment for GCA involves high doses of corticosteroids, which can cause corticosteroid toxicity. A temporal artery biopsy (TAB) is therefore often used to determine whether corticosteroid treatment can be withdrawn rapidly, thereby reducing the risk of toxicity, or whether a patient needs long term treatment with corticosteroids. The TAB results become less useful the more corticosteroid therapy a patient has received, so an early biopsy is preferable to help determine the diagnosis and the course of treatment required. The British Society of Rheumatology guidelines for the management of GCA recommend i) a TAB preferably be done within 1 week of starting corticosteroids, and definitely within 2 to 6 weeks, ii) patients are reviewed by a clinical specialist within 6 weeks of starting steroids, and iii) patient information leaflets are given to patients to explain how they will be treated. An audit carried out in April and May 2016 showed TABs were not generally carried out within 1 week, patients were not always reviewed within 6 weeks of starting steroids, and patient information was not consistently given to patients. The Rheumatology Team agreed a new package of safety measures and patient education, which included a plan to centrally record all GCA referrals for TAB; the central record would be monitored by the duty rheumatology registrar and the rheumatology secretaries. The rheumatology secretaries would then ensure biopsies occur on time and follow up in clinic takes place within 4 weeks. A re-audit was carried out on patients seen following the introduction of the changes. The findings of the re-audit demonstrated significantly more temporal artery biopsies were being carried out within one week of starting steroids, and significantly more within two weeks. The findings also showed no patient was seen by a clinical specialist longer than six weeks following starting steroid treatment, and that almost 50% more patients were given patient information leaflets about their condition and treatment.
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 2016/17.

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

NHS Number and General Medical Practice Code Validity

We continue to use the national data quality dashboard tool to support a review of the accuracy and quality of data submitted, and benchmark against the rest of the NHS. As with previous years, we submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are published nationally.

The percentage of records in the published SUS Data Quality Dashboard for the period April 2016 to March 2017 which included a valid NHS number can be seen in the table below.

<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 care</td>
<td>99.7%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>99.9%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Accident and emergency care</td>
<td>96.2%</td>
<td>-0.7%</td>
</tr>
</tbody>
</table>

The percentage of records in the published SUS Data Quality Dashboard for the period April 2016 to March 2017, which included a valid General Medical Practice Code can be seen in the table below:

<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 care</td>
<td>99.9%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
Clinical Coding

Ensuring that the clinical information recorded for our patients is complete, accurate and reflective of the care and treatment given is important for the management of our clinical services and the recovery of income for the care we deliver. The Trust has a continuous programme of audit and training in place to ensure high standards of clinical coding are delivered. The programme involves audits by CSUs to ensure a general overview of all areas.

In line with the IG Toolkit a 200FCE (finished consultant episode) Clinical Coding audit was undertaken. The speciality areas included in the audit were:

- Elective Orthopaedics
- Ear, Nose & Throat (ENT)
- Oral Surgery
- Respiratory Medicine

Table 26: Clinical Coding Audit Findings

<table>
<thead>
<tr>
<th>Area audited</th>
<th>% Diagnoses Coded Correctly</th>
<th>% Procedures Coded Correctly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Chapel Allerton - Elective Orthopaedics</td>
<td>92.17</td>
<td>94.00</td>
</tr>
<tr>
<td>St James’s - Ear Nose Throat</td>
<td>88.37</td>
<td>94.44</td>
</tr>
<tr>
<td>St James’s - Oral Surgery</td>
<td>91.67</td>
<td>94.74</td>
</tr>
<tr>
<td>St James’s - Respiratory Medicine</td>
<td>92.00</td>
<td>86.18</td>
</tr>
<tr>
<td>Overall</td>
<td>91.00</td>
<td>92.66</td>
</tr>
</tbody>
</table>

In order to achieve Level 2 accreditation for the IG Toolkit, coding accuracy needs to be 90% on primary diagnosis and primary procedures, and 85% on secondary diagnosis and procedures.

The Trust has taken a number of steps in response to this year’s recommendations, including:

- A member of the Clinical Coding Team had achieved Clinical Coding Auditor accreditation.
- All members of the Coding Team have had feedback from the audit, the individuals involved have had a separate session to go through the errors and gain a greater understanding of the issues raised.
- An individual has been employed to systematically go through the clinical coding with the clinical teams to ensure accuracy and consistency.
- The Trust is undertaking a review of all patient pathways and education about what the correct information on the PAS system should be. Additional reporting will be provided to closely monitor data quality issues.

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.
Table 27: Timeliness of Accurately Coded Data

<table>
<thead>
<tr>
<th></th>
<th>Jan-14</th>
<th>Jan-15</th>
<th>Jan-16</th>
<th>Jan-17</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>
</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>
</tr>
<tr>
<td>Payment by Results Flex Date</td>
<td>95.9%</td>
<td>100%</td>
<td>98.7%</td>
<td>99.96%</td>
</tr>
<tr>
<td>Payment by Results Freeze Date</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Information Governance (IG) Toolkit

The Information Governance (IG) toolkit is an annual self-assessment audit that the Trust is required to complete to ensure that the necessary safeguards are in place for managing patient and personal information.

A scoring system ranks a Trust from level 0 to 3, with 0 being the lowest score. Leeds Teaching Hospitals NHS Trust is required to achieve a minimum standard of level 2 against all 45 standards, which we achieved. Initiatives included within the measured areas include:

- Information Governance Management
- Confidentiality & Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance.

The IG toolkit is self-assessed by the organisation and in 2016/17 the Trust maintained its overall level 2 rating. This demonstrates to patients and service users that the Trust has robust controls in place to ensure the security of patient and staff information.

Table 28: 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’ts</th>
<th>Overall Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 14</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>(2016-2017)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Version 13</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>(2015-2016)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Version 12</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>(2014-2015)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Version 11</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>22</td>
<td>45</td>
<td>82%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>(2013-2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Version 10</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>12</td>
<td>45</td>
<td>74%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>(2012-2013)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Version 9</td>
<td>0</td>
<td>0</td>
<td>42</td>
<td>3</td>
<td>45</td>
<td>68%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>(2011-2012)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Version 8</td>
<td>0</td>
<td>0</td>
<td>45</td>
<td>0</td>
<td>45</td>
<td>66%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>(2010-2011)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.4 Goals agreed with Commissioners (CQUINS)

The 2017/18 CQUIN scheme has been agreed; these goals have been set nationally and also by NHS England for specialist services. This is included in Appendix E.

Local Quality Incentive Scheme CCG 2016/17

The national and local CQUIN scheme agreed with commissioners for 2016/17 is provided in the following tables, including achievement of the goals that has been signed-off by our Commissioners. The schemes included new national quality goals for improvement relating to NHS staff health and well-being, sepsis, and antimicrobial stewardship.

Table 29: 2016/17 CQUIN (national and local goals) summary as at 28/06/2017

<table>
<thead>
<tr>
<th>Quarter Requirements</th>
<th>CCG - National CQUINS</th>
<th>CCG - Local CQUINS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1 Signed off Performance</td>
<td>Q2 Signed off Performance</td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>CCG - National CQUINS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a NHS Staff Health &amp; Well-being - Initiatives re physical activity/mental health/access to physiotherapy</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>1b NHS Staff Health &amp; Well-being - Healthy food for NHS staff, visitors &amp; patients</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>1c NHS Staff Health &amp; Well-being - Improving the uptake of flu vaccinations by front line staff - Target 75%</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>2a Sepsis - Timely identification &amp; treatment for Sepsis in emergency depts &amp; Inpatient wards</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>2b Sepsis - Timely identification &amp; treatment for Sepsis in emergency depts &amp; Inpatient wards</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>• Screening - % of patients who met the criteria for sepsis screening &amp; were screened</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>• Treatment and day 3 review - % of patients with severe sepsis, red flag sepsis &amp; sepsis shock - antibiotics within 1 hour &amp; 3 day review.</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>• Initiation of treatment and day 3 review - mean time to antibiotics.</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>3a Anti-Microbial Resistance - Reduction in antibiotic consumption by 1%. 3 parts: Total antibiotic, Total Carbapenem, Total Piperacillin-tazobactam</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>3b Anti-Microbial Resistance</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Ensure empiric review of antibiotic prescriptions</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>CCG - Local CQUINS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Outpatients - Reducing delays &amp; achieving better care, better value in follow-ups</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>5a Improving Care Pathways (Respiratory)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>5b Improving Care Pathways (Cardiology)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>6 Smoking in Pregnancy - Contribute to reducing prevalence of smoking among pregnant women</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>7 Acute Kidney Injury</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Further CQUIN goals agreed with NHS England Commissioners for specialist services are listed in the table on the next page.
Table 30: 2016/17 CQUIN (specialist services) summary as at 28/06/2017

<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>NHSE - Specialised CQUINs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Local QIPP Engagement &amp; Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Improving HCV Treatment Pathways through ODNs - Governance &amp; Partnership</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Improving HCV Treatment Pathways through ODNs - Stewardship &amp; Nice Compliance</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>3 Clinical Utilisation Review (CUR)</td>
<td>Not Applicable</td>
<td>Reviewed in Q2</td>
<td></td>
<td>Income foregone</td>
</tr>
<tr>
<td>4 Adult Critical Care Timely Discharge</td>
<td></td>
<td></td>
<td></td>
<td>Income foregone</td>
</tr>
<tr>
<td>5 Enhanced Supportive Care for Advanced Cancer Patients</td>
<td></td>
<td></td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>6 Optimal Devices - Cardiac devices</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 CAMHS Screening for Paediatric Patients with Long-term conditions (LTCs).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Improving Haemoglobinopathy Pathways through Operational Delivery Network (ODN).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Multi-System Auto-Immune Rheumatic Diseases MDT Clinics, Data Collection &amp; Policy Compliance.</td>
<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Spinal Surgery: Networks, Data, MDT Oversight.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11 Nationally Standardised Dose Banding Adult Intravenous SACT.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>12 Local Adult Critical Care Scheme</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHSE - Dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Dental - Orthodontic Data Collection - Secondary care providers to collect the same data set as primary care providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Dental - Day Case Audit - (Some day case procedures may be coded as 'outpatient with procedure')</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>NHSE - Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Diabetic Retinopathy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Breast Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 AAA Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Neonate Bloodspot Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Cervical Cytology Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHSE - Armed Forces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Waiting List/Access Policy Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- Red: Not achieved
- Orange: Partial achievement
- Green: Local assessment to be signed off
- Green: Achieved
Part 5: Participation in Clinical Research

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

Research underpins excellent clinical services; for example, recent work led by Leeds researchers has confirmed that patients with colorectal cancer have better clinical outcomes in research-intensive hospitals. Therefore a strategic goal is to ensure that all our specialist services are research-intensive. Working in partnership with the University, the Trust has strengthened its research programmes in key areas of strategic strength, including;

Musculoskeletal Disease
The National Institute for Health Research (NIHR) has designated the Trust as a Biomedical Research Centre (BRC) in Musculoskeletal Disease. £6.7m has been awarded for 5 years from April 2017. The Trust is one of only 20 NIHR Biomedical Research Centres and, although ranked 18th nationally by funding amount, the quality of the clinical science was noted as “outstanding” by the international review panel.

Cardiovascular Disease
Cardiovascular imaging is a nationally recognised strength in Leeds – for example, a Leeds study has changed clinical practice in the use of scanning techniques to detect heart disease. The 3T Magnetic Resonance Imaging (MRI) system which is part of the Medical Research Council National Centre for Hyperpolarised MRI is now operational in the new Advanced Imaging Centre at the Leeds General Infirmary. The National Centre is a partnership with the University of York and is developing novel MRI tracers to improve diagnosis and monitoring of a wide range of diseases. Professor Sven Plein was appointed to a prestigious British Heart Foundation Chair in Cardiovascular MRI and Professor Jurgen Schneider, a world-leading pre-clinical MR imaging scientist from Oxford, was appointed to a Chair of Cardiovascular Imaging. The Cardiovascular Research Group also received a £2.4m doctoral training award from the British Heart Foundation and a leading group member, Professor Robert Ariens, received a prestigious Wellcome Trust Investigator award for his work on the behaviour of blood clots.

Cancer
The National Cancer Research Institute (a partnership organisation which includes Cancer Research UK) completed a benchmarking exercise for Centres of Excellence in Academic Radiotherapy. The exercise was led by two international reviewers. Leeds has been assessed overall as an "Emerging Centre of Excellence" which compares well with peers.

The Trust was a partner in a successful bid to Cancer Research UK to create a Paediatric Experimental Cancer Medicine Centre Network. The Network comprises eight Children’s Hospitals and will support early phase clinical trials in children.

Significant investment (over £5m) in Leeds by Yorkshire Cancer Research to fund a series of wide-ranging research programmes has been a welcome and prominent feature of 2016.

£750k has been awarded by the NIHR for the Clinical Research Facility. The Facility comprises a hub and spoke model, with major spokes in Bexley Wing, Jubilee Wing, and the Dental Hospital. The Facility conducts early phase research with leading-edge medicines and technologies across a range of diseases, with cancer particularly prominent. Trials of new drugs for the treatment of blood cancers have been particularly successful.
The University and Trust invested significantly in cancer research, appointing four new Chairs and 10 University Academic Fellows. Leeds receives more than £100m income for cancer research and has the second largest clinical trials cancer activity in the UK. Leeds now has five Cancer Research UK programme grants totalling over £5m, demonstrating the charity’s perception of our overall scientific strength.

**Precision Medicine**

Precision (or personalised) medicine is an approach for the treatment and prevention of disease that is informed by individual variability in genes, environment, and lifestyle. The Trust and University were designated as a Precision Medicine Centre by Innovate UK, with the aim of helping UK Life Sciences industry commercialise precision medicine technologies (for example, new tests in cancer including wider use of tumour genetic testing to select appropriate treatments). This builds on the existing Trust NIHR Diagnostic Evidence Cooperative (one of only 4 nationally). The Trust is working with the Leeds Academic Health Partnership to create a Personalised Medicine and Health System in Leeds which would span laboratory discovery to Leeds-wide adoption of precision medicine technologies. The Trust, in partnership with Sheffield Teaching Hospitals and Sheffield Children’s Hospital, was successful in achieving designation as a Genomics Medicine Centre by Genomics England.

**Research Performance**

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

During 2016/17, the Trust maintained its position as one of the Top 10 performing trusts in England for projects recognised by the National Institute for Health Research (NIHR), playing a leading role in recruiting patients into high quality studies. This year we have involved 12468 patients in 487 research studies.

![Figure 46: Top 10 Performing Trusts in England for projects recognised by NIHR](image)

The Trust has maintained its performance against the NIHR initiation and delivery targets for clinical trials. This means patients continue to be recruited into trials in a fast and effective manner. During 2016 92% of trials were started within the required 70 day timeline and 62% of commercial trials recruited the agreed number patients within the agreed recruitment period.

6.1 Care Quality Commission

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

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

The CQC undertook a planned inspection on 10-13 May 2016. This was a follow up visit following the comprehensive inspection that had been undertaken in March 2014. The CQC published their final reports on 27 September 2016, and we were delighted to have been rated as “Good”.

<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 has been developed to address the recommendations from the CQC reports. A summit meeting was held on 15 November 2016 with the CQC and other stakeholders, where the action plan was formally presented and agreed. Particular discussion focused on those actions that required support from partners, including:

- Patients waiting on trolleys for an inpatient bed
- Staffing
- Patients in Critical Care
- Patients being operated on at night.

Progress on implementation of the actions is being overseen by the Quality Assurance Committee and reported to the Trust Board.

The plan is also being monitored in conjunction with our local CQC Inspection Manager through their routine engagement meetings with the Trust, and through routine quality meetings with the CCG. Implementation is being overseen by NHS Improvement.
Statement of Directors’ Responsibilities in Respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

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

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

By order of the Board

30/6/17
........................................ Date ................................................................. Chair

30/06/17
........................................ Date ................................................................. Chief Executive
Appendix B - Statements from Local Stakeholders

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

The Trust provides clear information about how their patient and public engagement has progressed and influenced quality improvement. We have seen significant progress in the Trust wide approach to engaging with local people and patients with work progressing every year. The use of the extensive data base and the development of the patient leaders are commendable as is the spread across good practice in engagement across the organisation. There is a clear aim to make the document more user friendly with a summary of key points planned after the formal submission.

Given that around 20% of Leeds’s population includes Black and Minority Ethnic (BME) communities, it is hoped that the work to understand and adapt services to meet the needs of all communities will continue.
Thank you for giving the Leeds Clinical Commissioning Groups the opportunity to comment on the Quality Account for Leeds Teaching Hospitals NHS Trust 2016-17. We have reviewed this in accordance with NHS regulations and are pleased to provide the following statement:

The Leeds CCGs continue to work closely with the Trust to gain understanding of the quality of care provision and the experience of patients using its many services. We do this through meeting regularly with the hospital team to consider the systems and processes that the Trust have in place to promote safe, effective and high quality care delivery. We believe that the information published in this year’s Quality Account provides a good representation of the Trust’s achievements and its commitment to delivering high quality of care.

It is encouraging to read about the development of the Leeds Improvement Method as a result of the collaborative partnership with the Virginia Mason Institute, and the other many programmes of improvement work. The results of such quality improvement approaches are demonstrating some great successes in a number of clinical areas and staff clearly appreciate the opportunity to contribute directly to improving services and the work environment.

The year on year improvement in the scores of the Staff Friends and Family Test has shown that the Trust’s inclusive approach to engaging with all staff members has resulted in a workforce that is proud to be part of the organisation. Implementation of a number of staff health and wellbeing measures has, no doubt contributed to this and excellent progress has been made through the national Staff Health and Wellbeing CQUIN indicator.

Whist nurse recruitment continues to be a challenge on a national level; the CCGs recognise that the Trust has taken a proactive approach in holding internal recruitment events and maximising opportunities to attract staff from elsewhere in the country. A number of additional roles for support staff with a career progression pathway have been introduced and it is good to see the Trust working with partners to promote Leeds as a city of choice in which to work.

We are pleased to hear about the progress made in developing the Patient Reference Group and a Trust Patient Experience Strategy. Involvement of patients and public in developing services will bring benefits to both the organisation and the local community. The Leeds CCGs are delighted to work in partnership with the Trust with our Patient Leader programme to support this work going forward.

The ‘Get Me Better’ work to support people with a Learning disability by developing Champions across the Trust is a vital contribution to reducing health inequalities and improving the experience of those using services. This builds on the excellent work referred to in the 2015 Quality Account and we are delighted to see this work continuing and being embedded in the organisation. We congratulate the Trust on their award for the Yorkshire Evening Post Healthcare Team of the Year in relation to supporting those with a learning disability.

We recognise the significant progress made by the Trust in regards to the complaints process, including the feedback initiatives such as Speak to Sister. We would like to see more about how the Trust responds to feedback from the public and how this has been incorporated into service improvements.
Whilst it is disappointing that a higher number of MRSA bacteraemia cases occurred in 2016-17, we acknowledge that the Trust have made significant achievements in reducing the levels of Clostridium difficile, progressing the antimicrobial stewardship programme and demonstrating a collaborative approach to working with partners. We look forward to seeing how the quality improvement work to reduce blood stream infections progresses over the coming year.

The implementation and roll out of Safety Huddles in the Trust has contributed significantly to a reduction in patient harms and it is pleasing to note that this work is receiving national interest. The introduction of carer and patient views into these discussions is welcomed and we will watch with interest to see how this develops.

The CCGs commends the Trust on its commitment to working with the CCGs in a collaborative and transparent manner, and we look forward to continuing to work in partnership over the coming year.

Kind regards

Jo Harding
Director of Nursing
Independent auditor’s limited assurance report to the directors of
The Leeds Teaching Hospitals NHS Trust on the Quality Account

We are required to perform an independent assurance engagement in respect of The Leeds Teaching Hospitals NHS Trust’s Quality Account for the year ended 31 March 2017 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of Directors and auditors
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH on 29 January 2015 (“the Guidance”) and applicable to 2016-17; and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.
We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback from the Commissioners dated May 2017;
- feedback from Local Healthwatch dated May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2017;
- the latest national patient survey 2016;
- the latest national staff survey 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017; and
- the annual governance statement dated May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of The Leeds Teaching Hospitals NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Leeds Teaching Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- documenting key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Leeds Teaching Hospitals NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
• the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
• the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Gareth Davies, Partner for and on behalf of Mazars LLP
Tower Bridge House, St Katharine’s Way, London, E1W 1DD
27 June 2017
## Appendix C: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Hospital Trust</strong>:</td>
<td>an NHS organisation responsible for providing healthcare services.</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>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>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>Cardiotocography (CTG)</strong>:</td>
<td>measures the baby's heart rate and contractions in the womb (uterus). CTG is used both before birth (antenatally) and during labour, so doctors and midwives can see how the baby is doing.</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>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>Friends and Family Test</strong>:</td>
<td>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&amp;E departments to their friends and family if they needed similar care or treatment.</td>
</tr>
<tr>
<td><strong>Gram-negative bacteria</strong>:</td>
<td>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.</td>
</tr>
</tbody>
</table>
**HDU:** High Dependency Unit; a level of care between intensive care and general wards.

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

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

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

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

**In-reach Service:** A service that enables safe transition of care from hospital to community by providing appropriate support at home for patients.

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

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

**Leeds Institute for Quality Healthcare (LIQH):** The Leeds Institute for Quality Healthcare is a partnership initiative between the University of Leeds, the three Clinical Commissioning Groups, Leeds City and the three NHS Trusts in Leeds. Based on international best practice, it aims to secure improvements in healthcare across the city.

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

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

**Myocardial Infarction:** a heart attack.

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

**National Institute for Health and Care Excellence (NICE):** an independent organisation responsible for providing national guidance on promoting good health, and preventing and treating ill health. It produces guidance for health care professionals, patients and carers, to help them make decisions about treatment and health care.

**National Institute for Health Research (NIHR):** an organisation which aims to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.

**National Payment by Results (PBR):** the payment system in England under which commissioners pay healthcare providers for each patient seen or treated.

**National Reporting and Learning System (NRLS):** enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.
| **Never Events:** | serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented |
| **Patient Advice and Liaison Service (PALs):** | offers support, advice and information on NHS services to patients, their carers, the general public and hospital staff. |
| **Patient Leaders:** | A representative of the public that ensures the voice of patients and carers is considered to help influence key decisions. |
| **Patient Reported Outcome Measures (PROMs):** | a measure of quality from the patient’s perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre and post-operative surveys. |
| **Quality Summit Meeting:** | a group of healthcare quality experts meet to discuss quality initiatives to improve health care. |
| **RESPECT:** | A Recommended Summary Plan for Emergency Care and Treatment, that is agreed by a patient and their healthcare professional. It includes recommendations about the care an individual would like to receive in future emergencies if they are unable to make a choice at that time. |
| **Safety Thermometer data collection tool:** | a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. |
| **Secondary Uses Service:** | provides anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. |
| **Summary Hospital-level Mortality Indicator (SHMI):** | an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital. |
| **The Leeds Way:** | The ‘Leeds Way’ is the Values of Leeds Teaching Hospitals Trust created by staff. It defines who we are, what we believe and how we will work to deliver the best outcomes for our patients. The Values are Fair, Patient Centred, Collaborative, Accountable and Empowered. |
| **Trust Members:** | Trust Members have a say in the services the Trust offers and help us understand the needs of our patients, carers and local population, in order to improve our services. Anyone aged 16 years or over living in England or Wales can become a member. |
| **Venous thromboembolism (VTE):** | a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vein can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT). |
| **West Yorkshire Accelerator Zone:** | A system that has been set up for rapid implementation of improvements in urgent and emergency care delivery across the West Yorkshire & Harrogate. |
| **WTE:** | Whole time equivalent; the workload of one fully employed person. |
## Appendix D: Trust Participation in NCEPOD and National Audits

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

<table>
<thead>
<tr>
<th>National Confidential Enquiry</th>
<th>Participation Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of patients with mental health problems in acute general hospitals</td>
<td>92%</td>
</tr>
<tr>
<td>Non-invasive ventilation</td>
<td>89%</td>
</tr>
<tr>
<td>Chronic Neurodisability, focusing on cerebral palsy</td>
<td>Not yet available**</td>
</tr>
<tr>
<td>Young People’s Mental Health, focusing on self harm</td>
<td>Not yet available**</td>
</tr>
<tr>
<td>Cancer in Children, Teens, and Young Adults</td>
<td>Not yet available**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Participation Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Asthma</td>
<td>32%</td>
</tr>
<tr>
<td>Asthma (Paediatric &amp; Adult) care in emergency departments</td>
<td>100%</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management</td>
<td>100%</td>
</tr>
<tr>
<td>Case Mix Programme</td>
<td>52%</td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric Cardiac Surgery)</td>
<td>100%</td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit</td>
<td>65%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database</td>
<td>94%</td>
</tr>
<tr>
<td>Female Stress Urinary Incontinence</td>
<td>56%</td>
</tr>
<tr>
<td>Head and Neck Oncology Audit</td>
<td>100%</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme</td>
<td>100%</td>
</tr>
<tr>
<td>Lung Cancer (NLCA)</td>
<td>100%</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 Dementia</td>
<td>99%</td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit</td>
<td>100% ***</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>100%</td>
</tr>
<tr>
<td>National Cataract Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme: Re-audit of Patient Blood Management in Scheduled Surgery</td>
<td>31%</td>
</tr>
<tr>
<td>National Diabetes Core Audit</td>
<td>99%</td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit</td>
<td>Denominator not known</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit</td>
<td>84%</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>73%</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Data not fully submitted****</td>
</tr>
<tr>
<td>National Neonatal Audit Programme</td>
<td>100%</td>
</tr>
<tr>
<td>National Neurosurgery Audit Programme</td>
<td>100%</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>98%</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>100%</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>93%</td>
</tr>
<tr>
<td>Nephrectomy Audit</td>
<td>97%</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric intensive care (PICANet)</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric Pneumonia Audit</td>
<td>41%</td>
</tr>
<tr>
<td>Patient Reported Outcomes Measures - Hernia</td>
<td>47%</td>
</tr>
<tr>
<td>Patient Reported Outcomes Measures - Hip replacements</td>
<td>88%</td>
</tr>
<tr>
<td>Patient Reported Outcomes Measures - Knee replacements</td>
<td>93%</td>
</tr>
<tr>
<td>Patient Reported Outcomes Measures - Varicose veins</td>
<td>75%</td>
</tr>
<tr>
<td>Percutaneous Coronary Intervention (PCI)</td>
<td>99%</td>
</tr>
<tr>
<td>Percutaneous Nephrolithotomy</td>
<td>47%</td>
</tr>
<tr>
<td>Radical Prostatectomy Audit</td>
<td>99%</td>
</tr>
<tr>
<td>Renal Replacement Therapy (Renal Registry)</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>100%</td>
</tr>
<tr>
<td>Severe Sepsis and Septic Shock</td>
<td>100%</td>
</tr>
<tr>
<td>Trauma Audit &amp; Research Network (TARN)</td>
<td>86%</td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Participation rate is calculated as the number of patients for whom data have been submitted as a proportion of the number for whom data should have been submitted.

** Study currently taking place; participation rate not available.

*** NICOR is resolving a technical issue relating to location of operations; data for all 2016/17 patients has been collected by LTHT, and will be submitted once the issue is resolved by NICOR.

**** The system provider for joint replacement surgery is experiencing technical issues, preventing submission of the full dataset to the NJR.
### Summary table of participation in other national audits

<table>
<thead>
<tr>
<th>National Audit</th>
<th>Participation Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast and Cosmetic Implant Registry (BCIR)</td>
<td>25%</td>
</tr>
<tr>
<td>Consultant Sign Off</td>
<td>100%</td>
</tr>
<tr>
<td>Cystectomy Audit</td>
<td>100%</td>
</tr>
<tr>
<td>NAP6: Perioperative Anaphylaxis in the UK</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Clinical Management of Complicated Intra-abdominal Sepsis (CABI)</td>
<td>100%</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry (NBSR)</td>
<td>100%</td>
</tr>
<tr>
<td>National Complicated Diverticulitis</td>
<td>100%</td>
</tr>
<tr>
<td>National Maternal and Perinatal Audit (NMPA)</td>
<td>100%</td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme</td>
<td>100%</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>100%</td>
</tr>
<tr>
<td>Society for Acute Medicine’s Benchmarking Audit (SAMBA)</td>
<td>84%</td>
</tr>
<tr>
<td>Urethroplasty Audit</td>
<td>100%</td>
</tr>
</tbody>
</table>
### 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

<p>| BI1 Improving HCV Treatment Pathways through ODNs | Providers participation in ODN &amp; 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 |</p>
<table>
<thead>
<tr>
<th>CA2 Nationally Standardised Dose Banding for Adult Intravenous Anticancer Therapy (SACT)</th>
<th>Standardisation of chemotherapy doses through a nationally consistent approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>WC4 Paediatric Networked Care</td>
<td>This scheme aims to align to the national PIC service review</td>
</tr>
<tr>
<td>IM2 Cystic Fibrosis Patient Adherence (Adult)</td>
<td>Improved adherence and self-management by patients etc</td>
</tr>
<tr>
<td>Local QIPP Incentivisation Scheme</td>
<td>Engagement with NHSE local QIPP proposals and delivery of agreed savings</td>
</tr>
</tbody>
</table>
### Appendix F: Performance against National Priority Indicators

<table>
<thead>
<tr>
<th>Section A - National Operational Standards</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Incomplete</td>
<td>&gt;=92%</td>
</tr>
<tr>
<td>RTT Failing Specialties: Incomplete</td>
<td>0</td>
</tr>
<tr>
<td>A&amp;E Performance</td>
<td>&gt;=95%</td>
</tr>
<tr>
<td>Diagnostic Waits</td>
<td>&gt;=99%</td>
</tr>
<tr>
<td>Cancelled Ops: Not rebooked within 28 days</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B - National Quality Contract Requirements</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI: MRSA</td>
<td>=0</td>
</tr>
<tr>
<td>HCAI: CDiff</td>
<td>&lt;=119</td>
</tr>
<tr>
<td>VTE RCA Completion Rate</td>
<td>100%</td>
</tr>
<tr>
<td>VTE RCA Incomplete 52+ Week Waiters</td>
<td>=0</td>
</tr>
<tr>
<td>Ambulance Handovers: 30 - 60 mins</td>
<td>=0</td>
</tr>
<tr>
<td>Ambulance Handovers: Over 60 mins</td>
<td>=0</td>
</tr>
<tr>
<td>A&amp;E 12 Hour Trolley Waits</td>
<td>=0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C - NHSE Quality and Contract Requirements</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Incidents (SUIs)</td>
<td>10</td>
</tr>
<tr>
<td>Gynaec Cytology 14 Day TATs</td>
<td>100%</td>
</tr>
<tr>
<td>Harm Free Care</td>
<td>&gt;=95%</td>
</tr>
<tr>
<td>Readmissions to PICU Within 30 Days</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D - Local Quality and Contract Requirements</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP FUP Backlog: &gt; 3 Mths Overdue (Total Pts)</td>
<td>7,394</td>
</tr>
<tr>
<td>OP FUP Backlog: &gt; 3 Mths Overdue (Specialties &gt;100 Pts)</td>
<td>36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section E - Internal Monitoring</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Performance: Stage 1</td>
<td>&gt;=90%</td>
</tr>
<tr>
<td>Dementia Performance: Stage 2</td>
<td>&gt;=90%</td>
</tr>
<tr>
<td>Dementia Performance: Stage 3</td>
<td>&gt;=90%</td>
</tr>
<tr>
<td>Pressure Ulcers (Grade 3)</td>
<td>5</td>
</tr>
<tr>
<td>Pressure Ulcers (Grade 4)</td>
<td>0</td>
</tr>
<tr>
<td>Histo &amp; Diagnostic Biopsy 7 Day TATs</td>
<td>53%</td>
</tr>
<tr>
<td>OP Appts Cancelled 2 or More Times (Total)</td>
<td>2,720</td>
</tr>
<tr>
<td>OP Appts Cancelled 2 or More Times (By Hospital)</td>
<td>1,489</td>
</tr>
</tbody>
</table>