The Mid Yorkshire Hospitals
NHS Trust

70 YEARS OF THE NHS 1948 - 2018

2017/2018

# ANNUAL REPORT AND FINANCIAL ACCOUNTS

Striving for excellence

## Contents

## Chairman's statement

Welcome to our Annual Report and Accounts for 2017/2018.

Last year I mentioned that the health service had seen consistently high levels of demand and 2017/2018 has continued to see those demands increase. Throughout most of the year we were the busiest Emergency Department of our type in England and the fourth busiest across all ED departments. Despite that we improved ambulance handover times to be the best in the North.

What we usually refer to as winter pressures now seems to cover autumn, winter and early spring. We have made a great deal of progress but still have much to do in the context of delivering our vision 'to achieve excellent patient experience each and every time'.

Across most measures of performance the Trust has improved when compared to 2016/2017. Importantly the staff survey reflects an improving perception of the Trust by staff and staff sickness levels are down. Measures across A&E, harm free care, hospital mortality and cancer waiting times are all improved. We had 4 MRSA infections attributed to the Trust against a target of 0 and against there being only 1 in 2016/17. That is a disappointment. Finance continues to be challenging.

Achieving our vision means that every contact with a patient should be the best they could experience on admission, in hospital, in outpatients, in theatres, in our community services, in their contact with porters, with security staff, with anyone employed or volunteering within Mid Yorkshire Hospitals NHS Staff. From the performance figures it would appear that we are on track to deliver our vision. This is due to everyone and I must thank our hard working teams for this achievement. Everyone's contribution counts whether employed or a volunteer and across the whole organisation.

With the fact that we are about to celebrate the 70th Anniversary of the NHS I am reminded it was built on certain principles. Our modern day interpretation of those principles is reflected in our values, of Caring, Delivering High Standards, Improvement and Respect, all of which link to our vision. Making these values real will deliver quality care free at the point of delivery.

Finally I would like to reflect on the death in service of the following friends and colleagues who are sadly missed:

Rev John Arnold, Lead Hospitals Chaplain
Miss Carley Jennings, Healthcare Assistant
Mrs Carol Parker, Sister/ Charge Nurse
Mrs Teresa Riley, Healthcare Assistant
Miss Hayley White, Registered Nurse

My condolences to their families and my thanks, on behalf of the Board and colleagues, for their service to the NHS.

I commend this Annual Report to you.

**Jules Preston MBE**
**Chairman**

CHAPTER ONE

# PERFORMANCE REPORT

## Chief Executive's performance statement

This annual report covers the period of my second year as the Accountable officer for the Trust. In several important aspects, the Trusts performance has demonstrated year on year improvements.

The only performance standard which has deteriorated was the financial performance where the underlying gap between income and expenditure increased by some £7 million, largely due to our expenditure on agency staff being £5 million more than our plan.

The year saw progress towards achieving NHS Constitutional standards. The 18 week referral to treatment standard improved from 80% in April rising to 85.1% in March 2018. We still need to do more though in order to achieve the 92% standard.

The number of people seen and treated in our Accident and Emergency Departments was higher than the previous year and 3,700 patients less than the previous year had to wait more than four hours, a reduction of 9.6%.

However, we are still falling short of meeting the 95% standard. In particular we need to reduce the length of time patients who are to be admitted to hospital, wait in the Accident and Emergency department for a bed on a ward to become available.

This cause of delays does not lead to a good experience for patients and leads to overcrowding in the Accident and Emergency Department at Pinderfields Hospital. Increasing the timely availability of beds is a key priority for 2018.

In 2014 the Trust received approval to make some significant changes on how and where it would provide a range of clinical services, with the aim of improving the quality of these services, as well as their resilience, by making the most effective deployment of skilled clinical staff and making these services as cost effective as possible.

In September 2017 the final phase of the reconfiguration successfully took place centralising Intensive Care Unit (ICU) capacity at Pinderfields in an enlarged ICU; centralising specialty specific medical admissions at Pinderfields; establishing two Frailty Assessment Units, one at Dewsbury and District Hospital and the other at Pinderfields; transferring some rehabilitation beds to Pontefract Hospital from Pinderfields Hospital; and establishing 'step down' wards at Dewsbury and District Hospital and some 'step down' beds at Pontefract Hospital. These beds are used for patients who have moved on from the acute phase of their illness, but are not yet ready (for a variety of reasons) to return home.

The Care Quality Commission returned to carry out a full inspection of the Trust's services. Whilst the overall outcome was classifying the Trust as 'Requires Improvement', the inspectors noted a number of important improvements since their previous inspection.

The outcome of the assessment reflects our own view i.e. that we are an improving Trust whilst still having some way to go to achieve NHS Constitutional Standards and our ambition of each patient having an excellent experience each and every time.

I continue to be impressed and humbled by the motivation, expertise and hard work of our staff.

In my 45 years in the NHS I have never seen so many staff work under so much pressure for such prolonged periods of time. I am not just talking about the impact of 'winter pressures', the gap between demand and capacity, but also the pressure caused by the Trust having vacancies for many clinical staff reflecting the regional/national shortage of Doctors and Registered Nurses in particular.

The Trust will continue to strive to retain our existing staff and recruit to the vacancies. An example of this is the exciting development of having a locally based 'School of Nursing' at Dewsbury and District Hospital which opens on 23 April 2018. This innovation has happened as a consequence of a brilliant partnership with Bradford University.

Another key priority is ensuring the Trust is a good place to work. The Care Quality Commission annual staff survey continues to show year on year improvement in the feedback from staff, but in some key areas we have low scores in comparison to similar Trusts.

A great deal has been achieved in 2017/18 inside the Trust, but another very important highlight is the very noticeable improvement in which the Trust works with the two main Local Authorities and Clinical Commissioning Groups (North Kirklees and Wakefield).

Instrumental to this was the establishing of a weekly Monday morning meeting of senior operational staff chaired by the Corporate Director, Adult Health and Community of Wakefield Local Authority.

This improved support to the Trust has been invaluable in the Trust reducing the number of escalation beds and getting through the 'winter pressures' period.

I thank all of our staff, as well as our local Clinical Commissioning Groups, Local Authorities, partners, GPs and volunteers for their help and support.

**Signature:**

**Chief Executive and Accountable Officer:** Martin Barkley
**Organisation:** The Mid Yorkshire Hospitals NHS Trust
**Date:** 24 May 2018

## Overview: About the Trust

This overview section sets out: the purpose and activities of the Trust; the issues and risks which could affect the Trust in delivering its objectives; an explanation of the adoption of the going concern basis; and a summary of performance for 2017/18 against the national standards.

The Mid Yorkshire Hospitals NHS Trust provides acute and community health services to more than half a million people living in the Wakefield and North Kirklees districts of West Yorkshire.

It offers services in three main hospitals – Pinderfields (Wakefield), Dewsbury and District and Pontefract – as well as in a range of community settings such as health centres, clinics, GP surgeries, family centres and in people's own homes.


*Trust hospital locations*

The Trust offers an extensive range of services, spanning hospital, intermediate and community care.

This means patients benefit from hospital and community services working closely together to ensure they receive their care in the most appropriate place for them – when and where they need it.

**A snapshot of the Trust:**

- **Three hospitals – Pinderfields (Wakefield), Dewsbury and District and Pontefract**
- **Adult community nursing across the Wakefield district**
- **Around 8,400 staff**
- **In 2017/18:**
  - **There were around 240,000 attendances to A&E**
  - **Around 160,000 patients were admitted**
  - **Patients attended more than 500,000 outpatient appointments**
  - **Around 6,200 babies were delivered**

The Trust provides two specialist regional services, in burns and spinal injuries, which are renowned across the North of England and beyond.


With 8,406 staff and an operating income around £500 million it delivers services by working in partnership with two local authorities, two Clinical Commissioning Groups (CCGs), and a wide range of other providers including voluntary organisations and the private sector, as well as patients, their carers and the public.

## Trust strategic direction, vision and values and behaviours

Through the first half of 2017 the Trust took the opportunity to refresh its Strategy: 'Striving for Excellence'. The aim of the refresh was to ensure the strategy provides a clear line of sight for all staff to the goals of the Trust and its vision; providing clarity around purpose, priorities and aligning the resources of the Trust to achieve its ambition of providing an excellent patient experience each and every time.

The Trust's mission / purpose is:

- **To provide high quality healthcare services at home, in the community and in our hospitals, to improve the quality of people's lives.**

The vision statement is:

- **We strive to achieve excellent patient experience each and every time.**

The Trust's strategic aims are:

- **Strategic aim one: Keep our patients safe at all times**

Patient safety is of paramount importance to the Trust. It is committed to keeping patients safe at all times.

This means the Trust will:
- Eliminate avoidable harm to patients
- Ensure patients are safe in our care
- Ensure all staff understand their roles in keeping patients safe and are competent in doing so
- Ensure staff feel able to raise concerns and they are swiftly responded to
- Ensure our environment and equipment is safe, functional, suitable, secure and clean
- Ensure we have effective quality governance arrangements
- Have a below average Hospital Standardised Mortality Rate (HSMR)
- Ensure we learn from experience

- **Strategic aim two: Provide excellent patient experiences that deliver expected outcomes**

Achieving the Trust's vision and mission means providing excellent patient experience to the people it serves, every time they encounter the care it delivers.

This means the Trust will:
- Provide clinically effective treatment and care, which is delivered safely
- Provide services which are accessed with ease and in a timely manner
- Ensure patients have a positive experience of care at the Trust
- Ensure patients are actively engaged in their care, they understand what is happening with their care and our communication with them is excellent
- Listen and act upon feedback and evidence learning when things have gone wrong
- Use national data to support our ambition for striving for excellence
- Work in accordance with national guidelines and best practice
- Meet national clinical standards and best practices

- **Strategic aim three: Be an excellent employer**

The Trust values its staff and aspires to be an excellent employer – one which people choose to join, want to stay and where they can develop their careers.

This means the Trust will:
- Value our staff and their contribution
- Have effective clinical leadership
- Create the right conditions so people want to work here and choose to stay
- Support all staff to live by our values and behaviours
- Provide healthy and safe workplaces

- Invest and promote appropriate education, training, development and leadership opportunities for all staff
- Support staff to achieve their career ambitions
- Provide high quality clinical education and professional development that is valued by our student placements
- Be an equal opportunities employer

- **Strategic aim four: Be a well-led Trust that delivers value for money**

The Trust is an NHS organisation with responsibility for providing best value for the use of the public's money. It will pledge to spend resources to meet the objectives.

This means the Trust will:
- Know our business and be flexible to change
- Invest in innovation and transformation which enables us to provide high quality care to patients
- Consistently comply with our regulators' standards
- Ensure there is a clear line of sight from 'ward to board' and manage and monitor issues effectively
- Consistently meet financial obligations
- Support all staff to understand their role in relation to the use of public resources and act responsibly to deliver best value
- Provide best value whilst improving patient care
- Ensure our Performance Management Framework is patient-centric and provides foresight and actively supports us towards our Vision
- Ensure it has effective governance arrangements

- **Strategic aim five: Have effective partnerships that support better patient care**

The direction of the NHS is to work more collaboratively with other providers and with commissioners for the benefit of patients and to safeguard the sustainability of services.

This means the Trust will:
- Work with other organisations to provide seamless patient care
- Have partnerships to deliver efficiencies and sustainability
- Explore and adopt new models of care
- Be an active member of Sustainability and Transformation Plan work streams to support the change and collaboration required
- Support and work with primary care to improve patient outcomes and experience
- Work with the third sector where and when it will enhance patient experience or support better patient outcomes
- Make a full contribution to West Yorkshire Association of Acute Trusts
- Make a full contribution to the Health and Wellbeing Boards to improve the health of the people of Mid Yorkshire

- **Strategic aim six: Provide excellent research, development and innovation opportunities**

As a learning organisation, with three acute hospitals and vibrant community services, the Trust is perfectly positioned to be actively involved in research, development and innovation opportunities. Enhancing its involvement in these will strengthen the offering to patients and staff as well as to the healthcare evidence base.

This means the Trust will:
- Make it easy for staff to present ideas and innovations
- Support staff to realise ideas quickly and effectively
- Work with academic and healthcare organisations to explore and support appropriate research partnerships to improve our care
- Actively engage our patients and the public in delivering effective research and development projects

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# MY BEHAVIOURS


**OUR MISSION (PURPOSE):** To provide high quality healthcare services, to improve the quality of people's lives.

**OUR VISION (AMBITION):** We strive to achieve excellent patient experience each and every time.

## HIGH STANDARDS

**Taking responsibility for providing the best services and patient experience.**

- I will strive to do things right first time, every time.
- I will speak up about and report any concerns I have.
- I will support and encourage others in the team.
- I will make first impressions count by being professional in my appearance, communication, body language and attitude.
- I will recognise, praise and celebrate a job well done.
- I will commit to continuing my development, learning new skills and sharing knowledge.
- I will take responsibility for my actions.
- I welcome feedback.

## CARING

**Ensuring quality of care is at the heart of everything we do.**

- I will avoid making assumptions and always treat people as individuals.
- I will make eye contact, smile and introduce myself with, "Hello, my name is…"
- I will listen and welcome different opinions.
- I will put myself in the other person's shoes and take time to understand their needs.
- When I make a commitment, I do what I say I am going to do.
- I will aim to give the standard of care or service I would expect for myself or my relative and ask myself, "would I be happy with this?"
- I will give time to people in distress or who need me.
- I will show genuine compassion to others by being kind and thoughtful.

## RESPECT

**Showing value and respect for everyone and treating others as they would wish to be treated.**

- I will protect the privacy and dignity of patients, service users and colleagues.
- I value the opinions of others and show consideration for their feelings.
- I will take the time to listen to others and consider their perspective, even if it is different to my own.
- I will treat people as individuals, taking into account their personal circumstances.
- I will listen, check my understanding and act with fairness, honesty and consistency.
- I will show appreciation by saying thank you for work well done.
- I will respect the confidential nature of information.
- I will strive to develop insights into how I impact on others, accepting and acting on feedback.

## IMPROVING

**We always look for ways to improve what we do. We encourage involvement, value contributions and listen to and positively act on feedback.**

- I will be responsive and adaptable to changing circumstances and new expectations.
- I appreciate learning can come from mistakes and I will take positive steps to change.
- I will continually reflect on my actions and take every opportunity to make improvements.
- I will work as part of a cohesive team, praise co-operation and value the views and contributions of others.
- I will learn from others, be receptive to new ideas and look elsewhere to see what works.
- I will speak up when I see or hear behaviour which does not reflect the Trust values.
- I will help seek opportunities to improve and take part in the way it is done.
- I will encourage creativity and support new ideas by suspending judgement until all the benefits and risks have been fully explored.

## Working in partnership

The Trust works in partnership with other organisations across the locality it serves, both formally and informally. In line with the NHS Five Year Forward View some partners are looking to work collaboratively in a very different way. In 2017/18 the Trust continued with a number of arrangements to work more closely together. These partnerships included:

- **West Yorkshire and Harrogate Health and Care Partnership**

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs). It brings together all health and care organisations across six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

West Yorkshire and Harrogate Health and Care Partnership

In February 2018, the Partnership published 'Our Next Steps to Better Health and Care for Everyone'. The document describes the progress made since the publication of the initial WY&H plan in November 2016 and sets out the next 12 months and beyond. You can read it at www.wyhpartnership.co.uk/next-steps

The partnership is built on organisations working together in the West Yorkshire and Harrogate six local areas to meet the needs of people. Partners also work together on nine priority programmes for the whole of WY&H, including mental health, hospitals working together (see WYAAT section below), maternity, stroke, urgent and emergency care.
The Partnership has attracted more than £45m of national funding to further improve healthcare, so it can move quickly on its priorities.

This includes £12.4 million of national funding to support work to improve early diagnosis and make more cancers curable, and funds to build a new mental health unit in Leeds for children and young people. It has also recently agreed an ambition to improve detection and management of Atrial Fibrillation (erratic heartbeat) and estimates this will prevent 190 strokes over three years.

- **West Yorkshire Association of Acute Trusts**

The West Yorkshire Association of Acute Trusts (WYAAT) is an innovative collaboration which brings together the NHS trusts who deliver acute hospital services across West Yorkshire and Harrogate.

West Yorkshire Association of Acute Trusts

It is about local hospitals working in partnership with one another to give patients access to the very best facilities and staff. WYAAT is made up of: Airedale NHS Foundation Trust; Bradford Teaching Hospitals NHS Foundation Trust; Calderdale and Huddersfield NHS Foundation Trust; Harrogate and District NHS Foundation Trust; Leeds Teaching Hospitals NHS Trust; and The Mid Yorkshire Hospitals NHS Trust.

The WYAAT vision is to create a region-wide high quality, efficient and sustainable hospital care system that embraces the latest thinking and best practice to consistently deliver the best possible outcomes for patients.

WYAAT is focusing on five principles, which are:

- Centres of excellence
- Developing West Yorkshire standardised operating procedures and pathways
- Collaborating to develop clinical networks and creating alliances
- Workforce planning at scale
- Deliver economies of scale in back office and support functions

- **Wakefield Multi-specialty Community Provider**

The Trust Board supported the plan to establish a Multi-speciality Community Provider (MCP) to serve the population of Wakefield. An MCP combines the delivery of primary care and community-based health and care services – not just planning and budgets. It also incorporates a much wider range of services and specialists wherever that is the best thing to do for a patient. As a starting point the Trust became a member of the 'New Models of Care Board' at its inaugural meeting in January 2017. This is the vehicle for leading closer integration of out of hospital services to improve outcomes and support for the people of Wakefield. The Trust has made a positive and constructive contribution to this very important initiative throughout the year. The work with Wakefield Council in establishing join leadership of the integrated services from the 'Connecting Care Hubs' has gone from strength to strength.

## Equality, Diversity and Inclusion

The Trust recognises the diversity and difference which exists within our workforce and the communities it serves. The Trust continues to ensure that in delivery of services it gives regard to the needs of diverse groups within the workforce and the wider population. The Trust is committed to promoting inclusive practices in all its day to day interactions with all patients, carers, visitors and staff regardless of their race, ethnic origin, gender, age, gender identity, mental or physical disability, religion and belief, sexual orientation, maternity or social class. During the year the Trust launched Project SEARCH, which provides work experience for young people with learning disabilities over the course of the academic year. The project is proving to be a real success with many departments offering placement opportunities.

The Trust has been continuing with efforts to improve the experience of Black, Asian and Minority Ethnic (BAME) staff. Recently the Trust invited applications for a local development programme specifically aimed at middle grade BAME staff. Four applicants were successful and started the programme in February. The Trust is looking forward to hearing about their experiences to help in deciding whether to offer similar opportunities in the future. Following expressions of interest from staff, and working in partnership with Wakefield Council, the Trust organised a number of autism awareness sessions to help staff understand how they might better support such patients when they access services. The sessions were oversubscribed so the Trust is currently organising further dates to allow more staff to take part. Working in partnership with the local CCGs and other NHS service providers the Trust again used the NHS Equality Delivery System (EDS) as a framework to engage local community groups across both Wakefield and North Kirklees. These groups provided comment on the Trust's efforts to involve patients and use the feedback from surveys to improve patient experience. The comments are being used to further improve work in this area.

## Activity levels in 2017/18

| | 2017/18 | 2016/17 |
|---|---|---|
| Emergency Department attendances | 239,183 | 236,053 |
| Admissions into hospital | 161,498 | 165,704 |
| Discharges | 161,450 | 165,806 |
| Outpatient appointments | 510,859 | 486,402 |
| Births | 6,286 | 6,412 |
| Radiology examinations | 517,734 | 518,903 |
| Blood tests | 548,550 | 544,369 |
| Home visits in the community | 273,875 | 274,766 |
| Patients who were admitted as an emergency | 64,555 | 68,089 |
| Total procedures | 93,665 | 95,680 |
| Total elective procedures | 69,738 | 70,023 |

## Commentary

### Financial sustainability

Like many NHS Trusts, Mid Yorkshire faced significant financial and operational pressures throughout the year. In order to deliver the financial control target of a £2.3 million deficit set by NHS Improvement (NHSI), the Trust embarked on an ambitious £24.7 million savings programme.

The financial control total included an opportunity to earn £13.5 million of income through the national Sustainability and Transformation Fund (STF). The Trust managed to secure £7.4 million of this income, which represented a shortfall of £6.1 million. In addition the Trust did not meet its savings target in full which contributed to a reported deficit of £25.8 million before any STF income and a net deficit of £18.4 million after the receipt of the STF.

This comes on the back of deficits reported by the Trust for a number of years. The Trust's auditors, as part of the annual audit, produce a statement which reviews the Trust's ability to remain as a going concern. The audit opinion draws attention to this matter but given the unique position of NHS providers the auditors consider the Trust to be a going concern.

In line with the requirements of the International Accounting Standard (IAS 1), the Trust Board considered the organisation to be a going concern for at least the next 12 months.

As the Trust has a financial plan agreed with NHSI, which includes the provision of cash support from the Department of Health and Social Care to ensure cash flows can be maintained, the Trust Board deemed the Trust would remain a going concern during this period.

There are no events since the end of the financial year affecting the financial statements of the Trust.

### Trust procurement

The Trust's Procurement Policy includes a section on governance which covers the following issues and ensures the Trust works in an ethical and responsible way:

- Ethical procurement
    - Corporate Social Responsibility
- Environmental Procurement
    - Packaging and Waste Directive
- Conflicts and Declarations of Interest
- Openness and accessibility
- Freedom of Information
- Press releases
- Bribery Act

In accordance with Section 54 of the Modern Slavery Act, the Trust is committed to ensuring workers: are not exploited; are safe; have the right to work and remain in the country; and their employment standards and human rights are adhered to. The Trust expects the same from its suppliers and is committed to working with them to ensure any issues are identified and proactively managed.

## 2017/18 Performance

The Well-led Framework used by NHS Improvement identifies effective oversight by Trust Boards as essential to ensuring trusts consistently deliver safe, sustainable and high quality care for patients. This includes robust oversight of care quality, operations and finance. At the Trust, an Integrated Performance Report is submitted monthly to the Board for assurance. For the purpose of reporting, indicators are grouped into the five domains of quality (caring, safe, effective, responsive and well led) identified by the Care Quality Commission.

Data is reported using a scorecard approach and, with the exception of measures under the Effective section, performance is assigned a Red or Green rating based on achievement against pre-defined thresholds. Under these assessments the ratings are:

- Red - Not Achieved: the required standard has not been met and performance is not within an agreed tolerance
- Green – Achieved: the required standard has been met for this indicator

Effective Ratings only:

- Red - Not Achieved: the required standard has not been met and performance is not within an agreed tolerance
- Amber – Within National Average: the required standard has not been met but performance is within an agreed tolerance (national average)
- Green – Achieved: the required standard has been met for this indicator

In summary the Trust's rating against the five domains at the end of March 2018 is as follows:

| | | | |
|---|---|---|---|
| **Caring** | **7** | | **1** |
| **Safe** | **14** | **8** | |
| **Effective** | **5** | **2** | **1** |
| **Responsive** | **12** | **11** | |
| **Well led** | **12** | **4** | |

The monthly report to the Trust Board identifies performance against: key operational and quality requirements mandated nationally; activity against planned levels; and finance.

The purpose of this approach is to ensure the Board is provided with robust and timely information on organisational and operational performance.

Further information is provided to the Board on an exception basis where underperformance in a particular area or against a specific target is identified.

The 2017/18 Trust performance against the five domains of quality is detailed in this section.

### Caring

All targets in this domain were achieved for the year, with the exception of 'the proportion of staff that would recommend the Trust to friends and family as a place to receive care/treatment'.

- **Staff Friends and Family Test – recommended and not recommended care**

The quarterly target for staff recommending the Trust as a place to receive care is ≥65% and ≤18% for not recommended.

Performance in quarter four of 2017/18 was 62% and 15% for these two indicators respectively. This is an improvement on the same period last year for both indicators.

### Safe

The Trust had four confirmed case of Methicillin-resistant Staphylococcus aureus (MRSA) in 2017/18. The prevalence of harm free care and reportable incidents which are harmful in the community are both outside their targets, with the highest contributing factor being pressure ulcers and falls which continued to be a concern for the Trust.

There was one never event that occurred in 2017/18.

- **Trust attributable Clostridium difficile infection (CDI) cases**

The Trust's annual objective is to have no more than 27 Trust attributable CDI cases.

In the full year 2017/18 the Trust reported 37 cases of Trust attributable CDI, however only 6 of these cases at the time of writing were linked to a lapse in care after review. This has been the result of a concerted effort in managing symptomatic patients so as not to lead to cross contamination and education with our frontline clinical staff.

- **NHS Safety Thermometer – harm free care**

Harm free care performance is measured using a monthly Safety Thermometer tool. This provides indicators of four key harms [pressure ulcers, falls, urinary tract infections (UTIs) in patients with a catheter, and venous thromboembolism (VTE)] on a specified date each month.

At the end of March 2018, harm free care was recorded for 93.22% of patients across the Trust against the 95% target. Performance on this indicator over the whole of 2017/18 was 93.41%. The peer group average for harm free care performance was 93.71% in 2017/18.

- **Proportion of reported patient safety incidents that are harmful – community services**

In March 2018, 65.45% of patient safety incidents reported relating to the Trust's community services were graded as harmful, against the ≤50% target set locally based on data for community services.

Of 165 patient safety incidents relating to the Trust's community services reported in March 2018, 108 were graded as harmful. Low harm incidents accounted for 105 of the harmful incidents reported in March, and the remaining three incidents were graded as moderate.

### Effective

- **Hospital Standardised Mortality Ratio (HSMR) – relative risk**

HSMR is the ratio of observed (actual) deaths in a period against the expected deaths in the period, standardised for factors known to impact the risk of death, for example age, sex, primary diagnosis etc. The calculation covers a basket of 56 diagnosis codes known to account for approximately 80% of in-hospital deaths. A relative risk above 100 indicates the number of actual deaths was higher than the expected number, and vice versa for a relative risk of less than 100.

There are three HSMR indicators included in the performance report to the Trust Board.

Based on the most recent data available, the Trust is currently statistically better than average in both overall HSMR and Weekday HSMR. Although within national benchmark, Weekend HSMR is slightly above the target of 100. Overall these are all improvements on 2016/17. Year-end information will not be available until June 2017, beyond the time of writing this report.

## Responsive

Performance against access standards for urgent care has been a significant challenge throughout the year. The Trust did not achieve the target for the four hour wait in the Emergency Department, which was also reflected nationally. Although the Trust also failed to achieve the ≥92% target for Referral to Treatment (incomplete pathway) within 18 weeks, Cancer 62 days and six week waits, they have all improved against the position in 2016/17. The Trust also continues to achieve the Cancer two week wait target.

- **Emergency Department (ED)**

In March 2018, 81.6% of patients attending the Trust's emergency care services were admitted, transferred or discharged within four hours of arrival. Performance was therefore below the ≥95% standard mandated nationally but was higher than the national average of 76.5%. The Trust's performance benchmarks well against other organisations, especially when taking into account the high demand on local emergency services. The Trust agreed a trajectory for further improvement during 2017/18 though performance in this area remains reliant on system wide actions taking place. The conversion rate from Emergency Department attendance to emergency admission remained below the national average throughout the year at a time when the Trust remained as one of the busiest – across its three emergency departments – in the country for attendances during 2017/18.

- **Ambulance handovers**

There are two national quality requirements relating to the timeliness of handovers between the Emergency Department and ambulance staff. The national standard is all handovers should take place within 15 minutes of arrival, with none taking place over 30 minutes and 60 minutes from arrival. In March 2017, there were 29 breaches of the 30 minute target and two of the 60 minute target. Following continued actions within the emergency department, at March 2018, this had improved to 9 breaches of the 30 minute target and zero breaches of the 60 minute target. At the time of writing, the Trust is ranked the best performing trust in the region for this target.

- **Referral to Treatment (RTT) waiting times – incomplete <18 weeks**

At the end of March 2018, 85.1% of patients waiting on incomplete RTT pathways were waiting less than 18 weeks, which was below the 92% standard mandated nationally. However March saw the third consecutive monthly improvement in performance.

With the exception of December 2017, the actions taken by the Trust have resulted in a month on month improvement in RTT performance. In March 2017, there were 6,801 patients waiting over 18 week but as at March 2018, this had reduced to 4,643. The three specialties with the highest volume of patients waiting over 18 weeks are Ophthalmology, Oral Surgery and Trauma & Orthopaedic.

- **Diagnostic waiting times over six weeks from referral to test**

At the end of March 2018, 98.9% of patients waiting on incomplete six week diagnostic pathways were waiting less than six weeks, which was below the 99% standard mandated nationally. Of 8,349 patients waiting for a diagnostic test, 91 were waiting over 6 weeks at the end of March 2018. The majority of these were patients waiting for non-obstetric ultrasound or an endoscopy procedure.

- **Cancer – 62 days from urgent GP referral to first definitive treatment**

The latest data for cancer access performance is March 2018 which shows 86.1% of patients receiving first definitive treatment for cancer in the month waited less than 62 days from GP referral.

This was above the ≥85% standard mandated nationally and also above the agreed STF trajectory of 85.7% for the month of March 2018.

Of 104 accountable pathways completed in March 2018, 20 had waited longer than 62 days from urgent GP referral. Of these, 9 were local breaches and 11 were shared pathways with another provider, equating to 14.5 accountable breaches for the Trust in total.

## Well-led

Indicators in this domain that were below target include those related to temporary staff spend (nurse and medical), sickness, staff turnover and non-medical annual appraisal rate.

Staff Friends and Family Test recommended place to work achieved the ≥52% each quarter* in 2017/18.
* no survey in Q3

- **Staff sickness absence**

The annual target for sickness absence performance at the Trust was set locally for 2017/18 at ≤4.8%.

The latest data for sickness absence is March 2018 which shows performance of 4.17% of FTE days available lost due to sickness absence in the month. This was a decrease from 5.04% the previous month.

This took performance in the year to date to 5.09%. Trends in sickness absence performance show an improvement in the corresponding 6 month of 16/17.

Across all service areas, anxiety/stress/depression accounts for the highest proportion of sickness absence at 23.9%, followed by ‘Other musculoskeletal problems’ at 15.3% and ‘Other known causes - not elsewhere classified’ at 10.5%.

## 2017/18 Actual Performance compared to 2017/18 National Target

| RAG Status | Performance Description |
|---|---|
| Red (R) | **Not Achieved** – the required standard has not been met and performance is not within an agreed tolerance |
| Green (G) | **Achieved** – the required standard has been met for this indicator |

## 2017/18 Performance compared to 2016/17 (Improved Position?)

| Status | Performance Description |
|---|---|
| Red (N) | **Declined:** 2017/18 has declined based on the 2016/17 performance position. |
| Green (Y) | **Improved:** 2017/18 has improved based on the 2016/17 performance position. |
| n/c | **No change in performance** |

| Performance Indicator | 2016/17 | 2017/18 | Improved Position? | 17/18 National Target |
|---|---|---|---|---|
| **Caring** | | | | |
| Mixed sex sleeping accommodation breach | 0 | **0** | **n/c** | 0 |
| **Safe** | | | | |
| Trust attributable MRSA infection cases | 1 | **4** | **N** | 0 |
| Trust attributable C. difficile infection cases | 45 | **37** | **Y** | 27 |
| Trust attributable C. difficile infection cases where lapse in care identified | 15 | **6** | **Y** | 27 |
| Venous Thromboembolism (VTE) risk assessment of eligible in-patients | 95.4% | **95.4% (Feb'17)** | **n/c** | ≥95% |
| NHS Safety Thermometer: harm free care | 93.1% | **93.41%** | **Y** | ≥95% |
| Duty of candour breaches | 0 | **0** | **n/c** | 0 |
| Never events: occurred in month | 4 | **1** | **Y** | 0 |
| Never events: identified in month | 3 | **2** | **Y** | 0 |

| Performance Indicator | 2016/17 | 2017/18 | Improved Position? | 17/18 National Target |
|---|---|---|---|---|
| Medication errors causing serious harm | 0 | **0** | **n/c** | 0 |
| Reported patient safety incidents that are harmful: trust level | 28.93% | **30.52%** | **N** | ≤29% |
| Reported patient safety incidents that are harmful: acute services | 23.36% | **24.53%** | **N** | ≤29% |
| Consistency of reporting to the National Reporting and Learning System (NRLS) – rolling 6 months | 6 mnth | **6 mnth** | **n/c** | 6 mnth |
| Outstanding open CAS alerts | 20003 | **1** | **Y** | 0 |
| **Effective** | | | | |
| Stroke care: SSNAP stroke unit domain score | 74 Dec'16-Mar'17 | **76.5 Apr'17-Jul'17** | **Y** | >70 |
| **Responsive** | | | | |
| A&E waiting times – admitted, transferred or discharged within 4 hours | 83.5% | **86.1%** | **Y** | ≥95% |
| Trolley waits in A&E longer than 12 hours | 2 | **3** | **N** | 0 |
| Ambulance handovers >15 minutes from arrival | 15386 | **3923** | **Y** | 0 |
| Ambulance handovers >30 minutes from arrival | 5038 | **1049** | **Y** | 0 |
| Ambulance handovers >60 minutes from arrival | 1296 | **137** | **Y** | 0 |
| Referral to Treatment (RTT): incomplete <18 weeks | 81.2% | **85.1%** | **Y** | ≥92% |
| Referral to Treatment (RTT): 92% incomplete pathways <18 weeks at specialty level | 3 | **5** | **Y** | 17 |
| Referral to Treatment (RTT): incomplete >52 week waits at month end | 40 | **0** | **Y** | 0 |
| Diagnostic waiting times: >6 weeks from referral for test | 2.87% | **1.93%** | **Y** | ≤1% |
| Cancer: 2 weeks from urgent GP referral to 1st outpatient | 96.6% | **96%** | **N** | ≥93% |
| Cancer: 2 weeks from urgent GP referral for breast symptoms to 1st outpatient | 97.5% | **97.2%** | **N** | ≥93% |
| Cancer: 31 days from diagnosis to first definitive treatment | 97.3% | **97.7%** | **Y** | ≥96% |
| Cancer: 31 days to subsequent treatment - surgery | 90.8% | **94.5%** | **Y** | ≥94% |
| Cancer: 31 days to subsequent treatment - drug | 99.9% | **100%** | **Y** | ≥98% |

| Performance Indicator | 2016/17 | 2017/18 | Improved Position? | 17/18 National Target |
|---|---|---|---|---|
| Cancer: 62 days from urgent GP referral to first definitive treatment | 83% | **84.9%** | **Y** | ≥85% |
| Cancer: 62 days from referral from NHS screening service to first definitive treatment | 95.5% | **96.4%** | **Y** | ≥90% |
| Last minute cancelled operations (non-clinical reasons) not re-booked within 28 days | 2 | **0** | **Y** | 0 |
| Delayed transfers of care – acute beds | 3.78% | **4.27%** | **N** | ≤3.5% |
| Delayed transfers of care – community beds | 12.27% | **5.99%** | **Y** | ≤7.5% |
| Urgent operations cancelled for a second time | 0 | **0** | **n/c** | 0 |
| **Well-led** | | | | |
| Completion of valid NHS number in acute commissioning dataset submitted via SUS | 99.8% | **99.8% (Feb'18)** | **n/c** | ≥99% |
| Completion of valid NHS number in A&E commissioning dataset submitted via SUS | 99.3% | **99.4% (Feb'18)** | **Y** | ≥95% |

## Sustainability Report

The NHS is a major consumer of the earth's scarce resources. The Trust is keen to play its part in ensuring it actively supports the government's sustainability agenda to make effective use of hospitals and services, particularly having strategies in place to improvement environmental performance and consumption.

The Trust is committed to having in place active carbon management arrangements across a range of service areas which will contribute to reducing its overall carbon footprint.

It is recognised a commitment to reduce carbon emissions, manage energy consumption and make effective use of resources for service delivery is of crucial importance.

The NHS Sustainable Development Unit developed the NHS Carbon Reduction Strategy for England with a target to deliver a 34% carbon dioxide (CO2) reduction by 2020.

The Trust is working towards this target with a number of key areas of activity.

## Energy Management

Building on the achievements of previous years and increasing the emphasis to reduce carbon emissions from the 2018/19 baseline the Trust's estates team, along with the PFI Estates Management, have continued to invest in energy reduction schemes.

These include:

- Combined heat and power (CHP) – a combined heat and power unit has been successfully installed on the Pinderfields site in the new Eye Centre. The unit is highly efficient in converting a fuel source into both electrical energy and heat and overall reduces energy consumption for the unit.

  Following the CHP feasibility study in 2018 the success of this project will be taken forward into other parts of the Trust.

- Improved Lighting – In 2018 the Trust successfully introduced a number of LED (light emitting diode) lighting schemes to upgrade internal and external lighting to reduce energy consumption and improve lighting levels. These schemes will continue in future years.

- Improved Insulation - Improved building insulation is a key contributor to a reduction in energy consumption. Studies have been undertaken and a number of small schemes have been put into place to improve insulation on service pipework and ventilation systems.

- Building Management System (BMS) – The BMS systems used on all sites continued to demonstrate that providing better computerised controls to manage temperature paid dividends by reducing any unwarranted use of energy in the Trust's hospitals.

For 2017/18 Trust's utility consumption and carbon emissions are reported in the table overleaf. Emissions are also reported through participation in both the EU Emissions Trading Scheme and the CRC Energy Efficiency Scheme.

### Utility consumption and carbon emissions in 2017/18

| Type | Total KWH | Utility cost (£k) | Total carbon (tonnes) | Reduction in carbon (tonnes) |
|---|---|---|---|---|
| Gas | 32,418,627 | 872 | 5,959 | 286 |
| Electricity | 31,635,734 | 328 | 12,067 | 1,922 |
| Water (m3) | 394,878 | 844 | Included in energy use | |
| Fuel oil | 174,000 litres | 73 | minimal | |

## Travel and Transport

The Trust has continued its environmental focus on transport by maintaining an effective shuttle bus service across the three sites.

The focus of this service for staff, visitors and out-patients is to provide a transport infrastructure which reduces individual car journeys and makes a major contribution to a major reduction of CO2 as detailed in the table below.

In 2018 the work to improve fuel efficiency of the Trust's own transport fleet continued. Vehicle procurement took the opportunity to trial new technologies including all electric vehicles and hybrid electric vehicles.

Following several trials with both electric and hybrid vehicles the Trust Transport Department has leased its first full electric vehicle for the Trust fleet. The vehicle (pictured) is based at Pinderfields and will be seen regularly around the hospital on postal and parcel deliveries.

Further work is in hand to expand the electric fleet further and a small project group are investigating the opportunities to provide further electric vehicle charging points for staff and visitor use to supplement the charging points already installed at Dewsbury and District Hospital.

| Fuel | Type | Miles | CO2 (tonnes) |
|---|---|---|---|
| Diesel | Shuttle bus | 199,758 | 43.35 |
| | | | **43.35** |
| Diesel | Shuttle bus cargo | 228,800 | 49.65 |
| Petrol | Passengers – medium cars | 659,631 | 230.87 |
| Diesel | Passengers – medium cars | 349,751 | 103.53 |
| | | | **384.05** |
| **Total CO2 savings by introducing the shuttle bus** | | | **340.70** |

## Waste Management

The Trust has continued to develop its waste management strategy and maintain its position as a leading Trust in Yorkshire for compliance and waste minimisation.

The 2017/18 year has seen unprecedented increased levels of healthcare provision, across the Trust. This placed significant pressure on all departments in terms of handling and moving waste.

The Trust has worked with its contract partners to ensure this has this been managed to the same standards as in previous years whilst maintaining the segregated waste streams.

The table overleaf identifies that year on year, despite the increase volumes, the Trust has maintained a very stable level of segregation which demonstrates how embedded the waste management system is across the Trust.

The Trust is working with its waste contractors to extend the levels of mixed recyclates, paper and cardboard recycling across all sites in what has been a challenging year for the waste industry.

The recent changes in China have put added pressure on the waste sector to provide innovative solutions in terms of waste, especially in the plastic and cardboard market.

The Trust continues to work with its waste partners to lower the levels of waste to landfill and increase the amount of waste to energy outputs.

The delayed opening of the Trust's main Healthcare waste contractor's purpose-built £10 million low-carbon centre of excellence, including cutting-edge thermal treatment processes using pyrolysis and gasification was a disappointment. However trials are now up and running.

Within the next year the Trust should see the majority of its incineration material and tiger waste directed to this plant, with the positive impact of growing amounts of energy generated.

The Trust has established and sustained an alcohol gel scheme with the waste ethanol being recovered and reused as a fuel source. Mid Yorkshire Hospitals NHS Trust is one of very few trusts in the country to have such a scheme.

The Trust continues to achieve high levels of compliance in external audits undertaken by independent auditors. These audits concluded the Trust's segregation efforts are amongst the best in the region.

The Trust, through its Infection Prevention and Control Team, has developed improved posters, bins labels and training programmes which have been rolled out in the early part of 2018. Improvements have also been made to the e-learning packages to improve communication to all clinical staff across the Trust.

The Trust's managed service contract within the Pathology Labs at Pinderfields, has included the recovery of waste materials and this has operated successfully throughout 2017. The Trust is working with the procurement department to seek further opportunities for similar contractual arrangements for other departments.

## Clinical waste tonnages 2017/18

| | ORANGE | YELLOW | YELLOW | RED | BLUE | PURPLE | TIGER | Total Tonnes |
|---|---|---|---|---|---|---|---|---|
| | | Infectious | Sharps | Anatomical | Pharmacy | Cytotoxic | Offensive | |
| | HDS | INCIN | INCIN | INCIN | INCIN | INC | WFE/LAN | |
| | WASTE | WASTE | WASTE | WASTE | WASTE | WASTE | WASTE | |
| | TONNES | TONNES | TONNES | TONNES | TONNES | TONNES | TONNES | |
| | 265.6 | 156.9 | 67.3 | 10.9 | 43.0 | 16.8 | 407.8 | **968.3** |
| **% 2017** | 27.4 | 16.2 | 6.9 | 1.1 | 4.4 | 1.7 | 42.1 | **100** |
| **% 2018** | 26.7 | 16.9 | 6.9 | 1.3 | 5.4 | 1.5 | 41.3 | **100** |


CHAPTER TWO

# HIGHLIGHTS OF THE YEAR

## Acute Hospital Reconfiguration

Acute Hospital Reconfiguration (AHR) was completed in September 2017 with the centralisation of acute inpatient care at Pinderfields Hospital.

AHR has been a long journey which was initiated because commissioners and the Trust needed to: improve care and safety across the Trust's hospitals; meet the latest national standards; ensure the workforce was being used in the most effective way; and put in place hospital services which are sustainable in the long term.

All this was set in the context of some very real financial challenges which the Trust was historically, and is currently (see Chapter Six), dealing with to improve financial sustainability.

The changes made as part of AHR mark the end of a three year reconfiguration programme to develop Pinderfields Hospital as the main site for treating the most seriously ill patients and to develop Dewsbury and District Hospital and Pontefract Hospital as Centres of Excellence for elective care and rehabilitation.

The entire AHR programme delivered:

### 2014

- An Ambulatory Emergency Care Unit at Dewsbury and District Hospital, offering rapid access to diagnosis and treatment without the need for hospital admission
- A Children's Assessment Unit at Dewsbury and District Hospital

### 2015

- Centralisation of acute cardiology services at Pinderfields Hospital
- A brand new state of the art Eye Centre for Ophthalmology patients at Pinderfields Hospital


### 2016

- A midwife-led Birth Centre at Dewsbury and District Hospital. All births requiring a consultant were centralised at Pinderfields Hospital

- Centralisation of neonatal services and children's inpatient care at Pinderfields Hospital and an Early Pregnancy Assessment Unit at Pinderfields Hospital

### 2017

- Transfer of inpatient care for acute medical patients from Dewsbury and District Hospital to Pinderfields Hospital
- Two new Acute Care of the Elderly (ACE) assessment units at Dewsbury and District Hospital and Pinderfields Hospital were established.
- The development of a Clinical Decision Unit at Dewsbury and District Hospital
- Increased rehabilitation facilities and medicine and elderly care step down wards at both Dewsbury and District Hospital and Pontefract Hospital

## CQC inspection

The Trust was inspected by the Care Quality Commission (CQC) between 16 and 19 May 2017 followed up by a number of unannounced visits in May and June.

The CQC rates NHS services by classifying them as Outstanding, Good, Requires Improvement or Inadequate against five criteria including whether services are safe, effective, caring, responsive and well-led.

Overall the CQC noted many improvements since the previous inspection. However the CQC issued the Trust with a Warning Notice because of some of the issues it found with some aspects of the quality of service provided to patients. This was due to the Trust having to open a lot of 'escalation beds' to help accommodate the number of patients in the hospitals. This notice was lifted at the start of 2018.

The CQC's main reports which were published on Friday 13 October highlighted the improvements in community services and upgraded the safe domain from inadequate to requires improvement.

The report noted that overall the culture within the Trust had improved since the last inspection and there were 'indications of a positive cultural shift'.

The report also highlighted the on-going challenges the Trust faces and the further improvements still needed such as: recruiting and retaining more staff; enabling more patients to access treatment sooner; improving the flow of patients through the hospitals; and making financial savings.

Areas the CQC highlighted for their high quality included:

- The Emergency Departments across the Trust had significantly reduced ambulance handover times by introducing ambulance handover nurses
- The Spinal Unit facilities at Pinderfields were modern, current and progressive for patients undergoing rehabilitation and therapies
- The e-consultation service in Cardiology service provided a prompt and efficient contact for primary care referrers
- Proactive engagement initiatives for people with people living with dementia and the use of technology by the dementia team were also praised in the report.

You can view the full CQC reports at: http://www.cqc.org.uk/provider/RXF

More information about the inspection, report and the actions the CQC has asked the Trust to take is available in both Chapter Four and the Appendices of this report.

### CQC judgement on quality and care

| Overall rating | Requires improvement |
|---|---|
| Are services caring? | Good |
| Are services safe? | Requires Improvement |
| Are services effective? | Requires Improvement |
| Are services responsive? | Requires Improvement |
| Are services well-led? | Requires Improvement |

# Caring

## Dedicated ward provides specialist care

The Trust opened a dedicated diabetes and endocrinology ward to help manage the care of patients. All high risk diabetes patients who are admitted to Pinderfields Hospital will now be treated on Gate 32 where specialist diabetes nurses can administer insulin, ensure meals are being eaten at the correct times and carry out foot checks amongst other essential duties.

People living with diabetes may have to deal with a number of complications as a result of their condition. These can have an impact on different parts of the body including: eyes, heart, kidneys, nerves and feet. For example, if foot problems are left untreated, they can cause foot ulcers and infections and, at worst, may lead to amputations. Keeping blood glucose, blood pressure and blood fat levels under control will greatly help to reduce the risk of developing complications.

Emily Watts, Programme Manager for Inpatient Care at Diabetes UK, said: “People with diabetes have complex needs and sometimes find it difficult to manage their condition. Having access to specialist support and a consistent team is a huge step forward for people experiencing diabetes-related complications.

*Pictured: (back, left to right) patients Craig Smith and Phillip Mountain, Dr Carol Amery, Dr Tolu Shonibare and Dr Abdul Basit. Front (left to right) Sister Louise Fraser and Emily Watts, Programme Manager for Inpatient Care at Diabetes UK.*

## Radiographers calming kids' hospital anxieties

The Radiology department at Dewsbury and District Hospital introduced a Starlight distraction box to help provide their staff with a variety of ways of distracting children whilst various medical procedures, such as x-rays, blood tests and MRI’s, are undertaken. These are being rolled out across all radiology departments within The Mid Yorkshire Hospitals NHS Trust in the coming months.


*Radiographers Jade Coserhil (left) and Aysha Nadeem*

The distraction box is a portable toolkit filled with a variety of toys, games and puzzles and was kindly donated by Starlight Children's Foundation. The charity help sick children rediscover the joy of childhood through wish granting and hospital entertainment and distraction programmes.

Lucy Beeley, Radiology Group Manager, at The Mid Yorkshire Hospitals NHS Trust, said “We’re absolutely thrilled with the Starlight distraction box. It really is helping our young patients through relatively invasive procedures without the need for sedation or general anaesthetic.”

## Age UK Wakefield Service helping older people home from hospital

Age UK Wakefield District (WD) has continued to provide the Trust with a supported transport service for medically fit and able patients within the district.

The hospital to home service is primarily from Pinderfields Hospital and provides support to Wakefield residents aged 60+ who have attended A&E or had a short stay in hospital on the assessment units at Pinderfields or Pontefract Hospitals.

Appropriate patients are identified by the hospital teams and are referred to the Age UK WD team for support with settling back at home in a safe, secure and comfortable manner.


*Five members of the Age UK Wakefield District Hospital to Home team (left to right) Nathaniel Bee, Natasha Pawson, Richard Stringer, Andrew Masterson, and James Bee.*

The team engage in a home assessment to identify any further needs that the patient may have.

This is then followed up with various offers of support and ensures that patients are receiving everything they need to remain as independent as possible.

## Hospital invests in state of the art facilities

The Trust continued to invest in patient care at Dewsbury and District Hospital with the addition of a state of the art scanner. Computed tomography (CT) scanning uses special x-ray equipment to create scans of the body, allowing doctors in radiology (radiologists) to more easily diagnose problems such as cancer, infection, strokes, heart disease and injuries. CT images of internal organs, bones, soft tissue and blood vessels provide greater detail than traditional x-rays and in emergencies can reveal internal injuries and bleeding quickly enough to help save lives.

A wider range of applications on the equipment means that the Trust now has more scanning capabilities at Dewsbury. This includes being able to carry out cardiac CT scans which were previously only carried out at Pinderfields. The new equipment is housed in a purpose built room which provides a much improved, more spacious, environment.


*From left to right: Ruth Clarke - Consultant Radiographer CT and MRI, Gillian Taylor - Clinical Support Worker and Sarah Hanson - Senior Radiographer with the new CT scanner.*

## Respect

### Trust gets on board with local campaign

The Trust has launched its backing of the Yorkshire wide 'Be a Hero' campaign which encourages people to sign the Organ Donation Register. Staff shuttle buses at the Trust, which are used to transport members of staff around the three sites, have been branded with the logo prompting people to 'Be a Hero' by signing the register.

Helen Buglass, Clinical Lead for Organ Donation at the Trust, said: "On average three people die every day in need of an organ transplant because there just aren't enough organ donors. We wanted to show our allegiance to this local campaign to help improve the prospects for those in need of a transplant. In the Yorkshire and Humber region alone there are over 400 active patients on the transplant register waiting for a donor and over 70% of these are in need of a kidney transplant."

### Home visiting pilot helping to keep more people out of hospital

A new home visiting pilot scheme which gives patients in Wakefield faster access to treatment at home was hailed as an early success. Community Matrons, from the Trust, who are part of the Wakefield Connecting Care hubs (made up of specialist health workers from different health, social care and voluntary organisations, across Wakefield) started the pilot on 1 August 2017.

The overall aim of the service is to provide a same-day visit for patients in their own homes, whilst helping to reduce the number of patients admitted to the Accident & Emergency (A&E) department, and as hospital admissions to wards. In addition, the new scheme hopes to reduce pressures on local primary care services.

The Community Matrons, based in Wakefield, visit patients who are identified as needing a same day urgent care home visit and who meet specific criteria. After patients have been triaged by their GP, the Community Matrons make an assessment of the patient's needs and make any necessary arrangements to help the patient remain in their home.

The service has proved successful and Wakefield CCG is making funding available to expand the service in 2018.

*From left to right: Rachel Harwick, Cheryl Greenwood Charles, Peter Hunter, Helen Buckles, Donna Harper and Katie Cheesman.*

### Trust Accessibility Checker goes live

The Trust launched its very own Accessibility Checker thanks to a new partnership with DisabledGo.com. It is totally free to use and has loads of detailed information about the accessibility of the Trust's departments, wards and services. The online access guide includes information for all three hospitals. Visitors, patients and staff can use this information to find out about the access to the service they are visiting so they can be confident about what they will find. Most importantly, all the details have been checked in person, so patients and visitors can be sure they get all the facts.

## Project SEARCH launches at Pinderfields

The Trust partnered with Highfield School, Wakefield Council, HFT Supported Employment Agency, Pennine Camphill Community and Wakefield College, to give young adults with learning difficulties the chance to gain valuable work experience, in a programme called Project SEARCH.

The Project SEARCH programme, which The Trust launched on 1 September 2017, is a one-year supported training and employment opportunity for adults aged 17-25 with a learning disability, which takes place entirely at the Pinderfields Hospital site.

Project SEARCH provides real life work experience combined with training in employability and independent living skills, as well as formulating a CV, to help young people make successful transitions from school to productive adult life. The goal for each student is competitive employment somewhere in the community using the skills they have acquired.

*Front row (left to right); Emily Robinson (Intern), Andrew Jones (Trust Director of Workforce and Organisational Development) , Martin Barkley (Trust Chief Executive), Diane Moore, John-Connor Widdop (Intern), Godspower Nnambi (Intern), Stephen Hicks (Teaching Assistant), Marcia Haigh (Project Search Job Coach).Back row (left to right); Ellie Valentine (Trust Assistant Director of HR), Gordon Smith (Trust Head of Diversity and Inclusion), Liam Newbigging (Intern), Joe Morris (Intern), Luke Anderson (Intern), Dave Brady (Project Search Tutor), Simon Jones (Assistant Head at Highfield School),Maxine Kneeslaw (HFT), Sharron Daley (HFT).*

## Unemployed enter work with Trust

The Trust, in partnership with Job Centre Plus (JCP) and Wakefield College, gave 18, local, unemployed people the opportunity to get a job. Each of the candidates was initially screened by the JCP and interviewed by a panel which also included the Trust and Wakefield College. The successful applicants were assessed against the Trust core values and chosen for their aptitude and appetite for work.

The first cohort completed a number of work related modules at Wakefield College which saw them awarded with certificates in food hygiene and customer service. They then started a four week placement in various housekeeping and domestic roles at Pinderfields Hospital. On successful completion they were given permanent employment by the Trust.

*Top left: Alia Mahmud and Martin Kadzirange – Recruitment Assistants at The Mid Yorkshire Hospitals NHS Trust, Charlotte Crane – Business Advisor DWP, middle of back row, Mary Bilics - Trust Team Leader, top right Ruth Ford - Lecturer, Wakefield College with the first cohort of candidates.*

Ellie Valentine, Assistant Director for HR and Recruitment at The Mid Yorkshire Hospitals NHS Trust, said: “We’re delighted to be working with local partners to give local people the chance to get into work. There are many reasons why people find themselves unemployed, and they often just need someone to give them a chance.

## High standards

### Trust occupational health team receives prestigious award

The Occupational Health and Wellbeing Service at the Trust received national recognition for the high standard of service it provides its employees. The team was re-accredited with the SEQOHS accreditation (Safe, Effective, Quality Occupational Health Service), a scheme run by the Royal College of Physicians in association with the Faculty of Occupational Medicine. To achieve the accreditation organisations are measured against a set of comprehensive standards designed to help raise the level and quality of care provided.

### Trust launches mobile clinic


*Claire Hirst (left), Clinical Team Leader, and Hayley Scott, Retinal Screener Grader, with the van.*

Eye screening experts from the Mid Yorkshire Hospitals NHS Trust can test more patients where they are located thanks to the introduction of a mobile testing clinic. A van contains all the equipment needed to offer eye screening to diabetes patients in places such as prisons and other secure units, care homes and harder to reach rural communities. Introducing the van means the service can offer more flexible appointments to more people than ever before.

### Trust and Lloyds Pharmacy enhance services


*The Lloyds Pharmacy team at Pinderfields with (fourth from left) Adam Crampsie (Head of Operations & Speciality Service Design at LloydsPharmacy), Jules Preston MBE (Chairman of the Trust) and Phil Deady (Trust Director of Pharmacy).*

LloydsPharmacy renewed their partnership with the Trust to enhance on-site outpatient pharmacy services at all three hospitals. Ceremonies to officially open the new facilities took place over summer 2017. The partnership improves pharmacy services at all three hospital locations. The new outpatients pharmacy at Pinderfields, for example, is open an extra 27 hours per week compared to the previous pharmacy.

The LloydsPharmacy team is trained to offer expert advice and efficiently dispense medicines. They also have the opportunity to work with the Trust's wider pharmacy team on complex issues. Phil Deady Director of Pharmacy at the Trust, said: "We are passionate about providing high quality pharmacy services to our outpatients, alongside LloydsPharmacy. We'll be working together to make sure our patients receive the medicines they need, when they need them, along with advice on how best to take them."

## Surgery success for bladder cancer patient

A bladder cancer patient treated at Pinderfields Hospital in became the first person in West Yorkshire to undergo a laparoscopic cystectomy with bladder reconstruction without the disease returning.

Mr Philip Hirst (60), from Wakefield, underwent a laparoscopic cystectomy with bladder reconstruction two years ago at Pinderfields Hospital in Wakefield as treatment for bladder cancer.

*From left to right: Mr Tiago Mendonca (Consultant Urological Surgeon), Mr Mohantha Dooldeniya , (Consultant Urological Surgeon), Mr Philip Hirst and Dr Jason Alcorn ( Macmillan Uro-Oncology Cancer Nurse Specialist- Team Leader)*

Mr Hirst was offered less invasive keyhole surgery to remove the bladder.
The procedure Mr Hirst underwent, involved removing the bladder using special instruments that are inserted through small cuts in the wall of the abdomen. Once the bladder was removed the tubes carrying the urine from the kidneys were plumbed into a newly constructed (orthotopic) bladder. This allowed an improved cosmetic result as Mr Hirst was able to pass water normally, without the need for a stoma.

## Mid Yorkshire Hospitals awarded for commitment to patient safety

The Trust was named as a National Joint Registry (NJR) Quality Data Provider, after successfully completing a national programme of local data audits. The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes for the benefit of patients, clinicians and industry.

To achieve the award, hospitals were required to meet a series of six ambitious targets during the year. Mr Ajit Shetty, Head of Clinical Service Trauma and Orthopaedics, at the Trust, said:
“Improving patient safety is of the upmost importance and something all staff take very seriously. We fully support the National Joint Registry’s work in facilitating improvement in clinical outcomes and governance for the benefit of joint replacement patients and we’re delighted to be awarded as a ‘NJR Quality Data Provider’.”

*The Arthroplasty team who led on the data reporting (left to right): Lynne Gee (Administration Assistant), Michelle Clarke (Nurse Practitioner - Arthroplasty), Jo Halliwell (Deputy Director of Operations – Surgery), Karen Rollinson (Nurse Practitioner - Arthroplasty) and Diane Waite (Administration Support).*

## Improving

### MY Quality Improvement System (MYQIS)

The Mid Yorkshire Trust's Quality Improvement System (MY QIS) is designed to help maximise quality and eliminate waste, based on the Toyota Production System. MY QIS is used to help improve the quality and value of services by looking at existing ways of operating, removing waste from processes and maximising activities which add value. Processes are observed, analysed and are redesigned by operational staff using their ideas and concepts to ensure high quality service provision.

*Rapid improvement events*

There have already been some real successes stories, as a result of more than 200 staff taking part Rapid Process Improvement Workshops (RPIWs). In the RPIWs the staff have implemented their ideas to make improvements to their service, reducing waste and improving outcomes for patients and colleagues.

These include:

- Emergency Department Stepdown

There are processes for stepping down patient from resus so they are cared for in the right place, at the right time by the right person which has resulted in patients being discharged from resus 50% quicker

- Non-Medical Recruitment

There has been a significant reduction in time from 58 days from the receipt of resignation to advert going live on NHS jobs to 1 day along with a 100% customer satisfaction rating from Recruiting Managers for the new process

- End of Life Discharge

Patients at end of life are being discharged much more quickly to the place they want to die. This is helping them and their families and also freeing up beds for other patients.

### Trust initiative keeps ambulances moving

*Stacey Howell, Sister in the Emergency Department at Pinderfields Hospital, booking in a patient with Yorkshire Ambulance Service Paramedic Philip Coulson*.

The Trust has played a huge part in helping to keep Yorkshire ambulances on the road. A new initiative launched in 2017 sees a dedicated flow nurse greet all ambulances on arrival to take responsibility for the patient, freeing up the paramedics to get back on the road as quickly as possible.

The flow nurse was introduced at Pinderfields Hospital as this was where the pressures to meet the target for taking handover within 15 minutes was being felt most. Since the changes Pinderfields Hospital has seen a sustained increase in performance – the average number of patients handed over within 15 minutes each month for the six months prior to the changes was 1,300 and for the last six months the average was 2,400.

Stacey Howell is one of the senior nurses in the Emergency Department at Pinderfields who regularly fulfils the flow nurse role.

A screen in the department shows Stacey how many ambulances are on route to the ED and how far away they are, enabling her to ensure she is ready to receive them.

Once the ambulance arrives the paramedics give Stacey the history of the patient so she can assess if they need to be in resus or cubicles. The patient is booked in at reception and together, Stacey and the paramedic check out the ambulance on the screen. The ambulance is then free to get back on the road.

### Innovative product goes national

A unique and universal hand and wrist splint developed by an Occupational Therapist from Pontefract Hospital, aimed at helping patients with rheumatology related health conditions, has been recognised by a national Orthopaedics company for distribution. Sue Phillips, an Occupational Therapist within the rheumatology team at the Trust, identified a gap in the market for a splint that would deliver more flexibility, comfort and functional support for her patients. .

Wrist and hand splints are provided to people who need protection and support for painful, swollen or weak joints and their surrounding structures. Functional splints are required to provide support and pain relief during activities. This improves confidence with grip and allows people to perform activities for longer and helps to protect joints.

The idea began almost ten years ago, when Sue decided to design a pattern to make a simple splint support for patients to wear, in place of other splints which were proving uncomfortable and tricky to fit. She created the splint using the new design and a sewing machine donated by a former colleague.

The splint she designed is universal and one size fits all. This has reduced the need for Occupational Therapists to keep a large range of different sized splints in storage. These universal splints are currently being manufactured in house by staff within the Splinting room of the Therapy Department at Pontefract Hospital. The splint has been used by Occupational Therapists within the Hospitals and in the Community as well as by Neuro-Physiotherapists for the last four years and received positive feedback from patients.

*Sue Philips (Occupational Therapist at Pontefract Hospital), showcasing her universal hand and wrist splint*

Sue recently began to explore the opportunity for income generation from her splint design with the idea to reinvest money into the service to provide more equipment for patients. She was supported by the Trust's Research and Innovation team to realise the full potential of her idea to help make a significant impact on the health economy nationally. Knowing there was positive feedback from therapists and patients, the design was registered and put in front of commercial partners. Sue has recently signed a contract with Beagle Orthopaedic, a leading Orthopaedic company, who will manufacture and produce the splints.

## Research and innovation

*The Research team.*

The NHS Constitution makes a commitment for research and innovation to:'…improve the current and future health and care of the population'. NHS England has made an obligation to ensure research systems are in place to promote and support participation by NHS organisations and NHS patients in research to contribute to economic growth. The Trust Annual Plan 17/18 sets out the priorities for the Trust; this includes objective 6 which is to "Provide Excellent Research, Development and Innovation Opportunities".

Mid Yorkshire has undertaken to providing excellent research, development and innovation opportunities and actively engages with academic and healthcare organisations to explore and support research partnerships to improve our care.

The Mid Yorkshire Hospitals NHS Trust is a partner organisation in the Yorkshire & Humber Clinical Research Network (YHCRN) (a regional network to support research). This partnership working helps the Trust to support national commitments to research and implement the National Institute for Health Research (NIHR) guidance for setting up research.

This joint working supports the national initiative to improve the quality, speed and co-ordination of clinical research by removing NHS barriers, unifying systems, improving collaboration with industry and streamlining administrative processes. Between 1 April 2017 and 31 March 2018, over 250 studies were active within the Trust. Of those, 50 studies were new and opened during 2017-18 and 33 are NIHR portfolio adopted studies. The Trust has research activity across a wide range of clinical specialities in areas as diverse but not limited to; Stroke, Ageing, Reproductive Health and Childbirth, Cancer, Diabetes and Mental Health.

Mid Yorkshire's NIHR study recruitment figures have exceeded our externally set NIHR target for the year successfully recruiting 2360 participants into non-commercial NIHR studies against the target of 1473.

Research activity is overseen quarterly by a multidisciplinary Research Committee, chaired by the Trust's Research Director. Research quality is monitored by the Research Quality Group (RQG), which reports to the Research Committee. Regular external monitoring and internal audits are conducted on research studies. Additionally performance against the high level objectives is managed by the YHCRN and national NIHR Coordinating Centre.

We are an active member of the local Academic Health Science Network which brings together organisations in Yorkshire and Humber which have an interest in the health and wealth of the region. The Trust also has a track record of engagement with commercial research organisations such as pharmaceutical companies and is a member of Medipex, a healthcare

innovation hub for NHS organisations across the North

## Highlights

Recently research trial offices have highlighted some of the work we have been doing. Which translate into real benefits for patients within and beyond the Trust.

The Multiple Sclerosis [MS] registry is a ground-breaking study designed to increase our understanding and knowledge of living with MS in the UK which will have a measurable impact on those affected by this debilitating disease.
We have supported 206 patients to take part in this study and have one of the highest levels of data completeness (a sign of high quality) across the country.

We have supported 98 patients taking part in I-Care, a study which aims to gain more information about some of the long-term benefits and also some of the health risks potentially associated with certain treatments for Inflammatory Bowel Diseases (IBD)

In Urology research we opened a study with a pharmaceutical company looking at the safety and efficacy of new treatments for urinary incontinence. The Country Head for UK & ROI of Clinical Operations has remarked that we were the first site in the UK to help a patient join this trial.

## Successes

During the year, in partnership with the University of Bradford, we were pleased to establish the Trust's first (and a world first) Clinical Professor of Radiography. Professor Bev Snaith is unique in occupying a dual role as an academic radiographer at the University of Bradford whilst continuing to work as a consultant radiographer at the Trust.

We have begun hosting a three year long NIHR funded 'Research for Patient Benefit' (RFPB) study called 'Motivar' which is developing an app to inspire weight loss in diabetic patients. We are working with the University of Bradford, University of Leeds and Kings College, London and a prototype will be used with patients in 18/19.

We have supported the development of an innovative and unique universal hand and wrist splint led by an Occupational Therapist from Pontefract Hospital.
The Crosby Wrist and Thumb Splint is aimed at helping patients with rheumatology related health conditions and has been recognised by a national orthopaedics company for distribution.

The Research team again hosted the annual research event, 'More and better research' showcasing the work of the department. The event, the largest yet, demonstrates the growing importance and confidence of the research department attracting over a 100 guests and sponsors. The department will also be recruiting Research Champions across the Trust, with each medical specialty investing in staff who promote and drive research in clinical service and help implement research alongside clinical activity.

In our desire to continuously improve, the department will be embarking on patient experience surveys in 18/19. We have recently piloted this in a research study in the Trust and have had some positive patient feedback.

The team has recruited three Patient Research Ambassadors who promote health research from a patient point of view to ensure that people using local NHS care have the best opportunities and choices about taking part in research studies.

The department is larger after recruiting to several new positions and the department was recognised as the NIHR team of month in February 2018, with Emily McDougal, of CRN Yorkshire and Humber, describing the team as 'proactive and innovative in their approach to research, supporting new ways of working and new researchers with a seemingly endless supply of enthusiasm, team work and expertise.'

## Charitable funds

Every year the Trust is overwhelmed by the generosity and support given to the Mid Yorkshire Hospitals Charity from the general public, staff and patients.

These donations are so vitally important and enable the Trust to go above and beyond for patients by providing additional resources which would not be routinely funded as basic NHS provision. In 2018 the charity will be exploring further opportunities to raise awareness and education around its work whilst increasing the opportunities for further donor support.

This is supported following the recruitment of the new Fundraising Coordinator in January 2018, who will be promoting the new brand and relaunch for MY Hospitals Charity from April 2018. All charitable donations are managed by The Mid Yorkshire Hospitals NHS Trust Charitable Fund (Charitable Funds) which has a specific committee, in order to safeguard donations and legacies.

This is a registered charity (number: 1067163), which is governed by the laws applicable to Trusts i.e. The Trustee Act 2000 and the Charities Act 2011. As a result, the aims and objectives of Charitable Funds are very simple:

- **To deliver improved patient care and well-being.**

The charity endeavours to ensure the wishes of those making donations are respected and upheld by reaching the designated department. There are also general funds to support Trust-wide services or services at specific hospitals.

If you wish to know more about charitable funds, please feel free to contact a member of the Charitable Funds team on email: charitablefunds@midyorks.nhs.uk. For fundraising enquiries please contact the Fundraising Coordinator on x56017 or email on: myhospitalscharity@midyorks.nhs.uk

CHAPTER THREE

# THE ACCOUNTABILITY REPORT

## Directors' Report

The Trust Board meets in public and the meetings are open to anyone who wants to attend. Details, including agenda and papers are available on the Trust website.

The Trust Board is made up of six Non-Executive Directors, including the Chair, and five executive directors, including the Chief Executive, and each member brings a variety of individual skills and experience.

The Trust also has two associate non-executive directors and a further three executive directors, all of whom do not have voting rights.

Non-executive directors are not employees of the Trust and are appointed to provide independent support and challenge to the Trust Board.

All Board directors are required to comply with the Trust Standards of Business Conduct, including declaration of any actual or potential conflict of interest.

**Signature:**

**Chief Executive and Accountable Officer:** Martin Barkley
**Organisation:** The Mid Yorkshire Hospitals NHS Trust
**Date:** 24 May 2018

### Board of Directors as at 31 March 2018

| NON-EXECUTIVE DIRECTORS |
|---|
| Jules Preston – Chair |
| Simon Stone – Senior Independent Director |
| Naseer Ahmed – Non-Executive Director |
| Julie Charge – Non-Executive Director |
| Jane Gilbert – Non-Executive Director, appointed 1 May 2017, sabbatical 1 February 2018 – 31 July 2018 |
| Lenore Ogilvy – Non-Executive Director, appointed 1 May 2017 |
| **EXECUTIVE DIRECTORS** |
| Martin Barkley – Chief Executive |
| Trudie Davies – Chief Operating Officer |
| Jane Hazelgrave – Director of Finance |
| David Melia – Director of Nursing and Quality / Deputy Chief Executive |
| Dr Karen Stone – Medical Director |
| **ASSOCIATE NON-EXECUTIVE DIRECTORS** |
| Mike Smith – left 31 March 2018 |
| Simon Harrison – appointed 1 July 2017 |
| **NON-VOTING EXECUTIVE DIRECTORS** |
| Mark Braden – Director of Estates, Facilities and IMT |
| Andrew Jones – Director of Workforce and Organisational Development |
| Debbie Newton – Director of Community Services |

### Directors who left the Trust in 2017/18

| NON-EXECUTIVE DIRECTOR |
|---|
| Terry Moran – Non-Executive Director, left 31 May 2017 |
| **EXECUTIVE DIRECTORS** |
| Caroline Griffiths (on secondment to Programme Office, West Yorkshire Association of Acute Trusts since 12 April 2016) – left 21 July 2017 |

## Declarations of interests for Directors in post 2017/18

Non-Executive Directors (NEDs) in post as at 31 March 2018

| Name | Title | Directorships, including non-executive directorships in private companies or plcs | Ownership/Part Ownership of private companies and businesses | A position of authority in a charity or voluntary organisation in the field of health and social care | Any connection with a voluntary or other organisation contracting for NHS services |
|---|---|---|---|---|---|
| **Jules Preston MBE** | Chair | Nil | Nil | Patron of SPINE charity | Nil |
| **Naseer Ahmed** | NED | Nil | Management consultant, primarily in the social housing sector | Non-Executive Director with Unity Housing Association in Leeds | Nil |
| **Julie Charge** | NED | Director of Finance, Salford University | Nil | Nil | Nil |
| **Jane Gilbert** | NED | Nil | Nil | Nil | Nil |
| **Lenore Ogilvy** | NED | Nil | Owner and Director of ConBrio Associates which provides consultancy to clients including NHS bodies | Nil | Nil |
| **Simon Stone** | NED | Nil | Owner Digitising Healthcare Ltd | External advisor to the NHS improvement Technology and Data Assurance Committee | Independent advisor to Strata Health Ltd. |
| **Simon Harrison** | Associate NED | Nil | Director of SCW Harrison Consulting Limited which provides consultancy in relation to the provision of medical care | National clinical lead for Urology in the NHS Improvement 'Getting it right first time' programme | Undertakes medico-legal work for a range of firms<br>Previously employed by Mid Yorkshire Hospital NHS Trust as a Consultant Urologist (to December 2016) |
| **Professor Mike Smith** | Associate NED | Chair and Non-Executive Director of Mediplex Ltd<br><br>Non-Executive Director of MPX Ltd. | Managing Partner with Harper Keeley LLP | Partner advises national and international organisations on maternal and infant health, midwifery services and health research<br>Partner is currently reviewing Midwifery Training for the NMC | Member of the Advisory Board of NIHR Invention for Innovation (i4i)<br>Fellowships with and advisor to:<br>Institute of Physical Sciences in Medicine;<br>British Institute of Radiology<br>Institute of Physics and Royal Society of Arts and Science<br>Emeritus Professor at Sheffield Hallam University<br>Son – Owner of iPatch |

## Declarations of interests for Directors in post 2017/18

Executive Directors in post as at 31 March 2018

| Name | Title | Directorships, including non-executive directorships in private companies or plcs | Ownership/Part Ownership of private companies and businesses | A position of authority in a charity or voluntary organisation in the field of health and social care | Any connection with a voluntary or other organisation contracting for NHS services |
|---|---|---|---|---|---|
| **Martin Barkley** | Chief Executive | Nil | Nil | Nil | Nil |
| **Mark Braden** | Director of Estates, Facilities and IMT | Nil | Nil | Nil | Nil |
| **Trudie Davies** | Director of Operations – Hospital Services | Nil | Nil | Nil | Nil |
| **Jane Hazelgrave** | Director of Finance | Nil | Nil | Nil | Nil |
| **Andrew Jones** | Director of Workforce and Organisational Development | Nil | Nil | Nil | Nil |
| **David Melia** | Director of Nursing and Quality / Deputy Chief Executive | Nil | Nil | Trustee, Wakefield Hospice | Nil |
| **Debbie Newton** | Director of Operations – Community Services | Nil | Nil | Nil | Sister in Law is employed in a clinical role by Mid Yorkshire Hospitals NHS Trust |
| **Dr Karen Stone** | Medical Director | Nil | Nil | Nil | Nil |

## Declarations of interests for Directors in post 2017/18

Directors who have left during 2017/18

| Name | Title | Directorships, including non-executive directorships in private companies or plcs | Ownership/Part Ownership of private companies and businesses | A position of authority in a charity or voluntary organisation in the field of health and social care | Any connection with a voluntary or other organisation contracting for NHS services |
|---|---|---|---|---|---|
| **Terry Moran** | NED | | | Chair – Together for Short Lives<br><br>Trustee – Social Care Institute for Excellence | |
| **Caroline Griffiths** | Director of Planning and Partnerships (on secondment for part of the year) | Nil | Nil | On secondment to Leeds Teaching Hospitals NHS Trust as Programme Director for WYAAT | Husband - NED of Tees, Esk and Wear Valleys NHS Foundation Trust |

## Arrangements for the performance review of Board members

All Board members have an annual appraisal. The Chair has his appraisal with the appropriate Director of NHS Improvement. The Chair conducts occasional performance review meetings with all Non-Executive Directors and an appraisal. The annual objectives of the Chief Executive reflect the priorities of the Trust set by the Trust Board and are agreed with the Chair. The Chair reviews the Chief Executive's performance against these objectives. Each executive director agrees objectives with the Chief Executive. The Chief Executive conducts quarterly performance reviews for each Director. The annual appraisals for all Executive Directors, including the Chief Executive, are reported to the Remuneration and Terms of Service Committee.

## Attendance at Trust Board meetings in 2017/18

| Name | Number |
|---|---|
| Jules Preston MBE | 9/11 |
| Simon Stone | 10/11 |
| Julie Charge | 9/11 |
| Naseer Ahmed | 10/11 |
| Lenore Ogilvy | 9/10 |
| Jane Gilbert | 5/6 |
| Mike Smith | 5/11 |
| Simon Harrison | 9/9 |
| Martin Barkley | 11/11 |
| David Melia | 9/11 |
| Jane Hazelgrave | 9/11 |
| Karen Stone | 10/11 |
| Trudie Davies | 9/11 |
| Andrew Jones | 11/11 |
| Debbie Newton | 11/11 |
| Mark Braden | 10/11 |

# Remuneration Report

## Salary and pension entitlements of senior managers
## A) Remuneration - Non-Executive Directors

| Name and title | (A) Salary (bands of £5,000) | (B) Expense payments (taxable) total to nearest £100 | (C) Performance pay and bonuses (bands of £5,000) | (D) Long term performance pay and bonuses (bands of £5,000) | (E) All pension-related benefits (bands of £2,500) | (F) Total (A to E) (bands of £5,000) |
|---|---|---|---|---|---|---|
| **2017-18** | | | | | | |
| | **£000** | **£00** | **£000** | **£000** | **£000** | **£000** |
| Jules Preston, Chairman | 35-40 | 7 | 0 | 0 | 0 | 40-45 |
| Simon Stone, Non-Executive Director from 1 June 2015 | 5-10 | 2 | 0 | 0 | 0 | 5-10 |
| Terry Moran CB, Non-Executive Director up to 31 May 2017 | 0-5 | 0 | 0 | 0 | 0 | 0-5 |
| Julie Charge, Non-Executive Director | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Lenore Ogilvy, Non-Executive Director from 1 May 2017 | 5-10 | 1 | 0 | 0 | 0 | 5-10 |
| Professor Mike Smith, Associate Non-Executive Director up to 31 March 2018(G) | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Jane Gilbert, Non-Executive Director from 1 June 2017 | 0-5 | 0 | 0 | 0 | 0 | 0-5 |
| Naseer Ahmed, Non-Executive Director from 1 April 2017 | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| **2016-17** | | | | | | |
| Jules Preston MBE, Chairman | 35-40 | 4 | 0 | 0 | 0 | 35-40 |
| Simon Stone, Non-Executive Director from 1 June 2015 | 5-10 | 1 | 0 | 0 | 0 | 5-10 |
| Charlotte Sweeney OBE, Non-Executive Director up to 31 January 2017 | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Terry Moran CB, Non-Executive Director from 8 December 2015 | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Julie Charge, Non-Executive Director from 8 December 2015 | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Dr Nisreen Booya, Non-Executive Director from 1 June 2015 to 31 March 2017 | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Professor Mike Smith, Associate Non-Executive Director from 1 October 2016 (G) | 0-5 | 0 | 0 | 0 | 0 | 0-5 |
| David Hicks, Non-Executive Director from 1 April 2015 to 31 December 2016 | 0-5 | 1 | 0 | 0 | 0 | 0-5 |

## A) Remuneration - Executive Directors

| Name and title | (A) Salary (bands of £5,000) | (B) Expense payments (taxable) total to nearest £100 | (C) Performance pay and bonuses (bands of £5,000) | (D) Long term performance pay and bonuses (bands of £5,000) | (E) All pension-related benefits (bands of £2,500) | (F) Total (A to E) (bands of £5,000) |
|---|---|---|---|---|---|---|
| **2017-18** | | | | | | |
| | **£000** | **£00** | **£000** | **£000** | **£000** | **£000** |
| Martin Barkley, Chief Executive (A) | 195-200 | 0 | 0 | 0 | 0 | 195-200 |
| Jane Hazelgrave, Director of Finance | 140-145 | 0 | 0 | 0 | 17.5-20 | 160-165 |
| Dr Karen Stone, Medical Director (B) | 190-195 | 0 | 0 | 0 | 47.5-50 | 240-245 |
| Caroline Griffiths, Director of Planning and Partnerships to 21 July 2017 (C) | 85-90 | 1 | 0 | 0 | 2.5-5.0 | 90-95 |
| David Melia, Director of Nursing and Quality | 140-145 | 0 | 0 | 0 | 37.5-40 | 175-180 |
| Matthew England, Interim Director of Planning and Partnerships. From 1 April 2016 to 31 July 2017 | 30-35 | 0 | 0 | 0 | 0 | 30-35 |
| Debbie Newton, Director of Operations (D) | 110-115 | 1 | 0 | 0 | 45-47.5 | 155-160 |
| Trudie Davies, Chief Operating Officer from 1 March 2018 Director of Operations from 1 September 2016 to 28 February 2018 (D) | 125-130 | 0 | 0 | 0 | 105-107.5 | 230-235 |
| Andrew Jones, Director of Workforce and OD from 1 December 2016 to 31 March 2018 (D) | 115-120 | 0 | 0 | 0 | 117.5-120 | 235-\240 |
| Mark Braden, Director of Estates, Facilities and IMT (D) | 110-115 | 1 | 0 | 0 | 70-72.5 | 180-185 |
| Sally Napper, Chief Nurse to 23 May 2017 (E) | 20-25 | 0 | 0 | 0 | 0-2.5 | 20-25 |

## A) Remuneration - Executive Directors (continued)

| Name and title | (A) Salary (bands of £5,000) | (B) Expense payments (taxable) total to nearest £100 | (C) Performance pay and bonuses (bands of £5,000) | (D) Long term performance pay and bonuses (bands of £5,000) | (E) All pension-related benefits (bands of £2,500) | (F) Total (A to E) (bands of £5,000) |
|---|---|---|---|---|---|---|
| **2016-17** | | | | | | |
| | **£000** | **£00** | **£000** | **£000** | **£000** | **£000** |
| Martin Barkley, Chief Executive (A) | 170-175 | 1 | 0 | 0 | 0 | 170-175 |
| Jane Hazelgrave, Director of Finance from 18 January 2016 | 140-145 | 0 | 0 | 0 | 142.5-145 | 285-290 |
| Dr Karen Stone, Medical Director (B) | 190-195 | 29 | 0 | 0 | 42.5-45 | 235-240 |
| Caroline Griffiths, Director of Planning and Partnerships (C) | 30-35 | 0 | 0 | 0 | 2.5-5 | 35-40 |
| David Melia, Director of Nursing and Quality | 135-140 | 0 | 0 | 0 | 130-132.5 | 265-270 |
| Matthew England, Interim Director of Planning and Partnerships. From 1 April 2016 | 100-105 | 0 | 0 | 0 | 62.5-65 | 160-165 |
| Debbie Newton, Director of Operations from 1 November 2016 (D) | 45-50 | 0 | 0 | 0 | 15-17.5 | 60-65 |
| Trudie Davies, Director of Operations from 1 September 2016 (D) | 70-75 | 0 | 0 | 0 | 90-92.5 | 160-165 |
| Andrew Jones, Director of Workforce and OD from 1 December 2016 (D) | 35-40 | 0 | 0 | 0 | 22.5-25 | 60-65 |
| Mark Braden, Director of Estates, Facilities and IMT from 1 November 2016 (D) | 45-50 | 1 | 0 | 0 | 27.5-30 | 75-80 |
| Julie Bolus, Interim Director of Staff and Patient Experience from 11 January 2016 | 35-40 | 0 | 0 | 0 | 0 | 35-40 |
| Bev Reid, Director of Operations from 3 August 2015 to 31 December 2016 (D)(F) | 0 | 0 | 0 | 0 | 0 | 0 |
| Mike Forster, Director of Operations from 18 May 2015 to 30 September 2016 (D) | 55-60 | 0 | 0 | 0 | 15-17.5 | 70-75 |
| Sally Napper, Chief Nurse (E) | 155-160 | 1 | 0 | 0 | 42.5-45 | 195-200 |
| Kevin Oxley, Director of Operations to 31 August 2016 (D) | 50-55 | 1 | 0 | 0 | 10-12.5 | 65-70 |

## Notes to Remuneration - Executive Directors tables

A – Paid on a full time basis from 1 June 2016, part time in May 2016, and was seconded part time from previous employer at no expense to the Trust.

B - Salary includes Medical Director Payment Clinical Excellence Award, on-call allowance and Additional Programmed Activity.

C – Salary includes additional responsibilities for the West Yorkshire Association of Acute Trusts. From 12 April 2016, 75% of the total remuneration has been recharged to Leeds Teaching Hospitals NHS Trust in respect of the secondment and no Board duties have been undertaken at Mid Yorkshire Hospitals NHS Trust. The table above includes 25% of the remuneration and a contractual payment for loss of office included within the exit package note.

D – Non-Voting Directors.

E – No Board duties have been undertaken at Mid Yorkshire Hospitals NHS Trust since May 2016 due to long term sickness and a subsequent secondment to NHS England from May 2016. Full remuneration costs are included in the table above.

F – Due to interim arrangements in 2016/17 this individual did not influence the decisions of the entity as a whole and therefore remuneration has been excluded from the table above in 2016/17.

G – Non Executive Directors and Interim Executive Directors not paid via the Trust's payroll for part or all of the year.

Salary includes all amounts paid and payable in respect of the period the individuals held office, including any salary sacrifice elements. Taxable expenses relate to lease car benefit in kind and taxable expenses.

## B) Pension benefits – Executive Directors

| Name and title | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2017 (bands of £5000) | Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) | Cash equivalent transfers value at 1 April 2016 | Real increase in cash equivalent transfer value | Cash equivalent transfer value at 31 March 2017 | Employers contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| **2017-18** | | | | | | | | |
| | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| Jane Hazelgrave, Director of Finance | 0-2.5 | 5-7.5 | 40-45 | 120-125 | 753 | 77 | 838 | 0 |
| Dr Karen Stone, Medical Director | 2.5-5 | 0-2.5 | 55-60 | 140-145 | 925 | 182 | 1,117 | 0 |
| Caroline Griffiths, Director of Planning and Partnerships to 21 July 2017 | 0-2.5 | 5-7.5 | 30-35 | 90-95 | 643 | 69 | 719 | 0 |
| David Melia, Director of Nursing and Quality | 2.5-5 | 7.5-10 | 55-60 | 165-170 | 951 | 106 | 1,067 | 0 |
| Matthew England, Interim Director of Planning and Partnerships. From 1 April 2016 to 31 July 2017 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Debbie Newton, Director of Operations from 1 November 2016 | 2.5-5 | 7.5-10 | 30-35 | 100-105 | 604 | 88 | 698 | 0 |
| Trudie Davies, Director of Operations from 1 September 2016 | 5-7.5 | 7.5-10 | 35-40 | 85-90 | 415 | 104 | 523 | 0 |
| Andrew Jones, Director of Workforce and OD from 1 December 2016 | 5-7.5 | 10-12.5 | 25-30 | 55-60 | 239 | 94 | 336 | 0 |
| Mark Braden, Director of Estates, Facilities and IMT from 1 November 2016 | 2.5-5 | 5-7.5 | 30-35 | 75-80 | 433 | 83 | 521 | 0 |
| Sally Napper, Chief Nurse to 23 May 2017 | 0-2.5 | 2.5-5 | 55-60 | 175-180 | 1,099 | 90 | 1,200 | 0 |

* The above table includes full year pension costs

## Staff Report

The Trust's integrated Workforce Strategy sets out four key priorities. These are:

- Being an excellent employer – creating a great place to work
- Recruitment and retention – attracting, selecting and retaining the 'right' number of the 'right' people
- Developing staff and their skills
- Inclusive leadership to inspire and deliver improvements and meet required standards and obligations.

The strategic priorities were developed from the themes emerging from: consultation with internal stakeholders, national and regional priorities: new models of care; and the Trust's Operating Plan.

The strategy is underpinned by a number of plans. These include:

- Nurse and midwifery recruitment and retention framework
- Medical workforce strategy
- Equality diversity and inclusion strategy
- Health and wellbeing strategy.

The Trust monitors the impact of the strategy through a workforce and organisational development scorecard.

This is an approach which measures performance across the Trust, and by staff group, in relation to performance and key metrics such as absence rates, vacancies, mandatory training rates and turnover.

The Trust specifically monitors turnover within the first 12 months of employment; or turnover attributable to reasons connected with employee experience and environment.
This scorecard is reported to the Resource and Performance Committee on a monthly basis.

This information is also provided to divisions on a monthly basis for discussion in senior business meetings, in order to inform any local action plans.

The Trust wants staff to enjoy their work and be proud of the quality of services provided and to demonstrate the core values of Caring, Respect, High Standards and Improving.

The Trust will also continue to celebrate their successes, both on an individual and team basis, internally and externally.

As highlighted elsewhere in this report the Trust continued to experience shortages in staffing in some parts of the organisation.

A number of pieces of work took place in 2017/18 to try to improve the position. The Trust continued its recruitment programmes across a number of professional and support vacancies. The Trust continues to monitor registered nurse vacancies, particularly in inpatient areas, and this remains a key measure in the Quality Account (see Chapter Four).

The Trust also implemented two new roles in its nursing workforce- Assistant Practitioner and Safety Support worker to improve the quality and safety of patient experience.

Activities which took place in 2017/18 included:

- Continuing the programmes of nurse recruitment which have resulted in around 230 Health Care Assistant (HCAs) and 125 Band 5 Registered Nurses joining the Trust across the year.
- Undertaking a programme of international recruitment in January 2018 in the Philippines to appoint to posts within Theatres and ICU. From this, the Trust has offered employment to 83 nurses who should commence their employment towards the end of 2018.
- Delivering bespoke recruitment campaigns (see photo below) for:
  - Nurses qualifying in the autumn of 2018 or spring 2019. Around 115 individuals have accepted offers of employment through these events.


  - Theatres- two open days in October 2017 and February 2018. These enabled the Trust to appoint a cohort of apprentice HCAs, four Operating Department Practitioners (ODPs), 15 student ODPs (who qualify between September 2018 and March 2019)

- Working in partnership with Job Centre Plus and Wakefield College to deliver a Sector Skills Academy to support 20 individuals (see photo below) from the local community who have been unemployed into ancillary roles within seven weeks of their interview.

- Attending careers events in local schools and colleges, Job Centre Plus, and at a number of Universities across England to showcase various career opportunities at the Trust including medical, nursing, therapies, clinical sciences, apprenticeships, and administration.
- Working in partnership with a local charity, several further educational providers including a local specialist educational provider and the local authority to support six young adults with learning difficulties into year-long internships as part of Project Search Mid Yorkshire.

## Analysis of ethnicity of staff

| | Total | % |
|---|---|---|
| Asian | 800 | 9.5% |
| Black | 161 | 1.9% |
| Mixed | 107 | 1.3% |
| Other | 114 | 1.4% |
| Unknown | 30 | 0.4% |
| White | 7194 | 85.6% |
| **Total** | **8406** | |

### Staff in post by band*

| | Number of people | |
|---|---|---|
| | **2017/18** | **2016/17** |
| Other | 29 | 42 |
| Medical | 795 | 774 |
| Band 9 | 8 | 6 |
| Band 8 | 279 | 243 |
| Band 7 | 544 | 543 |
| Band 6 | 1,187 | 1,226 |
| Band 5 | 1,577 | 1,616 |
| Band 4 | 385 | 386 |
| Band 3 | 996 | 996 |
| Band 2 | 1,966 | 1,733 |
| Band 1 | 632 | 517 |
| Apprentices | 8 | 8 |
| **Total** | **8,406** | **8,090** |

* Above figures include ENGIE (facilities) staff but exclude staff on External Secondment

### Staff profile*

| | Number of people | |
|---|---|---|
| | **2017/18** | **2016/17** |
| Add prof scientific and technical | 234 | 209 |
| Additional clinical services | 1,859 | 1,664 |
| Administrative and clerical | 1,625 | 1,576 |
| Allied health professionals | 621 | 587 |
| Estates and ancillary | 938 | 814 |
| Healthcare scientists | 151 | 151 |
| Medical and dental | 795 | 774 |
| Nursing and midwifery registered | 2,181 | 2,302 |
| Students | 2 | 13 |
| **Total** | **8,406** | **8,090** |

## Age profile of staff

| | Number of people | |
|---|---|---|
| | **2017/18** | **2016/17** |
| < 25 | 532 | 447 |
| 25 - 34 | 1,950 | 1,831 |
| 35 - 44 | 1,872 | 1,852 |
| 45 - 49 | 1,066 | 1,078 |
| 50 - 54 | 1,224 | 1,258 |
| 55 - 59 | 1,024 | 972 |
| 60-64 | 591 | 517 |
| 65+ | 147 | 135 |
| **Total** | **8,406** | **8,090** |

## Annual Staff Survey 2017

March 2018 saw the publication of the results of the national NHS staff survey 2017. The survey was open between September and the start of December 2017. The Trust invited staff to take part and 3,374 did, giving a response rate of 44 per cent, which is two per cent up on last year. As usual the national results compare the Trust to other, similar Trusts and the final report benchmarks Mid Yorkshire against the 42 other combined Trusts in England.

The results of the survey are based on 88 questions. Of those 88 questions the Trust improved on 52 compared to 2016, deteriorated on 20 and stayed the same on 16. Feedback from staff is more positive than in 2016. The Trust is continuing to move in the right direction in the majority of the questions.

However, the Trust is at, or near, the bottom for some important indicators, scoring the lowest of its peer group on the crucial questions of staff recommending the Trust as a place to work or receive treatment. In 2015 there were 51 questions where the Trust scored more than five per cent worse than the average for the combined acute and community Trusts group. This has now reduced to 12 which is a significant achievement.

One of the key measures in the survey is overall staff engagement, in view of its link to patient care. This measure is derived from nine of the 88 questions. The Trust improved its scores on all nine of these questions in 2016 and continued the trend with further improvements in five of these questions again in 2017.

*The national NHS staff survey results for 2017 can be found at www.nhsstaffsurveys.com*

## Working with our staff

It is vitally important staff members: are fully engaged in the working of the Trust; know about the challenges it faces; celebrate its achievements; and, crucially, have their voice heard.

The Trust uses a variety of tools to enable it to communicate with staff so they can be kept up-to-date with important news and information.


These include: face to face meetings; a team briefing process where information cascades through line managers; traditional newsletters, covering news and events as well as some looking at specific issues such as concerns or patient safety; social media channels like Facebook and Twitter; and through digital communications such as screensavers and the intranet.

Each month, after the Trust Board meeting, all the members of the Board visit wards and departments to speak to staff and listen to their views.

Staff can raise any concerns they have through a number of routes including confidential emails directly to the Chief Executive as well as through the Trust's Freedom to Speak Up Guardian, Kirsty McMullan who was appointed to the role on a full-time permanent basis in winter 2017.

In autumn 2017 Kirsty (pictured left) picked up the award, for 'Leading the change to speaking up becoming business as usual' category at the national Freedom to Speak Up Awards 2017. She also came runner up in the category 'Freedom to Speak Up Guardian or network of the year'.

The Trust works with its Joint Consultative and Negotiating Committee (JCNC) and involves it in developing and revising employment policies and managing change.

The committee is made up of management and union representatives.
There is also a Local Negotiating Committee consisting of doctors, union representatives and managers undertaking a similar role to the JCNC in respect of medical staff.

Importantly a new Partnership Agreement was agreed with staff side, providing a good foundation for constructive working.

## Training and development

During the year the Organisational Development team continued its effort to deliver the Trust's required level of mandatory and statutory training, in addition to providing innovative training and development opportunities for staff working in acute and community settings. E-learning now gives Trust staff a choice on how and when they complete their mandatory training.

The Trust continued to provide the highly successful new consultant programme and introduced a week-long induction programme for new mangers. Both focus on leadership skills, whilst addressing expectations of working within the Trust's values and behaviours framework. The Leading an Empowered Organisation and Institute of Leadership (ILM) programmes continued to grow a pipeline of future leadership talent.

Following feedback in the annual staff survey the Trust introduced a Staff Engagement Workshop for managers, providing advice on how to better engage and empower staff to make improvements in their services.

The Trust ensured all new clinical support staff successfully completed their Care Certificate and attended their Skills in Practice Programme.

Both courses last two weeks and cover crucial areas of knowledge and skills before these staff begin on in wards and departments.

By using the government's apprenticeship levy the Trust started to increase the number of apprentices and was pleases to see a number of these apprentices secure permanent jobs once qualified.

## Human resource policies

The Trust has a range of policies and procedures which support its commitment to being a good employer and to providing equal opportunities to present and potential staff members. In the last year the Trust has rationalised and modernised several HR policies.

The sickness absence management procedure is used to help ensure that a fair and effective approach to the management of sickness absence is adopted throughout the Trust.

The Trust takes all reasonable measures to support employees where there are problems and has developed a 'guide to good health and wellbeing' that can be accessed on the Trust's intranet. The recruitment and selection policy aims to ensure full and fair consideration is given to all applications for employment including those made by people with a disability or other protected characteristics described by the Equality Act 2010.

The policy is based upon national recruitment standards including NHS Employers employment check standards and the Department of Health Good Practice Guidance on the National Health Service (Appointment of Consultants) Regulations 1996.

In addition, the policy and Trust practice comply with the Department of Employment previous accreditation of the 'two ticks' symbol by providing a number of public commitments to disabled people, including a guarantee to interview all applicants with a disability who meet the minimum criteria for a job vacancy and to consider them on their merits. The Trust has actions underway to transfer to the new Disability Confident statement.

The Trust has also implemented a new Temporary Staffing Policy to enable the Trust to utilise temporary staff effectively whilst adhering to legislative and national guidance about these workers. At the start of 2018 the Trust introduced a new Pay Progression Policy which sets the minimum required standards to achieve an incremental pay increase. This specifically links mandatory training and appraisal to future increases in pay from 1 April 2018. In accordance with Section 54 of the Modern Slavery Act, the Trust is committed to ensuring workers are not exploited, are safe, have the right to work and remain in the country and their employment standards and human rights are adhered to.

## Library services

The purpose of the healthcare library and information services is to provide knowledge and evidence to enable excellent healthcare and health improvement for patients.

Trust library staff ensure all staff are supported in having the right knowledge and evidence when and where they need it. With 2,395 registered members, the library supported all the students on clinical placements from across the region and all staff studying for clinical and non-clinical qualifications in pursuit of their continuing professional development.

Librarians have made a critical by: ensuring teams are supplied with evidence from research to inform decision-making; targeting and tailoring information to manage information overload; and keeping colleagues updated on emerging research.

In the past year the team has:

- Published bulletins to support evidence based practice:
  - What's New? is monthly and includes all NICE and Royal College standards
  - Non-Medical Prescribing is quarterly sharing up to date information for CPD
- Grown its social media presence with more than 1,500 followers on Twitter and Facebook
- Answered 17,350 enquiries
- Issued 11,505 items from stock
- Had 25,296 visitors to use the facilities at the library at Pinderfields.

## Celebrating staff

The Trust has many terrific employees and it has initiatives in place to recognise and reward staff. Each month staff can nominate their colleagues for a MY Star Award.

All the nominations are then reviewed and a winner is selected. The winner receives £100 of high street gift vouchers and a framed certificate at a surprise presentation.


Annually the Trust runs its Celebrating Excellence Awards. The aim of the awards is to recognise and celebrate the fantastic achievements of individuals and teams across the Trust.

Every day colleagues and teams go above and beyond the call of duty to make a difference to Trust services, patients and staff. These awards are the Trust's annual opportunity to acknowledge these outstanding contributions and to show appreciation to staff for what they do.

The 2017 awards also included the first Dr Kate Granger Award for Compassionate Care, which was nominated by patients and members of the public. This was won by Nurse Bipin Bipinraj (right, at the awards ceremony) for the outstanding care he delivers at Pinderfields.


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## Teams of the week

The Trust introduced 'Team of the week' in April 2016 recognising the team which has gone 'the extra mile'. The staff receive a certificate and a tin of chocolate biscuits.

In 2017/18 teams which received this recognition were:

### April 2017

- Nursing team on night shift on 25/3/2017 on the Intensive Care Unit at Pinderfields Hospital
- Ward 2, Dewsbury and District Hospital (DDH, below)


- End Of Life Care – Gate 44
- Physiotherapy Outpatient Team at DDH

### May 2017

- Ward 14, DDH
- A1 and the Strike Unit move
- WICU for the environment and garden improvements
- Sarah Milton Smith and Team re Sepsis prescribing in PGH ED
- IT Team
- CQC Hub Team
- Celebrating Excellence Team

### June 2017

- The Diabetes Eye Screening Programme
- Nurse Recruitment Team
- Cross-Site Endoscopy Team
- Oncology Ward (below)

### July 2017

- Ward 6B
- Gate 42
- HSDU Drivers (below)

- Contracts and Performance Team

### August 2017

- SAF Team
- Procurement Team
- The HIV transfer team (below)

### August 2017 (continued)
- SAU Team
- Procurement Team
- 18 week RTT Data Quality Team
- Patient Admin Recruitment Team

### September 2017
- Recruitment and Payroll Teams

### October 2017
- SPOC
- Finance Team (below)

- Paediatric Team hosting examinations

### November 2017
- Theatre Staff for recruitment open day
- Paediatric Team for innovative ways of managing capacity
- Dr Patrick O'Connor for NOF

### December 2017
- Respiratory Service for Best Practice Tariff
- IT and Radiology Staff responsible for the ICE Upgrade (below)

- Community Therapy Admin Team

### January 2018
- ED Team PGH
- Portering Team
- PACU for EOL care and ENT for RTT

- IPC Team (above)

### February 2018
- Boothroyd theatres (below) and the Integrated Care Team

- Patient Income Team in Finance
- The staff team at Wakefield Intermediate Care Unit (WICU)
- The Gastroenterology Team

### March 2018
- The Women's Health Team
- All staff for coping with the bad weather
- Grounds Staff at Pinderfields Hospital
- The Patient Experience Team

## Staff health and wellbeing

The Health and Wellbeing Team at the Trust is continuing to deliver services to staff to help improve and maintain their health and wellbeing.

A number of activities have continued to grow and the team is currently expanding the range of services provided. These include:

- Fitness centre at Dewsbury – The fitness centre has been through a period of change in 2017/18 due to staff changes. There are plans to refurbish the gym and provide new equipment in the new financial year to enhance the gym environment and get staff physically active. There will also an opportunity for the fitness instructor to work more closely with the physiotherapy team to will provide an opportunity to support the ageing work force and staff with long term ill health issues.
- Hydro fitness – These classes are continuing at Pinderfields and provide staff with the benefits of exercise and feeling good.
- Weight management – The 100 day weight management programme has been hugely successful with three courses running over the last year with 50 staff attending.
- Roadshows – Flu campaign and mocktails and health promotion materials were given away as well as finding out what activities staff would like to see in the Trust. Around 400 staff were spoken to across the three hospital sites.
- Stress awareness courses - The course helps staff to learn and employ coping strategies to offset the symptoms and to help them avoid stress related illnesses. The sessions have continued to be very popular across all sites; over 70 staff attending since last year.
- Menopause courses – The menopause classes focus on supporting staff to manage the menopause, the symptoms and focuses on issues including sleep management, Hormone Replacement Therapy (HRT), mood swings and hot flushes and other topics.
- Walking groups - The walking groups were set up as part of National Walking Month in May 2017, across sites walks took place on a weekly basis. The walks at Pinderfields continued into October with a maximum of 15 staff participating during some weeks. The Trust now has a staff member who leads the walk across Pinderfields site every week.
- Pilates - Physio-led Modified Pilates is a conditioning routine of mat exercises utilising strengthening, mobilising and stretching techniques. These sessions continue to run at Pinderfields physiotherapy gym and recently at Pontefract physiotherapy gym.

## Staff sickness absence

| | 2017/18 | 2016/17 |
|---|---|---|
| Total FTE Days Lost | 80,334 | 80,582 |
| Total staff years | 6,918 | 6,865 |
| Average Working Days Lost | 11.61 | 11.74 |

Staff sickness absence data is based on full-time equivalent days for the calendar year January 2017 to December 2017 (2016/17: January 2016 to December 2016.

## Staff facts and figures

### Average staff numbers based on Whole Time Equivalent (WTE)

| | 2017-18 | | | 2016-17 | | |
|---|---|---|---|---|---|---|
| **Staff group** | **Total** | **Permanently employed** | **Other** | **Total** | **Permanently employed** | **Other** |
| | **Number - WTE** | **Number - WTE** | **Number - WTE** | **Number - WTE** | **Number - WTE** | **Number - WTE** |
| Medical and dental | 860 | 754 | 106 | 861 | 750 | 111 |
| Admin and estates | 1,377 | 1,247 | 130 | 1,362 | 1,207 | 155 |
| Healthcare assistants and other support | 821 | 671 | 150 | 763 | 646 | 117 |
| Nursing, midwifery and health visiting | 3,033 | 2,862 | 171 | 3,055 | 2,924 | 131 |
| Nursing, midwifery and health visiting learners | 34 | 34 | 0 | 12 | 12 | 0 |
| Scientific, therapeutic and technical staff | 945 | 911 | 34 | 925 | 886 | 39 |
| Healthcare science | 305 | 300 | 5 | 289 | 283 | 6 |
| Other | 44 | 44 | 0 | 4 | 4 | 0 |
| **Total** | **7,419** | **6,823** | **596** | **7,271** | **6,712** | **559** |
| | | | | | | |
| **Of the above staff engaged on capital projects** | **3** | **2** | **1** | **6** | **3** | **3** |

* The table above includes a calculation for temporary staff (including bank and agency), data which are not included in other tables relating to workforce in this report. This table does not include staff managed by Engie as part of the Trust's Private Finance Initiative programme.

The 0-19 service transferred to Bradford District Care NHS Foundation Trust in April 2017. 124 WTE of nurses, 7 WTE of student nurses, 24 WTE of healthcare assistants and other support and 18 WTE of admin and estates staff transferred with the service

## Analysis of gender distribution of staff

| | Female | Male | Total | % Female | % Male |
|---|---|---|---|---|---|
| Directors | 7 | 10 | 17 | 41.2% | 58.8% |
| Other Senior Managers | 10 | 10 | 20 | 50.0% | 50.0% |
| Employees excluding the above categories | 6871 | 1498 | 8369 | 82.1% | 17.9% |
| **Total** | **6888** | **1518** | **8406** | **81.9%** | **18.1%** |

## Employee benefits gross expenditure

| | 2017 - 18 | | | 2016-17 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently Employed | Other | **Total** | **Permanently Employed** | **Other** |
| | £000s | £000s | £000s | **£000s** | **£000s** | **£000s** |
| Salaries and wages | 281,472 | 243,117 | 38,355 | 274,419 | 235,760 | 38,659 |
| Social Security costs | 22,166 | 22,166 | 0 | 21,349 | 21,349 | 0 |
| Apprenticeship Levy | 1,198 | 1,198 | 0 | | | |
| NHS Pensions Scheme | 28,310 | 28,310 | 0 | 27,768 | 27,768 | 0 |
| Other pension costs | 35 | 35 | 0 | 742 | 742 | 0 |
| Termination Benefits | 0 | 0 | 0 | 60 | 60 | 0 |
| **Total - including capitalised costs** | **333,181** | **294,826** | **38,355** | **324,338** | **285,679** | **38,659** |
| Recognised as: | | | | | | |
| Costs capitalised as part of assets | 199 | 138 | 61 | 385 | 164 | 221 |
| Total - excluding capitalised costs | **332,982** | **294,688** | **38,294** | **323,953** | **285,515** | **38,438** |

## Expenditure on consultancy

In 2017/18 the Trust's expenditure on consultancy was £433k (2016/17: £1,841k). These costs mostly relate to property & construction consultancy and the Trust's contribution to consultancy costs incurred by the West Yorkshire Association of Acute Trusts.

## Pay multiple statement

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind but not severance payments.

It does not include employer pension contributions and the cash equivalent transfer value of pensions. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of the total staff in the Trust, excluding the highest paid director. This is based on the annualised full time equivalent remuneration as at the reporting period date.

The banded remuneration of the highest paid director in Mid Yorkshire Hospitals NHS Trust in the financial year 2017/18 was £195,000 to £200,000 (£185,000 to £190,000 in 2016/17).

This was 7.89 times (2016/17, 7.34) the median remuneration of the workforce, which was £25,000 - £30,000 (£25,000 - £30,000 in 2016/17).

The ratio has slightly increased this year as the highest paid director in 2016/17 was paid on a full time basis from 1 June 2016, part time in May 2016, and was seconded part time from previous employer at no expense to the Trust.

In 2017/18 eleven employees received remuneration in excess of the highest paid director.

Remuneration ranged from £195,000 to £380,000 (in 2015/16 [excluding benefits in kind] there were fourteen employees ranging from £190,000 to £230,000).

| | 2017/18 | 2016/17 |
|---|---|---|
| Range – based on bands of £5000 | £15,000 - £380,000 | £15,000 - £230,000 |
| Highest paid director's total remuneration | £195,000 - £200,000 | £185,000- £190,000 |
| Median total remuneration | £25,000 - £30,000 | £25,000- £30,000 |
| Ratio | 7.89 | 7.34 |

## Pay policy

The Trust continues to adhere to national pay and terms and conditions of service but also utilises provisions related to recruitment and retention premia where necessary and in order to assist staffing and service delivery.

## Exit Packages agreed in 2017/18

| Cost band (including any special payment element) | Number of compulsory redundancies | Cost of compulsory redundancies (£) | Number of other departures agreed | Cost of other departures agreed (£) | Total number of exit packages | Total cost of exit packages (£) | Number of departures where special payments have been made | Cost of special payment element included in exit packages (£) |
|---|---|---|---|---|---|---|---|---|
| **2017-18** | | | | | | | | |
| < £10,000 | 0 | 0 | 41 | 133,613 | 41 | 133,613 | 0 | 0 |
| £10,001 - £25,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| £25,001 - £50,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| £50,001 - £100,000 | 1 | 60,000 | 0 | 0 | 1 | 60,000 | 0 | 0 |
| £100,001 - £150,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,001 - £200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| > £200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **1** | **60,000** | **41** | **133,613** | **42** | **193,613** | **0** | **0** |
| | | | | | | | | |
| **2016-17** | | | | | | | | |
| < £10,000 | 0 | 0 | 68 | 131,419 | 68 | 131,419 | 0 | 0 |
| £10,001 - £25,000 | 0 | 0 | 1 | 22,929 | 1 | 22,929 | 0 | 0 |
| £25,001 - £50,000 | 0 | 0 | 1 | 25,084 | 1 | 25,084 | 0 | 0 |
| £50,001 - £100,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| £100,001 - £150,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,001 - £200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| > £200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 0 | 0 | 70 | 179,432 | 70 | 179,432 | 0 | 0 |

This note provides an analysis of exit packages agreed with staff during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure.

Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

## Exit Packages – Other departures analysis

| | 2017-18 Agreements | 2017-18 Total value of agreements | 2016-17 Agreements | 2016-17 Total value of agreements (£) |
|---|---|---|---|---|
| | Number | £000s | Number | £000s |
| Voluntary redundancies including early retirement contractual costs | 0 | 0 | 0 | 0 |
| Mutually agreed resignations (MARS) contractual costs | 0 | 0 | 0 | 0 |
| Early retirements in the efficiency of the service contractual costs | 0 | 0 | 0 | 0 |
| Contractual payments in lieu of notice | 41 | 134 | 70 | 179 |
| Exit payments following Employment Tribunals or court orders | 0 | 0 | 0 | 0 |
| Non-contractual payments requiring HMT approval | 0 | 0 | 0 | 0 |
| **Total** | **41** | **134** | 70 | 179 |
| Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary | 0 | 0 | 0 | 0 |

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

A single exit package can be made up of several components each of which will be counted separately in this note the total number will not necessarily match the total numbers in the note above which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

## Off-payroll engagements

**Table 1: Off-payroll engagements longer than six months**
For all off-payroll engagements as of 31 March 2018, greater than £245 per day and that last for longer than six months:

| | Number |
|---|---|
| Total number of existing engagements as of 31 March 2018 | 2 |
| *Of which, the number that have existed:* | |
| for less than one year at the time of reporting | 1 |
| for between one and two years at the time of reporting | 0 |
| for between two and three years at the time of reporting | 1 |
| for between three and four years at the time of reporting | 0 |
| for four or more years at the time of reporting | 0 |

**Table 2: New Off-payroll engagements**
For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months:

| | Number |
|---|---|
| Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 | 3 |
| *Of which:* | |
| Number assessed as caught by IR35 | 1 |
| Number assessed as not caught by IR35 | 2 |
| Number engaged directly (via PSC contracted to department) and are on the departmental payroll | 1 |
| Number of engagements reassessed for consistency / assurance purposes during the year. | 2 |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

**Table 3: Off-payroll board member/senior official engagements**
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

| | Number |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year | 0 |
| Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure should include both on payroll and off-payroll engagements | 0 |

# Annual Governance Statement

## Scope of responsibility

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

## The purpose of the system of internal control

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

## Risk Management Framework

Within the Trust, overall responsibility for risk management lies with the Chief Executive with other roles and responsibilities clearly defined.
The Risk Management Framework aims to provide assurance that the Trust is:

- Providing high quality care in a safe environment
- Complying with legal and regulatory requirements
- Meeting key strategic objectives and values.

The Trust has processes in place, as described in the Risk Management Framework, which ensure a best practice approach to identifying, understanding, monitoring and addressing current and future risks. The Scheme of Delegation for the Trust reserves the approval of the Risk Management Framework as a decision for the Trust Board.

The Trust Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Trust's governance framework and system of internal control. Risk management involves much more than noting risks in a register – it is about identifying and managing risks, particularly those that present the biggest challenge to the Trust in meeting its objectives.

The Risk Management Framework sets out guidelines to assist staff in identifying and analysing risks in their respective areas. This includes the purpose of the risk assessment process, the risk grading tool/matrix and the risk register.

The benefits of an effective approach to risk management are as follows:

- Reduction in risk exposure through more effective targeting of resources to address key risk areas
- Improvements in economy, efficiency and effectiveness resulting in a reduction in the frequency, and/or severity of incidents, complaints, claims, staff absences and other losses

- Demonstrates compliance with applicable laws and regulations
- Enhances reputation of the Trust and increased public confidence in the quality of the services
- Development of a 'lessons learned' culture and improvements in systems and controls.

### Capacity to handle risk

All Trust risks are recorded using the DATIX system. Access to DATIX is via username and password, staff only receive log on details once they have been trained in the use of the system and the wider risk management system, i.e. how to recognise, assess and record risks, control, and actions. The DATIX system is menu driven and requires those recording risks to identify the controls in place, and any gaps in control; this then forms the basis of the action plan to mitigate the risk. The Risk Management Framework sets out the scoring methodology and this is used universally across the Trust for risks and is tested in a number of places. The Risk Management Framework also sets out the review and escalation procedures for risk from Ward to Board. Risk Registers are reviewed on a regular basis as follows:

*Divisional Management Teams* – review all new risks and are therefore able to consider if risk scoring is appropriate and consistent

*Clinical Executive Group* – all divisional, corporate and Trust Level risks are reviewed bi-monthly at CEG, one focus of this review is the consistency of scoring and recording of risks across the Trust.

*Divisional Risk Deep Dive* –regular, divisional deep dive risk register reviews are carried out to identify if risks recorded properly, out of date actions, risks no longer required, consistency of scores etc.

The Trust Board and Committees are familiar with the suite of risk registers used in the Trust:

- Trust Level
- 4 separate operational Divisions (Surgery; Medicine; Care Closer to Home; Families and Clinical Support Services)
- 5 Directorate Risk Registers (Finance; Workforce and OD; Estates, Facilities and IM&T; Nursing and Quality; and Medical Directorate)
- Specialty and Department risk registers.
-

In early 2017, the Trust Board considered the approach to risk appetite at a Board seminar. Having reviewed different models for setting out the Board's declared risk appetite for specific matters, it was felt that they were too prescriptive and it did not feel appropriate to set parameters. Instead the Board adopted a Risk and Escalation Policy which aims to identify how risks are identified across all areas of the Trust's work and at what point, and to where, escalation is required.

The Board Assurance Framework (BAF) is based on the risk of not achieving the six objectives in the Trust Five Year Strategy. These are known as the Trust's principal risks and include financial performance, patient safety and compliance. This is reported quarterly to the Trust Board with actions identified for gaps in assurance and controls.

The Trust Level Risk Register typically includes 18 – 20 risks over the year and is also presented quarterly to the Trust Board. Trust Level risks include clinical and non-clinical risks, for example:

- Nurse staffing levels and vacancies and recruitment
- Management of cyber security risks
- Financial position and achievement of the Cost Improvement Plan
- Administration of medicines.

All risks identify the controls and the mitigating actions to manage the risk. The arrangements for training staff on risk management and use of DATIX are set out in the Risk Management Framework. The Trust continues to work closely with Internal Audit to further develop the Risk Management and Internal Control Framework.

The Head of Internal Audit has concluded that the system of internal control in place during 2017/18 offered Significant Assurance. This is based on a range of work undertaken as part of the annual internal audit plan, including assessment of the BAF and an assessment of the range of individual opinions arising from risk based audit assignments throughout the year.

## Governance arrangements

### Trust Board

The Trust is governed by the Trust Board comprising of six Non-Executive Directors including the Chairman, two Associate Non-Executive Directors (non-voting), and eight Executive Directors (three non-voting), including the Chief Executive. During 2017/18, there have been no changes to the Executive members of the Board, and the following changes to the Non-Executive members of the Board:

- Naseer Ahmed, appointed as Non-Executive Director from 1 April 2017
- Lenore Ogilvy, appointed as Non-Executive Director from 1 May 2017
- Terry Moran, Non-Executive Director, resigned, effective from 31 May 2017
- Jane Gilbert, appointed as Non-Executive Director from 1 July 2017
- Simon Harrison, appointed as Associate Non-Executive Director from 1 July 2017

The overarching governance framework for the Trust is set out in detail in the Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

The Board has overall responsibility for determining the future direction of the Trust and ensuring delivery of safe and effective services in accordance with legislation and principles of the NHS. The Trust Board also ensures that the organisation complies with relevant regulatory standards.

The Trust Board consider performance against national priorities set out in the NHS Improvement *Single Oversight Framework for NHS Providers*, which sets out how NHS Improvement works alongside trusts to support the delivery of high quality and sustainable services for patients. The Trust is rated as ‘4’ on the NHS Improvement Finance Score Metric.

Performance is reported and discussed monthly at the Trust Board meeting in an integrated report to ensure that quality and finance, as well as workforce and access, are considered together.

During 2017/18, there was good attendance at Board and Committee meetings by Board members. Quality, Finance and Workforce governance are all overseen by Tier 1 Committees to provide assurance to the Trust Board.
The Trust Board routinely receives the minutes of all Tier 1 Committees, as well as a summary of the key issues and

assurances from the meetings to be brought to the whole Board's attention.

### Committees of the Trust Board

During 2017/18, there were five Tier 1 Committees of the Trust Board and their roles and responsibilities are set out in Terms of Reference approved by the Board and described in the Trust Scheme of Delegation and Reservation. Each Committee has an annual work plan and minutes are provided for the Board to review progress and decisions. Three committees are Statutory and two are Assurance. The Trust also participates in two Committees in Common with other provider trusts.

### Remuneration Committee (Statutory)

The purpose of the Remuneration and Terms of Service Committee is to determine on behalf of the Trust Board the remuneration and terms of service for the Chief Executive and other Executive Directors (both voting and non-voting members of the Trust Board) and to recommend the level and structure of Executive Directors' pay.

The Committee oversees, via six month reviews, the performance and appraisal of the Chief Executive and Executive Directors. The Committee also approves financially significant contractual severance payments. Membership of the Committee is restricted to Non-Executive members of the Trust Board. Executive Directors have no involvement in determining their own remuneration.

The Remuneration and Terms of Service Committee met four times during 2017/18 and considered the following key matters:

- The performance management and appraisal of the Chief Executive and Executive Directors
- Reviewed its Terms of Reference
- Reviewed all VSM salaries as requested by Secretary of State
- Executive redundancies and severance payments
- Job descriptions, person specifications and recruitment arrangements for the new Directors.

The Committee fulfilled its objectives for the year and the Chair of the Committee drew to the attention of the Trust Board any issues that required disclosure to the Board, or required executive action. The Committee also has responsibility for considering any issues pertaining to the Fit and Proper Tests for Board members, there were no issues arising in 2017/18.

### Audit and Governance Committee (Statutory)

The Audit and Governance Committee, which meets five times per year, reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities that support the achievement of the Trust's objectives. The Committee is a Non-Executive Committee made up of three Non-Executive Directors.

The Director of Finance (lead Executive Director), Financial Controller and the Company Secretary attend the meetings. Representatives from external audit, internal audit and the Local Counter Fraud Specialist also attend. Individual Executive Directors and other senior managers are invited to attend as required where the Committee is discussing items relevant to their areas and where there is concern or further assurance is required. The Chief Executive and Trust Chair attend the Committee once per year.

The Chair of the Committee provides a written report to the Trust Board after each meeting. This report sets out where the Committee has received assurance, risks and gaps in assurance to escalate to the Board, any items that need to be included in risk registers or the BAF, matters that need to be reported to another Tier 1 Committee, and anywhere that further work or investigation has been requested. The Trust Board has been able to take this assurance into account in the performance of its functions.

During 2017/18 the Committee has received updates from Internal Audit and External Audit at each meeting. The Committee has escalated concerns where individual reports have received limited assurance, including reports on Software Licences and Overseas visitors, new arrangements have been embedded in 2017/18 ensuring robust and timely follow up of audit recommendation action plans leading to a significant reduction in overdue actions.

The Committee has carried out a self-assessment of its effectiveness and the results were reported to the March 2018 meeting. Actions have been identified where arrangements could be improved, including actions relating to induction arrangements for Committee members.

### Charitable Funds Committee (Statutory)

The Board acts as the Corporate Trustee for the Charity. The Charitable Funds Committee is a sub-committee of the Board and reports matters to Board to enable it to fulfil its role as Corporate Trustee. The committee was chaired by the Trust's Chair and the membership included the Associate Director of Planning and Partnerships, the Director of Finance and another two Non-Executive Directors.

To provide a patient and public perspective on the committee, a member of the Stakeholder Forum also attended. The Head of Communications now attends alternate meetings.

The Committee has reviewed its Terms of Reference during the year, it has developed and completed its committee work plan in 2017/18 and has planned the programme for 2018/19. During 2017/18 the Committee met four times and routinely reviewed:

- The Charity's financial activities, acceptance of legacies, any expenditure proposals above £25,000 and the benefits realised from the grants provided by the Charity on a sample basis
- The performance of the Charity's investments, supported by professional advice from CCLA, the appointed Fund Managers, monitored spend against the policy of seeing donations being spent within 2 years
- the Charity's risk register to gain assurance that adequate controls were in place to minimise risks

The Committee has carried out a self-assessment review of its effectiveness. The Chair added a section to the Non-Executive induction checklist regarding charity trustee responsibilities and more specifically in relation to this Charity. Other areas identified for development were promoting the Charity and increasing fundraising activities. Further steps have been taken by the Committee with the appointment of a new fundraiser on 8 January 2018. These developments have been approved by the Trustees following recommendations and assurances from the Charitable Funds Committee.

### Quality Committee (Assurance)

The Quality Committee provides assurance to the Board on matters relating to clinical quality, patient and staff safety and experience as well as the adequacy of systems governing quality and its associated risks.

The Committee has met monthly throughout 2017/18. The role of the committee is to:

- Provide assurance to the Trust Board that there are robust systems of governance across the organisation
- Foster the development of a learning organisation ensuring we are listening to feedback from patients and carers, learning from concerns, complaints, compliments and incidents and acting to improve care
- Provide assurance to the Trust Board on the clinical quality and safety of all services across the organisation ensuring all required standards are achieved
- Allow for planning and driving continuous improvement
- Identify and managing risks to quality of care
- Identify, share and ensure delivery of best practice
- Investigate and take action on substandard performance

The Terms of Reference were reviewed along with the Divisional Clinical Governance Groups' Terms of Reference to reinforce assurance mechanisms, and were later approved by the Trust Board. As a consequence of the review the Committee and the Board agreed to amend the Terms of Reference and associated operational arrangements including membership, sub committees and moving to largely exception-based reports from the Divisions and Sub-Committees, with effect from 1 July 2017. The Non-Executive Committee Chair reports a summary of the Committee's activity each month to the Trust Board.

An annual committee work-plan is developed and also approved by the Trust Board. As a matter of routine the Committee reviews:

- Performance against key indicators relating to clinical quality and patient safety
- Trust compliance with the Care Quality Commission requirements and associated internal programmes of work / action plans.
- Divisional governance performance
- Patient experience reports
- Serious clinical incidents
- Infection protection and control
- Complaints
- Legal claims
- Safeguarding issues
- Mortality rates.

During the year, the Committee had a particular focus on:

- Improvement work on Divisional governance arrangements and how they interface with the Quality Committee
- Public, patient and family/carer experience on accessing the Trust's services
- Improving the governance and monitoring the delivery of the CQC Chief Inspector of Hospitals Improvement Plan and the provision of assurance
- Improved format of the quarterly reports on quality and safety to provide clearer assurance on the oversight of patient safety and quality
- Identifying specific risks that need to be escalated to the Board and maintaining oversight of these as well as existing key risks to quality and safety

During the year there were changes in sub-committees supporting the Quality Committee

- The new Learning from Deaths Policy was implemented and reporting arrangements embedded
- Monthly chair's reports were received from the newly established Patient Experience Sub-Committee
- Monthly chair's reports were received from the Patient Safety and Clinical Effectiveness Sub-Committee

The Committee has carried out an annual self-assessment and is taking forward actions arising.

### Resources and Performance Committee (Assurance)

The Resources and Performance Committee met 10 times in 2017/18. The role of the Committee is to provide assurance to the Trust Board on matters of financial performance, operational performance and workforce including Organisational Development.
Membership of the Committee consists of Three Non-Executive Directors, Director of Finance, Medical Director, Director of Nursing and Quality, Director of Workforce and Organisational Development, Director of Operations - Hospital Services and Director of Operations - Community Services. Other Trust directors and senior officers attend the meeting to present papers in line with the Committee's work-plan.
The main duties and responsibilities of the Committee are to:

- consider reports on the financial position and overall performance of the Trust, identifying and highlighting significant risks to the Board
- Standing agenda items include review of the latest financial position, updates on both the in-year and future savings plans, a report on workforce and associated issues, reports on the overall performance of the Trust, including a report on latest activity position, contract performance including CQUINS, and financial penalties
- In line with good practice, the agenda and work-plan have been reviewed during the year in order to focus the Committee on items of greatest concern to the Trust.

The Chair of the Committee provides a written exception report to the Trust Board after each meeting. This report sets out where the Committee has received assurance and where it believes issues need to be escalated to the Board. The Trust Board has been able to take this assurance into account in the performance of its functions. For example, the Committee has escalated concerns for Board consideration on the Trust's overall financial position, the Trust's inability to meet NHS constitutional standards and staffing issues, in particular high vacancy levels.
The Committee is provided with assurances from the Trust's monthly divisional Finance and Performance Committee (FPC) meetings, which are chaired by the director of Finance, where these issues are discussed in more detail with each division.
The Committee has carried out a self-assessment of its effectiveness in accordance with its terms of reference.

### External Audit

The Trust External Audit Appointment Panel is responsible for appointing the Trust's external auditors. The Trust external auditors prepare an annual risk based plan and provide assurance to the Audit and Governance Committee and Trust Board on the systems of internal control in place (liaising as appropriate with Internal Audit) and provide an opinion on the financial statements, the quality account and a value for money opinion.

## Internal Audit

Internal Audit issued 4 (16%) limited assurance reports during the year (12 (44%) were issued in 2016/17):

- IT Strategy
- Overseas Visitors
- Discharge Arrangements
- Business Continuity

This shows a significant reduction in the number of Limited Assurance Audit reports in 2017/18 compared with the previous year.

Internal Audit has issued 20 (80%) High/Significant assurance reports during the year (15 (56%) in 2016/17), again, a significant proportional improvement compared with the previous year:

- DBS Checks
- Cash Office
- Remuneration Committee
- Policy Management
- IG Toolkit
- Recruitment and Right to Work Checks
- Fire Safety
- Charitable Funds
- Patient Experience
- Junior Doctor Induction
- NICE Guidance
- Job Plans
- Medical Equipment
- Safeguarding
- Financial Planning and Budgetary Control
- Payroll
- Financial Ledger
- Security Management
- Medical Consent
- 18 week Referral to Treatment

## Local Counter Fraud Specialist (LCFS)

The Trust has an LCFS who attends Trust induction sessions so that all staff have an initial induction and awareness session. The LCFS provides updates and tailored sessions across the Trust and carries out any required investigations as well as continued preventative and awareness raising. The LCFS reports to every meeting of the Audit and Governance Committee.

## Quality Governance

The Trust has robust and effective quality governance arrangements which include:

- a review of the operation of the Quality Committee in early 2017 and embedding of new arrangements
- The Board has carried out self-assessments against the Well Led Framework in 2014, 2015 and 2016. Action plans have been developed and implemented with all actions complete. In 2017/18, the Trust has commenced a Well Led Developmental Review self-assessment. This will cover all operational divisions and corporate directorates. Once this work has been summarised, an external provider will be engaged to carry out a review, directed by the findings of the self-assessment. The external review is planned for Q3 in 2018/19
- An annual Clinical Audit programme which is approved at Quality Committee.
- All Serious Incidents and Never Events are subject to Root Cause Analysis and are reported to the Quality Committee for discussion and understanding of the learning from the event
- The Trust Board is assured by minutes and a report from the Chair of the Quality Committee and reporting in the Reportable Issues Log which is presented to the Board each month in private

## Clinical Audit

The Trust has a Clinical Audit Programme, with an Annual Audit Priority Programme which is approved by Patients Safety and Clinical Effectiveness Sub-Committee.

During the 2017-18 year 49, (94%) of the Quality Account national clinical audits and five, (100%) national confidential enquiry covered NHS services that the Trust is eligible to participate in.

A further **101** audits in addition to those in the Quality Accounts tables were completed between 1 April 2017 and 6 February 2018. Quarterly Audit Reports for each Division are published Trust Wide and shared across all clinical and management groups.

The reports of all national clinical audits were reviewed by the Trust in April 2017 to March 2018 and the Trust intends to take the following actions to improve the quality of healthcare provided based on the national recommendations and individual results when available. National audit reports are all reviewed through the Trust's governance framework.

### Annual Quality Account

The Trust, in accordance with the National Health Service (Quality Accounts) Regulations 2010 (as amended), prepares an Annual Quality Account which sets out the work that is being done to improve quality, safety and patient experience. The Quality Account is included in full in the Trust 2017/18 Annual Report.

### Information Governance

The Trust has not reported any level 2 serious incidents relating to Information Governance in 2017/18.

### Data Quality

The Trust has a data quality team whose role and purpose is to ensure that data is recorded accurately and in accordance with standard definitions. This includes the data to record elective waiting times.

The Trust's approach to recording and reporting data is clearly documented where each department has documented procedures that comply with NHS data standards for recording waiting time data. Data is monitored and shared throughout the Trust on a monthly basis with the intention of highlighting recording issues to relevant departments and providing support to ensure they are addressed. Mandatory training ensures all staff understand all aspects of the data they collect and how others use the data. Further training is available which includes appropriate refresher courses for all staff. The Trust undertakes routine data quality audits, including elective referral to treatment incomplete waiting list audit, clinical coding audits, and case note audits as required by the Information Governance Toolkit
Internal Audit test and validate the recording of access waiting times on an annual basis. This work focuses on the processes for accurately collating and reporting on the performance indicators and also assesses the Trusts processes for identifying adverse performance, assigning responsibility for taking remedial actions and monitoring the implementation and effectiveness of these actions.

### Regulation

### Care Quality Commission

During 2017/18, the CQC carried out a full inspection. They published their findings, and those from a follow up visit, on their website on 13 October 2017 and 25 January 2018 respectively. The overall rating for the Trust is Requires Improvement. A detailed action plan is in place to address all of the must and should do actions identified by the CQC in their report. The Trust continues to prepare for the new inspection regime which will be implemented at the Trust in 2018.
The Trust is fully compliant with the registration requirements of the Care Quality Commission.

### Compliance with the NHS Provider Licence Requirements

In 2017/18, NHS Trusts have been required to make an annual statement of confirmation in relation to compliance with elements of the NHS Provider Licence as follows:

- G6 – Meeting the requirements of the licence and the NHS Constitution, and, having implemented effective arrangements for the management of risk
- FT4 – Relates to corporate governance arrangements covering systems and processes of corporate governance in place and effective; effective Board and Committee arrangements; compliance with healthcare standards; effective financial decision making; sufficient capability and capacity at Board and all levels in the organisation; accountability and reporting lines.

The Board confirmed that it met the above requirements in May 2017 and is expected to confirm this position again, in May 2018.

### Assurance

### NHS Pension Scheme

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

### Equality, Diversity and Human Rights

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

### Carbon Reduction

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

### Review of economy, efficiency and use of resources

The Trust has an established governance framework to underpin economy, efficiency and effectiveness of its use of resources in delivering its strategic objectives, operational plans and financial plans. Key matters are reported to Board through this framework which includes:

- A monthly Finance and Performance group chaired by the Director of Finance and attended by executive directors to hold Divisions to account for their overall performance including finance, performance, HR and activity. This balanced view of performance facilitates an in depth scrutiny of economy, efficiency and effectiveness at a more granular level
- The efficiency agenda is led by the Chief Executive Officer. A Programme Management Office (PMO) oversees the development of the robust Cost Improvement Plan (CIP). To facilitate delivery of the CIP plan, these plans are monitored at a weekly meetings chaired by the Director of Finance and monthly by the chief executive. The meetings are attended by senior divisional managers

- The Trust has effective, robust budgetary control systems, internal financial controls and procurement and tendering systems in place

The Trust has reported a deficit of £25.8m (excluding STF) for 2017/18. The CIP target was £24.7m which represented 5% of turnover but represented a significantly greater challenge when attributed to 'influenceable expenditure' after discounting fixed costs. The Trust achieved a CIP delivery of £17.3m and although this fell short of the target set is still a significant achievement. The Trust has required external borrowing to meet its cash requirements in year. The Trust has maintained controls around economy, efficiency and effectiveness of its use of resources despite the significant challenges it has faced.

## Conclusion

In conclusion, the Trust has a significant internal control issue in relation to Finance, which is described in the Review of Economy Efficiency and Use of Resources Section above, and included in the Board Assurance Framework.
As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Governance Committee, the Resource and Performance Committee and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

**Signature:**

**Chief Executive and Accountable Officer:** Martin Barkley
**Organisation:** The Mid Yorkshire Hospitals NHS Trust
**Date: 24 May 2018**


# CHAPTER FOUR
# THE QUALITY ACCOUNT

## Chief Executive's quality statement

We are pleased to present The Mid Yorkshire Hospitals NHS Trust Quality Account 2017-2018. This document is an honest reflection of our performance, challenges and achievements during 2017/18 and describes revised quality improvement priorities for 2018-2019.

During 2017, we reaffirmed our Trust values and refreshed our Trust Strategy for 2017-2021. Staff across the Trust, our clinical leaders, senior management teams, the Board and our external partners were asked to contribute to help determine our Vision, Mission, Values, Behaviours and to develop strategic aims that will support us moving ever closer to our vision of 'providing an excellent patient experience each and every time'.

Our regular Friends and Family Test surveys show that most people who encountered our services during the year had a positive experience. 96.8% said they would recommend the Trust to friends or family. This is a testimony to our dedicated staff, who constantly go the extra mile.

Whilst we have seen some significant and sustained improvement against indicators of safety and quality, such as mortality and infection prevention in recent years, we continue to face challenges in relation to matching our capacity to the demand for our services. Whilst more patients have been seen and treated within the 4-hour standard we nevertheless do not achieve the 95% target. Waiting time for out patients and for treatments are sometimes longer than the 18-week standard but the number of patients waiting longer than 18 weeks has reduced. More than 85% of patients are seen and treated within 18 weeks, a 5% improvement within the year.

In Spring 2017 the Care Quality Commission (CQC) arrived to inspect our services. The Trust received an overall provider rating of "Requires Improvement". Of note, the Trust rating against the safe key question improved from "inadequate" to "requires improvement" and we are rated 'good' for provision of services which are caring. We continue to work hard to deliver our very comprehensive action plan to address the areas for improvement identified in the inspection reports. The Trust Board monitors the quality of services against the Care Quality Commission (CQC) domains of caring, safe, effective, responsive and well led through monthly reports, which are reviewed in detail by the Quality Committee.

Members of the Board and Executive Team regularly visit the wards and departments across the Trust. This provides the opportunity for the Board to see first-hand the care being provided to patients and for staff to provide feedback on their own experiences.

We have successfully implemented The Mid Yorkshire Quality Improvement System (MY QIS). This has been developed using the Virginia Mason Production System (VMPS) principles; Virginia Mason Hospital in Seattle has successfully translated 'lean' philosophy and embedded it into the way they deliver healthcare.

This people-centred management and improvement philosophy and approach has been credited with transforming Virginia Mason and is now being transferred to other healthcare organisations throughout the world.

This approach is being used to drive up quality and patient safety and the successes we have achieved during 2017/18 are included in the MYQIS section of the Quality Account.

An important part of the Quality Account is looking forward to the year ahead. We are pleased to include our new Quality Improvement Priorities for 2018/19, which will support our endeavours to provide excellent and high quality healthcare for our patients.

Progress made against the new Quality Improvement Priorities will be monitored and reported via the established governance structure. This includes monitoring each of the priorities via the Quality Committee sub-committees where indicators and metrics are reported through the Quality Dashboard directly to the Tier 1 Quality Committee which, in turn, reports to Trust Board.

**Signed:**

**Chief Executive and Accountable Officer:** Martin Barkley
**Date:** 24 May 2018

## Priorities for improvement and statements of assurance from the Board

### Review of 2017/18 Quality Priorities

The Trust made a commitment to the following quality improvement priorities for 2017/18:

| Domain | | Outcome measure/indicator | How we will measure achievement | 2016/17 Performance | 2017/18 Performance | Improvement achieved? |
|---|---|---|---|---|---|---|
| Safe | 1 | Reducing all forms of Trust attributable healthcare associated infection (HCAI), specifically Clostridium Difficile (CDIFF) and methicillin-susceptible Staphylococcus aureus (MSSA) | Total number of CDIFF cases | 45 total attributable<br>15 preventable | 37 total attributable<br>6 preventable | |
| | | | Total number of MSSA cases | 23 Trust Attributable | 26 total attributable<br><br>5 preventable | |
| | 2 | Continually improve clinical services and practice with regard to two areas which can be a significant cause of mortality, namely Acute Kidney Injury (AKI) and Sepsis | =/> 90% of patients to be screened for sepsis in ED | 85% | 93% | |
| | | | =/> 90% of patients to be screened for Acute Kidney Injury | 33% | 55% | |
| | 3 | As part of its commitment to delivering 'Harm Free Care', the Trust will continue to build on work undertaken in 2015/16 to prevent avoidable harm, disability or death from falls | =/> 10% reduction in falls resulting in harm per 1,000 bed days | 1.89 | 1.71 | |
| | 4 | Reducing the consumption of antibiotics and optimising prescribing practice | 2% reduction in overall antimicrobial consumption | Target 3922 DDD/1000 admissions (i.e. 2016/17 performance was 2% above this) | Increase of 14% and 16% off target Currently 4462 DDD/1000 admissions | |
| | | | 1% reduction in piperacillin/tazobactam consumption. | Target 140 DDD/1000 admissions | Reduction of 61% Currently achieving monthly average of 55 DDD/1000 admissions | |

| Domain | | Outcome measure/indicator | How we will measure achievement | 2016/17 Performance | 2017/18 Performance | Improvement achieved? |
|---|---|---|---|---|---|---|
| **Safe** | | | 1% reduction in meropenem consumption. | Target 83.3 DDD/100 admissions | Currently achieving monthly average of 56 DDD/1000 admissions, reduction of 40% | |
| | 5 | Reduce the incidence of pressure ulcers | Pressure Ulcers – reduction in the rate of Trust attributed/Trust acquired pressure ulcer SIs (Category 3 and 4) per 1,000 bed days, calculated using data submitted to StEIS. 10% reduction from 2016/17 baseline | 0.13 (16/17 baseline) | 0.14<br>(+7.3% against the minus 10% target) | |
| **Experience** | 6 | Ensure safe and effective staffing levels on inpatient wards | Sickness 5% or less | 5.2% | 5.1% | |
| | | | Vacancy rate =/< 10% on adult inpatient wards | 8.4% | 14.5% | |
| | | | Staff FFT – positive responses to questions on staffing levels =/> 24% | 20% | 22% | |
| | 7 | To provide our patients with the best possible experience demonstrated by better than the national average Friends and Family score. | =/> 95.7% | 95.8% | 96% | |
| | 8 | Improve the understanding of information given to patients at discharge about the effects of their medication | Improved score in national patient survey | | | |
| **Effective** | 9 | Improve the pathway for patients with a hip fracture | All patients meet best practice tariff time between admission and review. | 41.6% | 48.7% | |
| | | | Average length of stay <15 days. | 27.9% | 37.9% | |

## What the Trust has done to address the Quality Improvement Priorities

### Priority One: Reduce all forms of Trust attributable healthcare associated infection (HCAI), specifically Clostridium Difficile (CDI) and methicillin-susceptible Staphylococcus aureus (MSSA)

The Trust has a comprehensive and robust infection prevention and control annual programme. This involves working with staff and the wider health economy to take the opportunity to learn from cases of infection across our services and are educating, supporting and facilitating clinical colleagues in the best infection prevention practices.

At the end of March 2018 the Trust had reported 37 Trust attributed CDI cases (45 cases in 2016/17) this is against the nationally set objective to have no more than 27 cases in 2017/18. 17 of the cases were deemed not preventable, whilst 6 were deemed as preventable (vs 17 in 2016/17) and 14 cases are awaiting confirmation.

A comprehensive Clostridium Difficile (CDI) reduction plan is in place led by the Head of Infection, Prevention and Control. A rigorous post-infection review is undertaken on all cases of CDI and the cases are reviewed jointly with the patient's clinical team, the Infection Prevention and Control Team and representatives of the Kirklees Infection Prevention and Control Team who advise the Wakefield and North Kirklees Clinical Commissioning Groups (CCGs). The remit of this panel is to scrutinise the cases to determine if there were any lapses in care that contributed to the development of the infection. This allows us to determine if the infection was preventable.

A number of clinical issues have been identified through the review process. These are a delay in:

- Testing of stool samples on patient presentation to our emergency departments and/ or on admission and recording of diarrhoea on a stool chart.
- Isolating patients with symptoms of a CDI was also identified and the review has also indicated a suboptimal antibiotic management by primary care and hospital clinicians.

To address these issues, the Infection Prevention and Control Team have taken a number of actions including:

- Hosting 2 CDI Summits where learning was shared and improvement pledges made by clinical staff from within the Division of Medicine (to which the majority of cases of CDI are attributed),

- Feedback on all cases has been given to clinical teams and ward managers so that learning could be shared at their team meeting.
- In addition, learning has been reinforced through staff training and safety briefs.
- Issues regarding antibiotic management and prescribing have been shared with prescribers and the wider health economy through the CCG Medicines Management Team.
- Lessons learned are disseminated through staff communication channels

Whilst there is no national objective for MSSA bloodstream infection cases, the reduction of cases of MSSA was included as a Quality Improvement Priority in the Trust Quality Account for 2017/18. At the end of March 2018 the Trust had reported 26 Trust attributed cases.16 of the cases were deemed not preventable, 5 cases were deemed preventable.

A post infection review (PIR) has been undertaken on all cases of MSSA up to the end of December 2017 and the cases are reviewed with the clinical team.

As described above, where a case is deemed preventable, learning is shared with the patient's clinical team and recurrent themes are addressed within the Trust and Divisional Health Care Associated Infection action plans.

**Priority Two: Continually improve clinical services and practice with regard to two areas which can be a significant cause of mortality, namely Acute Kidney Injury (AKI) and Sepsis.**

Sepsis and Acute Kidney Injury (AKI) were selected as quality improvement priorities for this year because we know that a significant improvement in clinical outcomes can be achieved through early detection of these conditions.

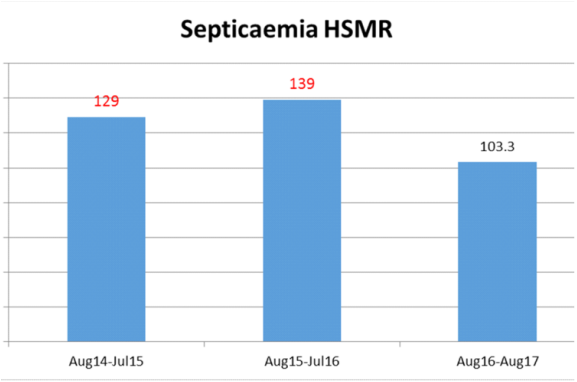
The aim was that 90% of eligible patients in the Trust's emergency departments would be screened for Sepsis. During 2017/18, 93% of eligible patients were screened for sepsis. This is an improvement on 85% the previous year.

For AKI the Trust committed to for key information showing that patients had been screened was to be recorded in discharge summaries. Performance during the year is currently 55% (target is ≥90%). The Trust has not seen the expected improvement therefore further actions have been identified to deliver this improvement. Subsequently, some improvement has been demonstrated.

This year the Trust focus on awareness and education to change and improve behaviour toward sepsis has been increased. A sepsis/AKI nurse has been introduced and new clinical leads for both sepsis and AKI are in place. The sepsis nurse has been raising awareness by teaching and auditing the use of the sepsis tool, targeting wards most likely to see patients presenting with sepsis to ensure maximum impact for effort. This has helped keep assessments over 98% and led to the identification and creation of 'sepsis champions' on a number of wards, across the Trust's three sites. The medical director's office has also spoken to junior doctors to draw attention to the benefits of more consistent clinical engagement and improved note taking to patients` care and also to make the notes easier to audit, so that the improvement in results to the standards of the sepsis CQUIN can be understood and tracked back to actions. The awareness raising plan includes engaging with heads of departments in its next phase.

The Medical Directorate has worked closely with the Trust's Pharmacy Department in conjunction with the Trust's Antimicrobial Stewardship Group, which has led to an improved intranet facility with more accessible evidence-based guidelines for infections. These are now readily available on wards with better access to recommended antibiotics on wards and signposting to help ward nurses access required drugs out of hours.

These projects along with the sepsis trolleys (trolleys that contain necessary equipment in one place to facilitate the swift clinical assessment of patients with suspected sepsis) have been implemented to reduce the time to treatment for those patients identified as septic.




The mortality caused by sepsis has seen a decrease from July 2016 to July 2017 with an improving trend. The Trust believes this is a direct result of its focus and awareness campaign that is leading to better practice. This started with the 'Think Sepsis' communications campaign which included reminders through routine communication channels, screensavers and promotional events last year and has continued into 2018.

There are several initiatives still in progress and plans are in place, being led by the Clinical Lead for Quality and Patient Safety, to learn from other Trusts.

The Trust's Emergency Department staff continue to lead the way in terms of developing the action plan, reviewing the screening tool and guidelines for treatment of Sepsis; they have continued to provide focus on these developments even whilst working in testing times throughout winter pressures.

The Trust's internal Sepsis Group has many energetic members taking initiatives and working together to co-ordinate improved management of sepsis at the Trust. This group reports to the Patient Safety and Clinical Effectiveness Sub-Committee (of the Trust Quality Committee).

The Trust continues to operate an alert system across hospital and community inpatient settings to ensure a rapid response to patients showing signs of AKI, seven days a week. The Trust AKI/Sepsis Quality Improvement Nurse receives these alerts and visits the appropriate clinical area to educate staff and review treatment plans. This nurse is part of the Medical Directorate team and is responsible to the Matron for Quality and Patient Safety.

Fluid management is a key factor in the prevention of AKI. Fluid management guidelines have been updated and published on the intranet and a new fluid balance chart is in use, work continues with VitalPac (the Trust electronic observation system, monitoring condition of patients within the Trust and facilitates the appropriate escalation of patients throughout the system) to introduce an electronic tool to support this.

During 2017 a policy for the use of intravenous contrast in patients with an AKI was developed and implemented. This is used to identify patients who cannot be given contrast due to contraindications for AKI, this means that patients with AKI are

not being further compromised by contrast being administered.

Education in detection and treatment continues to be provided to staff on the wards and for community staff and is integral to training for registered nurses and health care assistants.

A set of fluid balance competencies for nursing staff has been developed and added to the core competencies for Bands 3-7.

Monthly fluid balance chart audits form part of the monthly ward managers' audits and individual ward based actions are identified as a result of these, any themes are identified and discussed at the Trust AKI Group. The Trust will be delivering a 'Think Kidneys' campaign during World Kidney Week which commences on 8 March 2018.

**Priority Three: Continue to build on work undertaken in 2015/16 to prevent avoidable harm, disability or death from falls in line with the national and local priority to deliver harm free care.**

Ensuring patients do not come to harm whilst in the Trust's care is a key priority, it is reflected in the Trust's first Strategic Aim: Keep all patients Safe at All Times A range of potential causes of harm are monitored these include: pressure care, hospital associated infection and falls. The aim is that a minimum of 95% of patients have harm free care. Overall 93.4% of patients had harm free care during the year.

The definitions of levels of harm are nationally determined.

| Definition |
|---|
| No harm – no visible signs of injury and patient does not complain of pain |
| Low harm – resulting in harm that may need first aid, for example a graze or bruise. |
| Moderate Harm – where the harm may require treatment as an outpatient or a stay in hospital, for example a wrist fracture or a cut requiring stitches |
| Severe harm/death – where permanent damage such as a brain injury could occur or where the patient dies as a direct result of the fall |

This Quality Improvement Priority focuses specifically on harm caused by falls and aims to reduce the number of people who have a fall which results in severe harm or death per 1,000 bed days by 10%. This Trust has achieved this target with a 14.4% reduction in 2017/18.

A total of 2,024 falls involving Trust patients were recorded in 2017/18, compared with 2,108 in 2016/17 and 2,303 in 2015/16.

The Trust falls prevention programme was developed using evidence and experience from other Trusts, the Royal College of Physicians and NICE guidance.

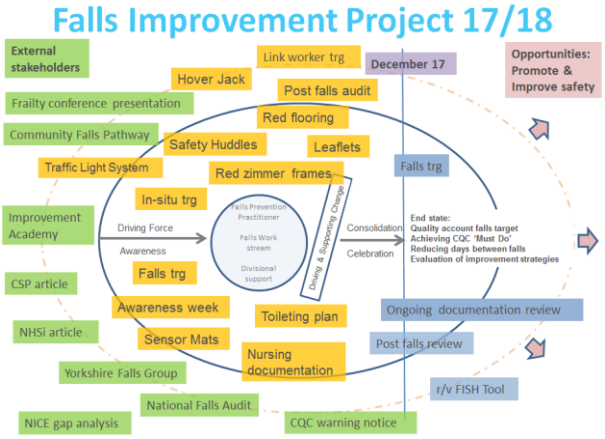
Practical falls prevention initiatives have been launched to assist all clinical and non-clinical staff to help reduce the risk of patients falling in our hospitals. We aim to reduce harm from falls and build upon the 'no falls culture' by improving awareness of ways to reduce the risk of falls and how to respond when a patient fall has occurred.

In 2017/18 we have worked hard to build on the achievements of the previous year and to expand the 'reduce falls culture' within the trust by developing a 'Harm Free approach' to falls prevention. This has been achieved by working alongside the Falls Workstream Group and with our other 'Harms' workstreams including Pressure Management and Nutrition/Hydration Groups harnessing a collaborative approach to patient safety. A number of projects have been introduced and are summarised below.

- Development and implementation of a ward-based falls prevention 'traffic light system' to raise awareness of patient mobility levels.

- Introduction of a bespoke falls training package, which uses real-life examples to make the training as realistic as possible.

- Continued implementation of safety huddles alongside the Improvement Academy.




During 2017/18 a number of practical falls prevention initiatives were launched across the Trust to assist all staff, clinical and non-clinical, to help reduce the risk of our patients falling whilst in the Trust's care. The aim was to reduce harm from falls and to enhance the 'reduce falls culture' by improving the recognition of falls prevention, and response when a patient fall has occurred. Examples of the strategies the falls prevention programme has implemented to achieve the priority include:

- Introduction of a Senior Nurse led, 24 hours falls bleep service to provide senior level leadership, lead a safety huddle and expedite lessons learnt.

- Development of a Community Falls Referral Pathway alongside Public Health Wakefield to support Trust Staff to identify the most appropriate service for patients identified as a falls risk whilst in hospital.

- A falls sensor mat 'bank', ensuring standardised safety equipment throughout the Trust has been established.

- Launch of Falls Awareness Week, promoting falls prevention to both internal and external stakeholders.

- An updated in-patient falls prevention leaflet which uses evidence from the Royal college of Physicians and NICE guidance.
- Introduction for advanced falls link worker training packages.
- An updated monthly falls data dashboard which can be accessed by all staff via the Trust intranet.
- Updated falls nursing documentation to coincide with NICE guidance updates.

- The development of the West Yorkshire Falls Group which encourages best practice and shared learning between falls practitioners across the region.

### Priority Four: Reduce the consumption of antibiotics and optimise prescribing practice.

During 2017/18 a great deal of work has been done to reduce the consumption of antibiotics and optimise prescribing practice in response to the national CQUIN to reduce total antimicrobial consumption and a reduction in Carbapenem use. This included revision of prescribing guidelines, ongoing nurse/pharmacist and pharmacist/pharmacist antimicrobial stewardship ward rounds. New and ongoing activities include:

- Revision of the Trust antimicrobial intranet webpage to improve access to guidelines.
- Introduction of local antimicrobial resistance patterns to inform guideline development.
- Regular presentations of audits and updated guidelines to executive, divisional, and specialty meetings.
- Support for the junior doctor antimicrobial prescribing audit.
- Education sessions for doctors, nurses and pharmacists.
- Quality improvement projects:
    - Gentamicin prescribing and review of gentamicin plasma levels.
    - Co-amoxiclav use in the Emergency Department.
- Post-prescription review and feedback on antimicrobial prescribing in Acute Care of the Elderly Unit.
- Intravenous to oral switch in General Surgery.
- Hospital-wide pharmacy technician-led intravenous to oral switch.
- Review of outpatient parenteral antimicrobial therapy.
- Antimicrobial prophylaxis in elective orthopaedic surgery.
- Influenza point of care testing machine introduced in the Emergency Department
- Introduction of a specialist antimicrobial pharmacy technician position.

Targets for 2017/18 in relation to antimicrobials are:

- A 2% reduction in overall antimicrobial consumption compared with January - December 2016. This target has not been achieved at the end of 2017/18, with an increase in consumption noted. The shortage of piperacillin/tazobactam led to changes to the antimicrobial guidelines. Instead of piperacillin/tazobactam, combinations of two or three antimicrobials were required. This in turn increased overall consumption of antimicrobials.
- A 1% reduction in piperacillin/tazobactam consumption compared with January – December 2016. This target has been achieved. This can be explained by a nationwide shortage and a comprehensive review of antimicrobial guidelines and stock holdings.
- A 1% reduction in meropenem consumption compared with January – December 2016. This target has been achieved. This is due to restriction of this antibiotic in guidelines.

A number of risks to achievement of the above indicators were identified including winter pressures these were driving an increase in antimicrobial consumption. The impact was compounded by a reduction to zero in the permanent staff base of medical microbiologists.

This has necessitated discontinuation of the restricted antimicrobial code system and has resulted in fewer microbiologists being available for ward rounds and reduced availability for phone advice.

### Priority Five: Reduce the incidence of pressure ulcers

Ensuring patients do not come to harm whilst in our care is a key priority. A range of potential causes of harm in the Trust are monitored and one of these areas is pressure ulcers. Pressure ulcers are a key quality indicator and over the last few years there have been widespread changes in clinical practice including the introduction of systematic risk assessment processes, investment in pressure relieving mattresses and numerous other quality improvement initiatives.

The Trust has a priority to reduce the incidence of pressure ulcers both within the hospital and also in the community and the measure set to demonstrate achievement last year was:

Reduction in the rate of Trust attributed / Trust acquired pressure ulcer serious incidents (category 3 and 4) per 1000 bed days calculated using data submitted on StEIS 10% reduction from 2016/17 baseline.

The Trust position for the financial year 2017/18 shows a 7.3% increase in the rate of Trust attributed / Trust acquired pressure ulcer serious incidents (category 3 and 4) per1000 bed days from the 2016/17 baseline.

The Trust position for the financial year 2017/18 shows 0.6% increase against the total number of all pressure ulcer incidents recorded compared to 2016/17. This positively is comprised of 4.9% decrease in Hospital Acquired pressure ulcers, recognising improvements are required for Community Acquired pressure ulcers.

Over the last 12 months a number of initiatives have been implemented to support the improvement in the reduction of Trust Acquired Pressure Ulcers.

The Tissue Viability Team previously sat in the Division of Surgery and the team moved into the Nursing and Quality Directorate in the autumn. The rationale behind this was to provide the tissue viability nurses with a quality and safety team infrastructure whose key focus is on improvement. Leadership to the team is provided by the quality improvement matron. This change in structure will also support the adoption of Trust wide improvement methodologies and ensure a consistent approach to data collection and data analysis.

The Purpose T assessment tool was implemented during the summer of 2017 and this was rolled out in a staged way to ensure all staff had training on the use of this risk assessment tool. This tool incorporates key risk factors (including skin status and pain) and makes a distinction between patients who have no pressure ulcers but are at risk and require primary prevention, and those patients who have an existing pressure ulcer or scarring from a previous pressure ulcer who require secondary prevention and treatment. This was supported by a weekly audit of completion compliance to ensure that the tool was embedded in practice.

Alongside this was the continuation of the implementation of the SSKIN document within the community. SSKIN is a five step approach to preventing and treating pressure ulcers. This had been launched in the hospital in early 2017.

The Trust refreshed its improvement plan for the reduction of pressure ulcers,

refreshed the improvement group membership and strengthened the governance approach for the Pressure Ulcer panels. CCG colleagues contribute to this group as the improvement needs to occur in care homes and with domiciliary care providers.

The Pressure Ulcer Improvement Group continues to meet monthly. All divisional and CCG colleagues are extremely engaged with the group and motivated to ensure all our patients receive the best possible care and reduce the number of acquired pressure ulcers. The group is a forum for sharing innovative practices and celebrating the improvements we are making.

In September, a new approach to quality governance was implemented and the Pressure Ulcer Improvement Group now reports to the Patient Safety and Clinical Effectiveness Committee. This new arrangement has strengthened the priority focus on the reduction of pressure ulcers within the Trust.

The 'React to Red' campaign was launched in December 2017 in acute care and community nursing, MY therapy and within Podiatry.

This campaign works in conjunction with the SSKIN pressure ulcer prevention care plan and highlights to staff caring for patients to prevent the harm to skin by reporting areas of redness to Tissue Viability nurses or senior staff on the ward/team. The aim of 'React to Red' is to improve awareness of skin care in both the community setting and acute hospitals and implement early interventions to prevent further damage of 'at risk' skin.
Training continues around React to Red. The Trust is supported with training materials and advice from NHS England.

The Division of Medicine have identified quality leads to implement React to Red and within the community they have appointed a Tissue Viability Nurse to support the reduction of pressure ulcers. We are to introduce cameras into our Emergency Departments to ensure we have an accurate skin assessment and pressure ulcer categorisation as the patient presents to the Trust.

### Priority Six: Ensure safe and effective staffing levels on all in patients wards

The Trust recognises that having safe and effective staffing levels on our wards has a direct impact upon patient experience and outcomes as well as the experience of our staff and patients. The delivery of safe and effective care is dependent on the Trust's ability to recruit and retain the right number of appropriately skilled and experienced staff.

Many changes have happened nationally that have affected the ability for all NHS organisations to recruit the levels of registered nurses.

The Trust has therefore explored alternative solutions to ensure that it can deliver safe and effective care with staff that have the appropriate skills. This may not always be a registered nurse.
The National Quality Board (NQB) support NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis. The resources from the NQB are used within the Trust to ensure that decisions are underpinned by the evidence from the resource.

The guidance sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive service.

The following summary illustrates the three key sections

<table>
<tr><th colspan="3">Safe, Effective, Caring, Responsive and Well-Led Care</th></tr>
<tr><td colspan="3">Measure and Improve<br><br>-patient outcomes, people productivity and financial sustainability - report investigate and act on incidents (including red flags) - patient, carer and staff feedback</td></tr>
<tr><td colspan="3">Implementation Care Hours per Patient Day (CHPPD)<br><br>-Develop local quality dashboard for safe sustainable staffing</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><td>Right Staff</td><td>Right Skills</td><td>Right Place and Time</td></tr>
<tr><td>1.1 evidence-based workforce planning<br>1.2 professional judgement<br>1.3 compare staffing with peers</td><td>2.1 mandatory training, development and education<br>2.2 working as a multi-professional team<br>2.3 recruitment and retention</td><td>3.1 productive working and eliminating waste<br>3.2 efficient deployment and flexibility<br>3.3 efficient employment and minimising agency</td></tr>
</table>

The Trust has taken a comprehensive and robust approach to securing the right workforce, not only through proactive recruitment, but also by paying close attention to making the Trust a better place to work – One of the Trust's Strategic Aims is to 'be an excellent employer'; emphasising that the trust wants people to choose to work at Mid Yorkshire and stay at Mid Yorkshire for their careers. The recruitment and retention plan for 2017-2018 identifies initiatives that are being adopted to ensure the Trust optimises the opportunities to recruit and retain its workforce.

A number of initiatives have been used to measure performance during 2017/18:

- Bi-annual establishment reviews through the in-patient staffing reviews to ensure that the skill mix for areas is appropriate and meets the care hours per patient day requirements of each ward.
- Graduate nurse programme. This programme is delivered to all 3rd year student nurse in final placement intending to work in the Trust.
  It is a series of four workshops; stepping up and empowerment, reflection for practice and resilience, and accountability and The Code. Evidence suggests that newly qualified nurses consider leaving by 8 months in post. Early figures indicate a significant reduction from last year in the numbers of nurses leaving at this point from 27% down to 3%, which is a significant improvement.
- Vacancy levels in all services are improving as a result of targeted work to attract people to come to work at the Trust, including proactive recruitment, maintaining contact with new recruits between interview and start date and encouraging nurses who have left the NHS or retired to return. In inpatient wards there was a 15% vacancy rate against a target of 10%.
- In-patient ward areas have an average sickness absence rate of 6% against a target of 5%. A number of new initiatives are being delivered to support staff. This includes the sideways transfer scheme where staff can transfer to different areas within the trust at the same grade. Staff looking for lower acuity areas to work to meet their health needs are supported throughout this system along with staff who want to further develop their career and look at new opportunities within the trust rather than looking external to the Trust

**Priority Seven: Provide our patients with the best possible experience by maintaining a better than national average Friends and family Test Score based on the 2015-16 baseline of 95.7%.**

The Friends and Family Test (FFT) is a national initiative which gives patients the opportunity to provide feedback on the care they have received, and gives staff valuable information to support service improvement.

The FFT question asks users of Trust services how likely they would be to 'recommend' the services they have used.

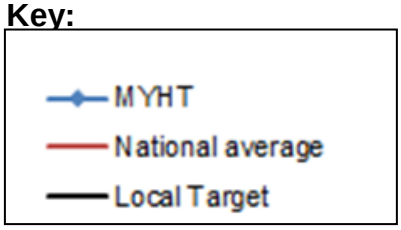
There is also the opportunity to leave comments on what was 'particularly good' or what 'could be improved', which provides a rich source of feedback on both good and poor patient experience.

The Trust 'Recommend' scores for inpatient & day case, emergency services, outpatient and community services have remained equal to, or above the national average.

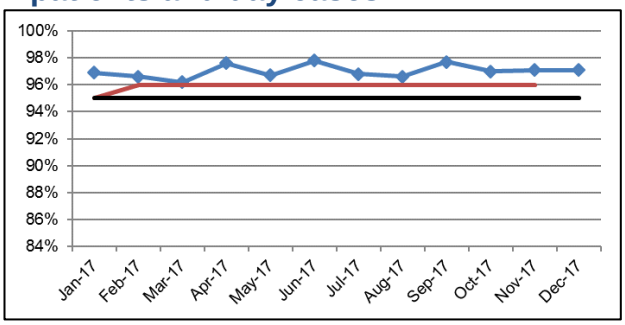
The majority of positive comments are focused around the quality of care and staff being friendly and helpful.

The following graphs show the proportion of patients who say they would 'recommend' the Trust as a place to receive care.

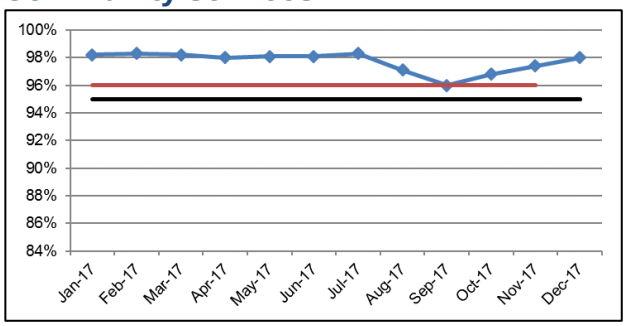
**Key:**



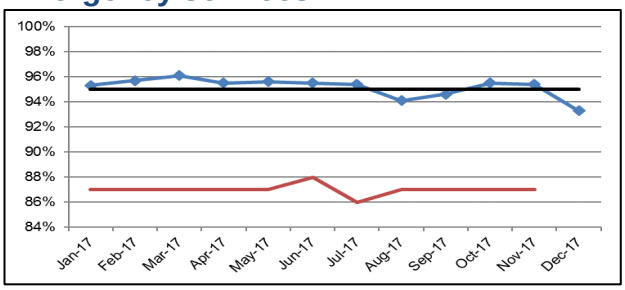

## Inpatients and day cases



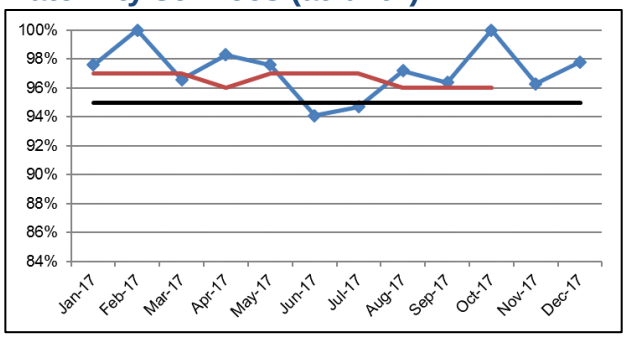

## Community services



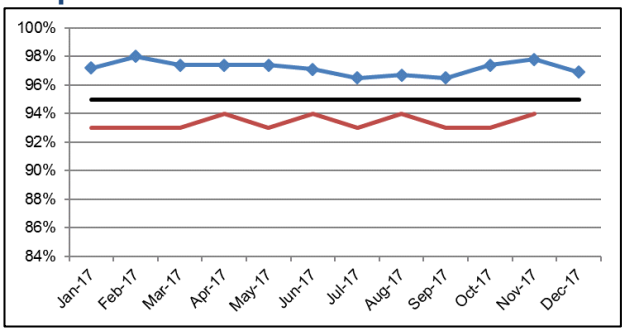

## Emergency services




## Maternity services (at birth)




## Outpatient services



The Trust continues to monitor and encourage participation in the national FFT.

Actions identified within The *Patient Family, & Carer Experience Action Plan*, developed by Patient Experience Sub Committee, aim to achieve improvements in patient experience against priorities identified for improvement.

### Priority Eight: Improve the accessibility of information given to patients at discharge on the effects of their medication

The Trust values feedback from patients through the national patient survey. In response to this feedback, the Trust is working hard to improve the quality of information that patients receive about their medication when they are discharged from hospital.

Actions have focused on listening to what patients fed back about their experience and also on encouraging patients to ask questions about their medicines.

Feedback from the national patient survey has been reviewed and the Pharmacy Patient Experience Group continues to work to improve information provided to patients.

The group reports into divisional and Trust-wide Patient Experience Groups, overseen by the Quality Committee (a sub-committee of the Trust Board) as it is recognised that a multi-disciplinary approach is required to maximise benefit to patients.

In-house patient surveys were carried out in March 2017 and September 2017, to ascertain patient satisfaction with information they receive regarding their medicines in hospital. These surveys demonstrated a sustained improvement in performance during 2017/18 and overall improved patient satisfaction. A survey was also undertaken in conjunction with our largest homecare medicines provider. This demonstrated that patients were satisfied with the service that they receive. Additional patient surveys are being coordinated with the Trust's provider of outpatient pharmacy services to understand patients' experiences and check that patients are receiving appropriate information about their medications.

A snap-shot audit was conducted to ensure the adults and children's 'Managing your medicines in hospital' leaflets were being effectively distributed in June 2017. The results showed that over the course of 18 months sustained improvements had been made in the information we provide to our patients about their medications although there are further improvements to be made. The Trust devised new information leaflets for patients, which outline how their medicines will be managed in hospital and provided the patient medicines helpline number for any post discharge queries. The results of the audit will feed into the Pharmacy Patient Experience Group and into nurse training and support projects planned to increase patient counselling.

Two near-patient dispensing terminals were implemented in the Pinderfields Hospital site during 2017/18, allowing patients to be discharged more quickly and for the Pharmacy Team to provide all necessary information to patients at the point of discharge.

During July 2017, the Medicines Optimisation Team took part in the 'STOP' campaign (Speak To Our Patients), to maximise our interactions with patients. This was followed by the 'Ask your Pharmacy Team' promotion week in November 2017, where advice services to staff and patients were promoted; this

encouraged patients to ask questions about their medicines and links to the regional School of Medicines Optimisation 'It's ok to ask' Campaign.

Guidance for pharmacy staff on the accessible information standard has been circulated. Work also continues with the pharmacy IT system provider to look at larger print labels for visually impaired patients, however this is dependent upon a national update to software.
The Pharmacy Team is exploring the use of a commercial tool to support development of more patient-friendly information about medicines and larger print leaflets.

### Priority Nine: Improve the pathway for patients with a hip fracture

During 2017, the Trust had been struggling to achieve the Best Practice Tariff (BPT) for treating hip fractures; indicating that best practice for patients with this type of fracture was not being delivered.

The Best Practice Tariff for fractured Neck of Femur includes milestones in a patient's treatment journey that when met, would mean they are receiving care that meets best practice guidelines. If achieved these milestones lead to significantly better outcomes for patients.

The key clinical characteristics of best practice were chosen by a group of clinicians and service managers chaired by the National Clinical Director for trauma care. The characteristics are applied to patients aged 60 years of age and over are defined as:

- Time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia
- Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon
- Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia
- Assessed by a geriatrician in the preoperative period: within 72 hours of admission.
- Postoperative geriatrician-directed multi-professional rehabilitation team
- Fracture prevention assessments (falls and bone health).

The key reason for the Trust non-compliance was that in many cases surgery was not being managed within the 36 hours.

To tackle the inconsistency, in October 2017 the organisation conducted a Plan, Do, Study, Act (PDSA) process; this was a result of a Rapid Improvement Process Workshop that took place in June 2017, both of these are part of the Mid Yorkshire Quality Improvement System process. A different way of working was implemented for a week. During this time one consistent consultant anaesthetist covered all the cases in one of the trauma theatres, with lists being scheduled as all day lists meaning that the team remained the same; a change from practice whereby the day may be split into two list with two different teams. A registrar was also present for most of the week to assist the consultant anaesthetist, allowing them to attend the morning trauma meeting. This ensured that patients with NoF injuries were prioritised without affecting the prompt start of surgery each day. The consultant also had an increased presence on the elderly care ward, which meant there was a closer working with the orthogeriatric team.

During the weeklong trial, the average time to surgery from admission was 19 hours. There were no early deaths, some patients were discharged home within five days of admission to the ward, and theatre efficiencies were achieved as well as a standardisation of anaesthetic care. As an additional achievement, all the teams involved worked together well, staff morale was high, and most importantly best practice was applied which indicates the patients were achieving higher levels of care.

Having a senior clinician providing continuity of care for the patients helped to ensure they were not delayed. This single point of contact also facilitated communication from the Emergency Department for early assessment and advice to occur when a patient with a NoF injury was admitted.

Dr Patrick O'Connor was the consultant anaesthetist involved in the trial, he said: "I want to thank everyone who was involved in the trial, particularly the staff on Ward 42 and the theatre team. It has illustrated that by adopting different ways of working we can make improvements, which are of benefit to everyone.
During the trial I felt as though we were making a positive difference to patient care and this was very rewarding."

The process was adopted as standard practice from the 2 January 2018. This has had a significant impact on the time it takes for a patient to get to surgery.

As recorded in the National Hip Fracture Database, the average time to theatre for patients with a NOF injury who were admitted to the trust in January 2018 was 22.4 hours, compared to an average of 42.6 hours in January 2017.

The average time to theatre in January 2018 was lower than the regional and national average. In January and February, our performance was third best in England.

## Priorities for improvement 2017/18

The Trust has undertaken a full review of progress made against the 9 Quality Improvement Priorities set for 2017/18, including a review of the areas of the Quality Dashboard where the Trust is currently not achieving the agreed standard.

This review was undertaken by the sub-committees responsible for management of each priority and recommendations were made to the Quality Committee with regard to continuation or amendment. Therefore, taking into account recommendations from the sub-committees, progress update on priorities, and a review of the Quality Dashboard, the Quality Committee approved the recommendation that the 2017/18 Quality Improvement Priorities be continued into 2018/19 to deliver further improvements, with updates made to three metrics.

The Trust has considered the views of the Trust's Stakeholder Forum, Healthwatch, the Local Authority Overview and Scrutiny Committees and Commissioners.

The following list of Quality Improvement Priorities for 2018/19 is therefore a product of this process.

Therefore, the Quality Improvement Priorities for 2018/19 remain the same as in 2017/18 except for the following amendments:

- MSSA has been replaced with MRSA and Gram Negative Blood Stream Infections.
- Re-wording of safe staffing levels priority to say: *Review all ward-nursing models of care to investigate alternatives to delegate identified tasks to other roles*.
- Prevent harm from avoidable falls. New wording taking out reference to disability or death.
- Improve the 'pathway for patients with a hip' fracture has been removed.
- Electronic discharge summaries will be sent to GPs within 24 hours has been added.

## 2018/19 Quality Improvement Priorities

| Domain | Outcome measure/indicator | Metric |
|---|---|---|
| **Safe** | Reducing all forms of preventable Trust attributable healthcare associated infection (HCAI): MRSA bloodstream infections, Clostridium Difficile infections (CDIFF) including a reduction in Gram Negative Blood Stream Infections-% reduction yet to be determined. | Total number of MRSA bloodstream infections-national objective being a Zero tolerance to preventable infections. |
| | | Total number of CDIFF cases-national objective for 2017/18 no more than 27 cases |
| | | Total number of gram negative blood stream infections-reduction objective to be determined. |

## 2018/19 Quality Improvement Priorities

| Domain | Outcome measure/indicator | Metric |
|---|---|---|
| **Safe** | Reducing all forms of preventable Trust attributable healthcare associated infection (HCAI): MRSA bloodstream infections, Clostridium Difficile infections (CDIFF) including a reduction in Gram Negative Blood Stream Infections-% reduction yet to be determined. | Total number of MRSA bloodstream infections-national objective being a Zero tolerance to preventable infections. |
| | | Total number of CDIFF cases-national objective for 2017/18 no more than 26 cases. |
| | | Total number of gram negative blood stream infections-reduction objective to be determined. |
| | Continually improve clinical services and practice with regard to two areas which can be a significant cause of mortality, namely Acute Kidney Injury (AKI) and Sepsis | =/> 90% of patients to be screened for Acute Kidney Injury. |
| | | =/> 90% of patients to be screened for sepsis in ED |
| | As part of its commitment to delivering 'Harm Free Care', the Trust will continue to build on work undertaken in 2015/16 to prevent avoidable harm from falls | Number of falls resulting in harm per 1,000 bed days to equate to 1.53 |
| | Reducing the consumption of antibiotics and optimising prescribing practice | Reducing the use of Carbapenems by 2%<br>Reducing overall consumption of antibiotics by 1% |
| | Reduce the incidence of pressure ulcers | Reduce the incidences of 2-4 pressure ulcers in the community by 10% from 17/18 baseline data - presented as a % of the patients held on the community caseloads. |
| | | Reduce the rate of incidence of Category 2-4 pressure ulcers in the Acute Trust to 4.23 |

| Domain | Outcome measure/indicator | Metric |
|---|---|---|
| **Experience** | Review all ward nursing models of care to investigate alternatives roles to delegate identified tasks to other roles' | Nurse staffing review for each area twice a year |
| | To provide our patients with the best possible experience demonstrated by better than the national average Friends and Family score. | =/> 95.7% |
| | Improve the understanding of information given to patients at discharge about the effects of their medication | Increasing % of patients report being told about medication side effects to watch out for when they go home |
| **Effective** | Electronic discharge summaries will be sent to GPs within 24 hours. | 90% electronic discharges sent <24 hours<br><br>Improvement in CQC National Patient Survey (2017/18 as baseline) |

## Statements of assurance from the Board

### Review of Services

During 2017/18, the Trust provided 23 relevant health services.

These are:

- Emergency Department
- Non-elective
- Maternity pathways
- New outpatient
- New outpatient procedure
- New outpatient non face to face
- Review outpatient
- Review outpatient procedure
- Review outpatient non face to face
- Pre-assessment
- Elective day case surgery
- Ward attenders
- Critical Care services
- Diagnostic services
- Therapies
- Pathology
- Pharmacy
- Rehabilitation
- Screening
- Elective in-patient
- Community services
- Intermediate tier services
- Specialist commissioning services

The Quality Account is based on a review of data available on the quality of care in all 23 of these services. The Mid Yorkshire Hospitals NHS Trust has reviewed all the data available on the quality of care in 23 of these relevant health services

The income generated by the relevant services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Mid Yorkshire Hospitals NHS Trust for 2017/18. The whole of the income the Trust received in 2017/18 was spent on these services.

Further information about the services the Trust provides can be found at:- http://www.cqc.org.uk/provider/RXF/services

### Participation in Clinical Research

The NHS Constitution made a commitment for research and innovation to 'improve the current and future health and care of the population'. NHS England has made a commitment to ensure research systems are in place to promote and support participation by NHS organisations and NHS patients in research to contribute to economic growth. In 2017 the Trust refreshed its five year strategy describing six strategic objectives which underpins delivery. One of these strategic objectives is "provide excellent Research, Development and Innovation Opportunities". We said that we would know we were achieving this because

- More staff are involved in funded research, development and innovation opportunities.
- There is an increase in the number of staff suggestions for innovation that are received and evaluated.
- Staff feel supported to develop their ideas and are encouraged to be part of funded research opportunities.
- The Trust communicates its successes widely and celebrates those involved.
- Income relating to Research and Development increases including National Institute for Health Research (NIHR).
- The Trust is recognised for being a key provider of Research and Development in the Yorkshire and Humber region.

The Trust recognises that it is perfectly positioned to be actively involved in research, development and innovation opportunities. Enhancing the Trust's involvement in these will strengthen our offering to patients and staff. We actively engage with academic and healthcare organisations to explore and support research partnerships to improve our care. The Trust is a partner organisation in the Yorkshire & Humber Clinical Research Network (YHCRN) (a regional network to support research). This partnership working helps the Trust to support national commitments to research, including the NHS Mandate, the NHS Operating Framework and NHS Commissioning Guidance.

In 2017/18, the Trust has continued to work with the YHCRN to implement the National Institute for Health Research (NIHR) guidance for setting up research in support of national initiatives to improve the quality, speed and co-ordination of clinical research by removing the barriers within the NHS, unifying systems, improving collaboration with industry and streamlining administrative processes. In April 2016, a new national research approval system was implemented, the Health Research Authority (HRA). The Trust continues to work hard to put in place mechanisms to ensure the smooth set up of studies.

Between 1st April 2017 and 31 March 2018, over 250 studies were active within the Trust. Of those, 50 studies were new and opened during 2017-18.

The number of patients receiving relevant health services provided or subcontracted by Mid Yorkshire Hospitals NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 2547.

95% (2430 participants) of this activity is related to research adopted onto the NIHR portfolio. NIHRs 'adoption' is a nationally recognised sign of quality, meaning studies "attempt to derive generalisable (i.e. of value to others in a similar situation) new knowledge by addressing clearly defined questions with systematic and rigorous methods". Other studies were local, student or commercial and are peer reviewed internally at Mid Yorkshire Hospitals NHS Trust by an expert Trust group, again ensuring high quality standards are maintained.

The Trust is pleased to say that NIHR recruitment figures have exceeded the target set for us by NIHR for 17/18, and that the Trust successfully recruited 2360 participants into non-commercial NIHR studies against the target of 1473.

The Trust has research activity across a wide range of clinical specialties. In 17/18 the 33 new NIHR portfolio adopted studies were in the following areas:

| | |
|---|---|
| Cardiology | 5 |
| Anaesthetics | 3 |
| Gastroenterology | 3 |
| Ageing | 2 |
| Childrens | 2 |
| Health Services & Delivery Research | 2 |
| Reproductive Health and Childbirth | 2 |
| Stroke | 2 |
| Urology | 2 |
| Accident and Emergency | 1 |
| Cancer – breast | 1 |
| Diabetes | 1 |
| Mental Health | 1 |
| Musculoskeletal Disorders | 1 |
| Ophthalmology | 1 |
| Orthopaedic | 1 |
| Pain Management | 1 |
| Radiology | 1 |
| Vascular | 1 |

These run alongside studies opened in previous years.

Research activity is overseen quarterly by a multidisciplinary Research Committee, chaired by the Trust's Research Director. Regular external and internal monitoring and audit are conducted on research activity with research quality overseen by a Research Quality Group, which reports to the Research Committee. Additionally, performance against the high-level objectives is managed by the YHCRN and national Coordinating Centre.

The Department of Health requires, via the NIHR, contracts with providers of NHS services and the publication on Trust websites of information regarding: i) the 70-day benchmark for clinical trial initiation (i.e. from a valid study submission to recruitment of first participant); and ii) the recruitment to time and target for commercial contract clinical trials.

The Trust reports quarterly to the Department of Health on the following performance measures (for clinical trials only):

Non-commercial studies: meeting a 70-day benchmark to recruit the first patient following site selection.

Commercial studies: recruiting to time and target for closed studies.

The Trust met the 70-day benchmark in 5 of the study trials submitted in the data collection period for 2017-18. The 70-day benchmark was not achieved in 2 studies, due sponsor delays in greenlighting and supplying drug; and the design of the study requiring the patient to be consented and then seen 40 days later to assess wound healing and whether they are then suitable for the Trial. The Trust, however, did meet the recruiting to time and target for the 2 commercial studies that closed in 2017-18. These reports are published quarterly on the Trust website.

The Trust is an active member of the local Academic Health Science Network which brings together organisations in Yorkshire and Humber which have an interest in the health and wealth of the region. We are a member of Medipex, a healthcare innovation hub for NHS organisations across the Yorkshire & Humber and East Midlands regions and industry and academia internationally. We also have a track record of engagement with commercial research organisations such as pharmaceutical companies and have been selected to recruit into 2 new multi-centre international commercial studies in the last year.

During the year, in partnership with the University of Bradford, the Trust was pleased to establish the Trust's first (and a world first) Clinical Professor of Radiography. Professor Bev Snaith is unique in occupying a dual role as an academic radiographer at the University of Bradford whilst continuing to work as a consultant radiographer at the Trust. She is at the forefront of research in radiology and committed to exploring, developing and testing new innovations and techniques to enhance the understanding of the profession and improve delivery of techniques to improve patient care.

As a result of Professor Snaith's research into point-of-care creatinine tests before contrast-enhanced imaging, the Trust has contributed as expert advisor for the Medtech innovation briefing (MIB) part of the NICE Medical Technologies Evaluation Programme. This is only the second time that NICE have done a multi-vendor assessment.

Recently the research trial offices have highlighted some of the work the Trust has been doing.

- The Multiple Sclerosis [MS] registry is a ground-breaking study designed to increase our understanding and knowledge of living with MS in the UK, which will have a measurable impact on those affected by this debilitating disease. The Trust has supported 206 patients to take part in this study and have one of the highest levels of data completeness (a sign of high quality) across the country. Katie Tuite-Dalton, Communications Officer at Swansea University Medical School Trial Team said "…Thank you because not only is all the data you are collecting some of the best from all the sites we work with, but you are always willing to go one extra mile."

- The Trust has supported 98 patients taking part in I-Care. This study aims to gain more information about some of the long-term benefits and some of the health risks potentially associated with certain treatments for Inflammatory Bowel Diseases (IBD). The I-CARE UK acknowledges the research team by giving a "Special Mention to Dr Deven Vani and his research team in Mid Yorkshire who are the joint highest recruiters in UK and 4th highest globally- thank you".

- In Urology research we opened a study with a pharmaceutical company looking at the safety and efficacy of new treatments for urinary incontinence. The Country Head for UK & ROI of Clinical Operations has remarked that we were the first site in the UK to help a patient join this trial.

- In mattress trials, a programme of work identifying key patient and organisational risk factors and quality of life of life impact of pressure ulcers. Lead by Professor. Jane Nixon at the University of Leeds, the Trust Research Team have recruited 246 participants, placing us as the second highest recruiting centre on the trial and the second highest acute trust contributing significantly to this work. Two members of our team were in the top 10 nurses for total numbers of patients recruited to the trial overall. The evidence based risk assessment framework (PURPOSE T) has been implemented within all clinical areas of the Trust. Professor Nixon said 'The Clinical Trial Research Unit have found all the members of the team at your organisation to be professional, responsive and enthusiastic to work with and we look forward to working with you again in the future' (January 2017).

Other highlights have been:

- The Trust has built on work in radiology to use point of care technology to undertake a blood test in radiology at the time of scanning. In 17/18, 80 patients have helped to identify whether point of care testing can be used to provide immediate information about renal function to help decide on the suitability of an injection of contrast media during some specific scans.

- The Trust has begun hosting a 3 year long NIHR funded 'Research for Patient Benefit' (RFPB) study called 'Motivar' which is looking at developing an App to inspire weight loss in diabetic patients. The Trust is working with the University of Bradford, University of Leeds and Kings College, London and a prototype will be used with Patients in 18/19.

- The Trust has supported the development of an innovative and unique universal hand and wrist splint led by an Occupational Therapist from Pontefract Hospital. It is aimed at helping patients with rheumatology related health conditions, has been recognised by a national orthopaedics company for distribution.

- In our desire to continuously improve the Trust will be embarking on patient experience surveys in 18/19. This has recently been trialled in one research active specialty in the Trust and have had some patient feedback:

Two patients who have recently taken part in research studies have said:

- "(the research nurse) and her team were a pleasure to work with on the trial. I felt safe in their care the entire time. They gave the impression that they had secure knowledge in the trial and the medication. I couldn't have asked for a better experience."
- "I thoroughly enjoyed this experience. I learnt a lot about my diabetes care. The access to support I had was amazing!"

## Participation in Clinical Audit

Clinical Audit helps the Trust to identify ways in which it can improve the care it provides. During the audit year **49** national clinical audits and **5** national confidential enquiries covered NHS services that The Mid Yorkshire Hospitals NHS Trust provides. Mid Yorkshire Hospitals NHS Trust participated in 46**, (94%)** of the national clinical audits and **5, (100%)** of the national confidential enquiries, it was eligible to participate in.

Of the remaining 3 projects, 2 are under negotiation for delivery in 2018-19 and 1 is undertaken locally using the national data set, giving the best achievable compliance with the audit programme. Four projects are yet to start nationally, the Trust will participate in these once started.

The national clinical audits and national confidential enquiries that Mid Yorkshire Hospitals NHS Trust was eligible to participate in during 2017-18 are shown in the table below.

This also shows the National Clinical Audits and National Confidential Enquiries that the Mid Yorkshire NHS Hospitals NHS Trust participated in and for which data collection was completed during 2017/18 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or entry

| National Clinical Audit and Clinical Outcome Review Programme | Host Organisation | MYH | Number Included (%) |
|---|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | National Institute for Cardiovascular Outcomes Research (NICOR) | Yes | 838, (100%) |
| Adult Cardiac Surgery | National Institute for Cardiovascular Outcomes Research (NICOR) | N/A | Patients treated at Leeds |
| BAUS Urology Audits: Cystectomy | British Association of Urological Surgeons | Yes | 36, (100%) |
| BAUS Urology Audits: Nephrectomy | British Association of Urological Surgeons | Yes | 62, (100%) |

| National Clinical Audit and Clinical Outcome Review Programme | Host Organisation | MYH | Number Included (%) |
|---|---|---|---|
| BAUS Urology Audits: Percutaneous Nephrolithotomy | British Association of Urological Surgeons | Yes | 20, (100%) |
| BAUS Urology Audits: Radical Prostatectomy | British Association of Urological Surgeons | Yes | 69, (100%) |
| BAUS Urology Audits: Urethroplasty | British Association of Urological Surgeons | Yes | *Not due to complete until February 2019* |
| BAUS Urology Audits: Female Stress Urinary Incontinence | British Association of Urological Surgeons | Yes | 23, (100%) |
| Bowel Cancer (NBOCAP) | Royal College of Surgeons | Yes | 313, (100%) |
| Cardiac Rhythm Management (CRM) | National Institute for Cardiovascular Outcomes Research (NICOR) | Yes | 731, (100%) |
| Case Mix Programme (CMP) | Intensive Care National Audit and Research Centre (ICNARC) | Yes | 1073, (100%) |
| Child Health Clinical Outcome Review Programme<br>a) Young Peoples Mental Health<br>b) Chronic Neurodisability<br>c) Cancer in Children and Young Adults | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Yes | a) 5, (100%)<br>b) 9, (100%)<br>c) No patients organisational audit completed |
| Congenital Heart Disease (CHD) | National Institute for Cardiovascular Outcomes Research (NICOR) | N/A | N/A |
| Coronary Angioplasty National Audit of Percutaneous Coronary Interventions (PCI) | National Institute for Cardiovascular Outcomes Research (NICOR) | Yes | 362, (100%) |
| Diabetes (Paediatric) (NPDA) | Royal College of Paediatrics and Child Health | Yes | 297, (100%) |
| Elective Surgery National PROMs Programme<br>a) Hips<br>b) Knees<br>c) Varicose Vein Surgery<br>d) Groin Hernia Surgery<br>*Figures to November 2017* | NHS Digital | Yes | a) Hips Surgery<br>Issued 306/286, (93.5%)<br>Response 48, (82.8%)<br>b) Knees Surgery<br>Issue 474/467, (98.5%)<br>Response 66, (71.7%)<br>c) Varicose Vein Surgery<br>Issued 302/68, (22.5%)<br>Response 5, (14.3%)<br>d).Groin Hernia Surgery<br>Issued 352/307, (87.2%)<br>Response 22, (16.7%) |

| National Clinical Audit and Clinical Outcome Review Programme | Host Organisation | MYH | Number Included (%) |
|---|---|---|---|
| Endocrine and Thyroid National Audit | British Association of Endocrine and Thyroid Surgeons | No | Local comparable audit in place |
| Falls and Fragility Fractures Audit Programme (FFFAP) | Royal College of Physicians | Yes | Inpatient Falls<br>30, (100%) *sample*<br>Hip Fracture Database<br>578, (100%) |
| Fractured Neck of Femur | Royal College of Emergency Medicine | Yes | Data collection ongoing |
| Head and Neck Cancer Audit | Saving Faces - The Facial Surgery Research Foundation | N/A | Removed from Quality Account |
| Inflammatory Bowel Disease (IBD) Programme | Inflammatory Bowel Disease (IBD) Registry | No | Under negotiation |
| Learning Disability Mortality Review (LeDeR ) | University of Bristol | Yes | 8, (100%) |
| Major Trauma Audit | Trauma Audit and Research Network (TARN) | Yes | 142, (43%) |
| Maternal, New born and Infant Clinical Outcome Review Programme | MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU) | Yes | Neonatal 3 *validated*<br>Maternal 28 *validated* |
| Medical & Surgical Clinical Outcome Review Programme<br>a) Pancreatitis Study<br>b) Non Invasive Ventilation | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Yes | a) 4 of 11 clinical questionnaires<br>100% case notes sent<br>b) 2 of 7 clinical questionnaires<br>6 of 7, (86%) case notes |
| Mental Health Clinical Outcome Review | National Confidential Inquiry into Suicide and Homicide (NCISH) | N/A | N/A |
| National Audit of Anxiety and Depression | *TBC to be commissioned by HQIP in 2017* | Yes | Not yet started Nationally |
| National Audit of Breast Cancer in Older Patients (NABCOP) | Clinical Effectiveness Unit, The Royal College Surgeons of England | Yes | *Organisational survey completed as required* |
| National Audit of Dementia | Royal College of Psychiatrists | Yes | 100, (100%) *sample* |
| National Audit of Intermediate Care (NAIC) | NHS Benchmarking Network | Yes | *Organisational survey completed as required* |
| National Audit of Psychosis | *TBC to be commissioned by HQIP* | N/A | N/A |
| National Audit of Rheumatoid and Early Inflammatory Arthritis | *TBC to be commissioned by HQIP* | N/A | Not yet started Nationally |
| National Audit of Seizures and Epilepsies in Children and Young People | *TBC to be commissioned by HQIP* | N/A | Not yet started Nationally |
| National Bariatric Surgery Registry (NBSR) | British Obesity and Metabolic Surgery Society (BOMSS) | Yes | 43, (100%) |
| National Cardiac Arrest Audit (NCAA) | Intensive Care National Audit and Research Centre (ICNARC) | Yes | Number of calls – 662<br>Cardiac Arrests – 156<br>Number Patients – 150 |
| National Chronic | Royal College of Physicians | Yes | 944, (100%) |

| National Clinical Audit and Clinical Outcome Review Programme | Host Organisation | MYH | Number Included (%) |
|---|---|---|---|
| Obstructive Pulmonary Disease (COPD) Audit Programme | | | |
| National Clinical Audit of Specialist Rehabilitation | London North West Healthcare NHS Trust | N/A | Applicable to Trauma Centres |
| National Comparative Audit of Blood Transfusion Programme;<br>Red Cell and Platelet Transfusion in Haematology Patient's | NHS Blood and Transplant | Yes | Red Blood Cells:<br>Inpatients - 17 (100%)<br>Outpatients - 26 (100%)<br>Platelets:<br>Inpatients - 8 (100%)<br>Outpatients - 16 (100%) |
| National Diabetes Adults;<br>a) National Diabetes Inpatient Audit (NaDIA)<br>b) National Pregnancy in Diabetes (NPD)<br>c) National Foot Care Audit (NFA)<br>d) The 4th Element Core Audit (NDA) | Health and Social Care Information Centre (HSCIC) | Yes | a) 171, (100%)<br>b) 13 consented<br>c) 47 consented<br>d) NDA is GP record based |
| National Emergency Laparotomy Audit (NELA) | The Royal College of Anaesthetists | Yes | Total 149, (100%) |
| National End of Life Care Audit | *TBC to be commissioned by HQIP* | N/A | Not yet started Nationally |
| National Heart Failure Audit | National Institute for Cardiovascular Outcomes | Yes | 802, (100%) |
| National Joint Registry (NJR) | Healthcare Quality Improvement Partnership | Yes | Eligible 1412<br>Uploaded 1291 (91%) |
| National Lung Cancer Audit (NLCA) | Royal College of Physicians | Yes | 478, (100%) |
| National Maternity and Perinatal Audit | Royal College of Obstetricians and Gynaecologists | Yes | 6406, (100%) |
| Neonatal Intensive and Special Care (NNAP) | Royal College of Paediatrics and Child Health *(babies may have more than one episode)* | Yes | Admissions 455, (100%) |
| National Ophthalmology Audit (2017 patients) | Royal College of Ophthalmologists | Yes | 2342 cataract surgery on 1918 patients (100%) |
| National Vascular Registry | Royal College of Surgeons of England | N/A | Patients treated at Leeds |
| National Neurosurgical Audit Programme | Society of British Neurological Surgeons | N/A | Patients treated at Leeds |
| National Oesophago - Gastric Cancer Audit (NOGCA) | Royal College of Surgeons | Yes | 177, (100%)<br>(5) High Grade Dysplasia |
| Paediatric Intensive Care (PICANet) | University of Leeds | N/A | Patients treated at Leeds |
| Pain in Children | Royal College of Emergency Medicine | Yes | Data collection ongoing |
| Prescribing Observatory | Royal College of Psychiatrists | N/A | N/A |

| National Clinical Audit and Clinical Outcome Review Programme | Host Organisation | MYH | Number Included (%) |
|---|---|---|---|
| for Mental Health (POMH-UK) | | | |
| Procedural Sedation in Adults (Care in Emergency Department) | Royal College of Emergency Medicine | Yes | Data collection ongoing |
| National Prostate Cancer Audit | Royal College of Surgeons | Yes | 281, (100%) |
| Sentinel Stroke National Audit Programme (SSNAP) | Royal College of Physicians | Yes | 845, (100%) |
| Serious Hazards of Transfusion (SHOT): UK | Serious Hazards of Transfusion National Haemovigilance Scheme Transfusion Associated Circulatory Overload (TACO) | Yes | TACO:<br>Inpatients - 20 (100%)<br>Outpatients - 20 (100%) |
| UK Parkinson's Audit | Parkinson's UK | No | Service restructure |

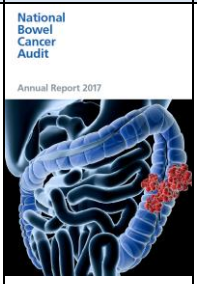
| Other National Audits 2017-18 | Provider | % of Cases |
|---|---|---|
| Penile Prosthesis | British Association of Urologists (BAUS) | Unknown until end date |
| Each Baby Counts | Royal College of Obstetricians and Gynaecologist | 2 cases verified |
| iBRA-2: Immediate Breast Reconstruction and Adjuvant Therapy Audit - | Association of Breast Surgery (ABS), British Association of Plastic and Reconstructive Surgery (BAPRAS), Royal College of Radiologists (RCR) and Oncologists | 10 cases as per national guidance |
| National Audit of Small Bowel Obstruction (NASBO) | Bowel Disease Research Foundation (NASBO)The Association of Coloproctological of Great Britain and Ireland (ACPGBI) | Report not trust level for numbers |
| Adult Asthma | British Thoracic Society | 20, (100%) |
| PASCOM (Podiatric Audit in Clinical and Outcome Measurement) | Society of Chiropodists and Podiatrists | 100% |
| Asthma In ED | Royal College of Emergency Medicine | 100, (100%) |
| Consultant Sign Off | Royal College of Emergency Medicine | 100, (100%) |
| Severe Sepsis and Septic Shock | Royal College of Emergency Medicine | 101, (100%) |

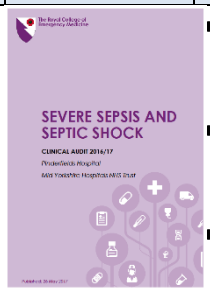
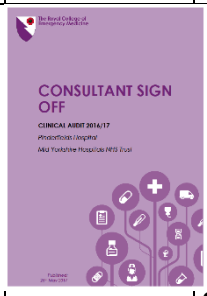
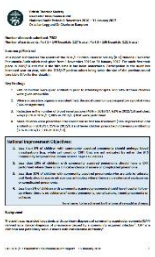
## Local actions developed from National Clinical Audits

Quarterly Audit Reports for each Division are published Trust Wide and shared across all clinical and management groups and include:

- Plans for level 1 projects started from the Annual Audit Priority Programme (AAPP)
- Summaries with action plans for audit projects which have been completed
- Tracking tables by specialty for progress of audit projects identified on the AAPP
- Action tracking tables for completed projects where actions have been identified.

The reports of 51 national clinical audits were reviewed by the provider in April 2017 to March 2018 and the Mid Yorkshire Hospitals NHS Trust intends to take the actions as outlined in the table below

| National Audit | Report | Local Actions/Recommendation from National Audit |
|---|---|---|
| National Bowel Cancer Audit ***378*** *(Royal College Surgeons NHS Digital)* |  | The audit was established to enable clinical teams to collect data in a standard way, ensuring local data is available for review and facilitating national comparison of similar services. Each year data is used to locally plan actions to address areas where compliance can be improved:<br>• Trust Cancer Information System Reporting: Mandatory Validation Report needs to be revised to include responsible and operative consultant information to aid validation of data<br>• Validation of data to ensure completion of MDT information required as part of a mandatory dataset , with specific regard to:<br>− Performance status<br>− Care plan intent<br>− Care Plan agreed date<br>− Planned Cancer treatment type<br>− No cancer treatment reason<br>• Improve compliance and outcomes by the reviewing of risk adjustment data on a regular basis and updating/correcting where necessary<br>• Commence completion specific audit data items at Multi-Disciplinary Team meetings<br>• Discuss barriers to laparoscopic surgery and ways of overcoming these at business meetings |

| National Audit | Report | Local Actions/Recommendation from National Audit |
|---|---|---|
| Severe Sepsis and Septic Shock ***347*** *(College of Emergency Medicine)* |  | • ED sepsis lead and protocol now in place, education provided for triage and assessment and use of sepsis tool to initiate treatment<br>• Implemented a 'sepsis bay' in the resus area to accept all YAS pre-alert patients with suspected sepsis to start treatment rapidly with a senior clinician review<br>• Pharmacy and antibiotic formulary reviewed to provide supply of appropriate anti-biotics for use in sepsis patients<br>• Monthly audit completed of sepsis patients and reported as part of the national CQUIN, both time to treat and initiation of antibiotics has improved<br>• Document oxygen management in case notes<br>• Implementation of 'sepsis trolley' contains all required equipment for treating patients with sepsis, re-stocked and checked daily |
| Consultant Sign Off ***345*** *(College of Emergency Medicine)* |  | • Paediatric ED managed by doctors graded CT3 or above doctors, the audit specified ST4 (equivalent) or above; doctors should review children <1yr with a fever. Therefore, excepting nights after 9pm, all children will be assessed by a registrar of CT3 level or above and those children would need to be discussed with an additional senior doctor. *Memo sent out to all trainees in ED to discuss all cases with ST4 level or above, include in*<br>• There may have been a discrepancy between the number of patients who actually had a senior review and those identified by the initial search as having had a review documented on the Symphony system. – *Publicise to all ED staff re documentation recording essential on symphony and in case notes; for all reviews including where verbal advice is given. Ensure locum senior staff identify clearly in notes their grade*<br>• Abdominal pain in patients aged 70 and over and unscheduled returns with 72 hours both need senior opinion before discharge. *Alert created on symphony to identify patients >70yrs and over attending with abdominal pain to trigger a senior review* |
| National Pae diatric Pneumonia Audit ***394*** *(British Thoracic Society)* |  | Resulting actions were:<br>• Publicity campaign to raise awareness of results and promote guidance:<br>- Create a poster<br>- Consider poster presentation for Governance Half Day Meeting<br>- Display in doctors area<br>- Circulate to clinicians<br>• Review of Mid Yorkshire pneumonia guidelines to include information about patients less than 2 years old and rationale for CXR<br>• Advise all doctors via e-mail to include advice for parents in the discharge letter |

| National Audit | Report | Local Actions/Recommendation from National Audit |
|---|---|---|
| National Diabetes Inpatient Audit (NaDIA) ***489*** *(NHS Digital)* |  | The audit identified areas for improvement including;<br>• Clarity of staff caring for person with diabetes in hospital<br>• Areas requiring improvement relating to foot care<br>Actions to address compliance included;<br>- Additional inpatient capacity now in place with a dedicated diabetes Hub/ward<br>- A specialist foot care practitioner been appointed who is on the ward rounds on a weekly basis<br>- Development of a foot care pack and accompanying patient information leaflet distributed to inpatients |
| The National Emergency Laparotomy Audit (NELA) ***378*** *(Royal College of Anaesthetists and Royal College of Surgeons)* |  | The aim of the audit is to evidence standards of care for patients undergoing emergency laparotomy and improve services to meet a national standard. Overall results were good, improvements in regards to pre-operative mortality risk scoring documentation and post-operative assessment of patients aged 70 years and over by a specialist in care for the older person. Plans are in place to:<br>• Actively promote completion of P-POSSUM data fields to ensure that risk estimation is accurate and useful<br>• Consider designing care pathways that contain NELA data questions as prompts for clinicians to deliver good care to patients<br>• Review local data to improve links with other national data systems<br>• A further time specific action plan covering areas for improvement will be developed jointly by the Anaesthesia and General Surgery Teams |

Presentation of completed audits takes place at a number of forums including the Clinical Governance Speciality and Divisional meetings. Findings and key learning for cross-divisional audit such as record keeping and consent are benchmarked and shared cross trust. Examples of changes resulting from audit projects are included below. Action plans for each completed audit are available in the Directorate Quarterly Audit Reports and on the clinical audit intranet site. Actions are monitored until they are completed.

## Actions developed from local clinical audits

The reports of 101 local clinical audits were reviewed by the provider in April 2017 to March 2018 and the Mid Yorkshire Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

### Examples of Actions to improve patient safety, quality and / or experience

### Re-Audit: Effective Use of National Early Warning Scores (Escalation of Deteriorating Patients) Trust Wide Audit (744)

Use of the National Early Warning Score (NEWS) was implemented in MYHT in March 2013 in order to improve patient safety and ensure early intervention for the deteriorating patient.

The audit aims to identify compliance with local policy requirements and provide information to facilitate improvements in patient safety and quality of care.

This is the 4th cycle of audit year on year with better compliance in most areas of practice. Areas for improvement identified in previous audits have been addressed through robust action planning and no new risks were identified during the completion of this audit. There are however two areas where further improvement can be made these are;

- Escalation of patients who trigger as high risk
- Time to first seen post escalation within 20 minutes

The actions identified below focus on improving compliance;

a) Auditor to highlight any areas requiring improvement with Ward managers (at time of completing the audit) to enable individual staff to be informed/educated of errors.
b) Use the ward league tables to flag and raise issues.
c) Refer and discuss key learning at the Deteriorating Patient Group (DPG) with particular focus on learning from incidents.
d) Dewsbury site; issues were escalated following the Warning Notice from CQC and a Rapid Process Improvement Workshop was undertaken. Focused work has resulted in impressive improvements and there are plans to scale up and spread the successful initiatives throughout the rest of the Trust.
e) Weekly compliance reports for timeliness of observations submitted to the Deputy Director of Nursing for Quality to take action in areas of concern.
f) Discussions with Organisational Development to ensure NEWS training become monitored, populating training matrixes on Electronic Staff Record.
g) Introduce bronze, silver and gold award scheme on behalf of the DPG to acknowledge wards who perform consistently well with timeliness of observations.
h) Pilot digital screens in focused ward areas to display VitalPAC observations due in order to provide a visual prompt of when observations are due and improve compliance.

### Management of Acute Kidney Injury (AKI) in Adults Re-audit (710)

Acute kidney injury occurs when the kidneys suddenly, within hours or days of normal functioning, stop working as they should. This is seen in 13-18% of all patients admitted to hospital and is particularly common in older people. It is often under recognised and under reported and is a major cause of inpatient morbidity and mortality which may be prevented by early recognition.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report (2009) on AKI identified poor assessment of risk factors for AKI with 33% of patients deemed to have received inadequate investigations.

Up to 30% of cases of acute kidney injury may be preventable. As such the initial and subsequent re-audit for AKI covered all inpatients with stage 2 and 3 AKI. Results showed an improvement on the previous 2015 audit, and overall care was satisfactory, however further improvement is still required around fluid balance recording. Recommendations and actions are:

a) Present the audit findings to the Fluid Balance Group (FBG)
b) Review the educational package for fluid balance training with consideration to recommendations from the Fluid Balance Group
c) Audit findings to be included in the junior doctor's induction package
d) Explore the possibility that AKI Care Bundle should become part of mandatory training
e) Provision of Nephrology In-Reach service to be explored. Presentation was made to the Clinical Cabinet and Clinical Commissioning Group on 27/07/17

### Compliance with NICE Quality Standard for Venous Thromboembolism (VTE) Prevention in Urology (738)

VTE is a risk factor for increased mortality and morbidity in hospitalised patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities can save lives. The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and on any predisposing risk factors (such as age, obesity and other related conditions). An integrated approach to provision of services is fundamental to the delivery of high-quality care to prevent and manage VTE. Seven core NICE Quality Statements were audited and where necessary areas for improvement had actions identified to improve compliance:

a) Letter to clinicians regarding documentation of provision of information leaflets
b) DVT leaflets to be available on Urology intranet page
c) Pre- assessment: Confirm and provide further information to patients
d) Clinical Nurse Specialist: Confirm and document in a letter about administration of VTE prophylaxis and improve communication with Central Waiting List Office and Stoma care
e) Admission: Clinician to confirm above and complete VTE form and prescribe
f) Ward Nurse: Document correct application of anti-embolic stocking (Box for signature in pharmacy chart)
g) Post Operatively: Operation notes to specify post-operative prophylaxis, inclusive of re-assessment in 24 hours
h) Discharge: Information to patients and check and prescribe extended prophylaxis (educate junior doctors during Boot Camp, induction, handover, ward rounds)

### Nursing Audits; Falls Prevention, Pressure Ulcer, Fluid Balance, Medications, Paediatric Early Warning Scores and Matrons Health Check (551, 552, 553, 554, 555 and 556)

Delivering high quality and appropriate care to patients is of paramount importance. Nurses and Midwives in the Trust must account for the quality and experience of care delivered to patients, and that care should be evidence based and appropriate to the needs of the patient.

For this reason, a 'nursing quality governance framework' was introduced to establish a programme that will improve quality, patient safety, experience and outcomes for patients and carers. The main purpose of this was to support ward, unit and department managers to understand how they deliver care, identify

what works well and where further improvements are needed.

A structured transparent approach to the nursing audits was introduced with the aim of identifying good practice, and where quality improvement is required. This meets the internal assurance and external validation and review requirements. Nursing audits continually change to meet the needs of the trust and in 2017-18 covered the following topics:

- Falls Prevention
- Pressure Ulcer
- Fluid Balance (changed to Nutrition and Hydration December 2017)
- Medication (incorporated in Matron Health Check)
- Matron Health Check
- Paediatric Advanced Warning Scores (children's only)

It is necessary for each division and ward to review their results so improvements can be put in place. Additionally, each Matron and Associate director of nursing should use this as a form of discussion during 1 to 1 meetings. The following actions are in place;

a) Circulate this report to all appropriate people e.g. Deputy Director of Nursing for Quality and Safety, Associate Directors of Nursing and Lead Nurses for Patient Experience and Quality.
b) Discuss Ward results at nursing governance meeting with Deputy Directors of Nursing and Quality Improvement Lead. Immediate actions are taken is this meeting to address issues with performance and compliance as well as praise given to areas of outstanding care.
c) Ward Managers to review individual ward results and update ward improvement plan as required together with Matron.
d) Division to discuss and agree appropriate actions to address reduced compliance across the division and provide updates to the Quality Improvement Lead.
e) Discuss the findings at additional relevant groups for that audit (e.g. Medicines Optimisation Group).
f) Associate Director of Nursing to ensure wards with poor performance have planning meeting with the Matron to discuss results and update ward action plan. Any updated ward action plan to be sent to Quality Improvement Lead.

### Timing of Acute Cholecystectomy (244)

Gallstone disease occurs when hard fatty or mineral deposits (gallstones) form in the gallbladder. Approximately 15% of the adult population are thought to have gallstone disease, most experience no symptoms. A small proportion of stones can cause symptoms such as pain, infection and inflammation. If these symptoms are left untreated, gallstones can cause more serious and in some cases life-threatening conditions such as cholecystitis, cholangitis, pancreatitis and jaundice. The audit measured practice and concluded that:

- The reported outcomes for the audit are quite good
- Acute gall bladder surgery for biliary diseases is safe, available and is associated with low morbidity
- Further Cholecystectomy audits needs to be completed to address the peri-operative complications and re admissions within 90 days and the timing between Anaesthetics attending and intervention

After the presentation discussion it was noted that early laparoscopic cholecystectomy is not always being achieved for acute cholecystitis, re-audit will evidence if there has been any improvement after the reconfiguration of services.

### Recommendations/Actions

a) To further enhance the acute gall bladder surgery service for biliary pathologies
b) To liaise with the Anaesthetic Team to ensure full understanding and development of acute gall bladder surgery pathway to comply with NICE
c) Reconfiguration of surgical services to develop hot gall bladder surgery and improve compliance with NICE (Clinical Guideline 188)
d) To publicise results for shared learning and education purposes
e) Enhance acute gall bladder service to include biliary pathologies within the gall bladder surgery pathway
f) Discuss GB surgery services and pathway development with Anaesthetic colleagues
g) To re-audit after six months of service reconfiguration with the aim of achieving over 90% standard and improve compliance with NICE guidance recommendation 1.2.4

### Ear Nose and Throat (ENT) Patient Information Audit (697)

The General Medical Council advises that good patient information is linked to improved patient experience and outcome. The ENT Department have a number of procedure leaflets but consistency in content and timescales for information giving was unclear. This local audit identified not only a lack of availability and use in clinics but also identified outdated leaflets. As a result of the audit:

a) All ENT patient information leaflets were reviewed and updated where necessary
b) All leaflets were made available in each ENT Clinic across Trust sites
c) Clinicians were asked to improve the provision of the patient information leaflets and documentation of verbal and written information given
d) A patient quality survey has been planned for 2018 to establish whether the updated/revised leaflets and verbal information given by ENT clinicians is fully addressing patients' needs

A re-audit is currently underway to establish if the availability and provision of leaflets has improved.

National audit reports are reviewed through the following mechanism within the Trust:

- Divisional Governance Committee meetings
- Specialty and Sub Specialty meetings
- Quarterly Audit Reports (circulated trust wide and available on the Intranet)
- Quality Committee (and relevant sub groups)
- Medical Directors Office
- Steering Groups (e.g. Falls Work Stream)

## Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services.

This income related to quality improvement is part of the Commissioning for Quality and Innovation payment framework, and formed part of agreements with local Clinical Commissioning Groups, NHS England and the Local Authority. The financial value attached through the framework to delivery of the agreed improvement goals in 2017/18 was 2.5% of the value of all healthcare services commissioned through the respective contracts. This equated to just above £9 million for the Trust in 2017/18.

There were 24 schemes related to 14 CQUIN goals for 2017/18. This includes 9 National (CCG) goals, 3 NHS England Specialised Commissioning goals and 2 Local Authority goals

A summary of the Trust's performance against the CQUIN indicators for 2017/18 is provided in the table below.

## CQUIN indicators

| CQUIN Indicator | Q1 Status | Q2 Status | Q3 Status | FOT Status |
|---|---|---|---|---|
| **Commission: National (CCG)** | | | | |
| **Acute** | | | | |
| Improvement of health and wellbeing of NHS Staff | N/A | N/A | N/A | ▲ |
| Healthy food for NHS staff, visitors and patients | N/A | N/A | N/A | ● |
| Improving the update of flu vaccinations for frontline clinical staff | N/A | N/A | N/A | ● |
| Timely identification and treatment for patients with sepsis in ED and acute IP | ! | ! | ! | ▲ |
| Assessment of clinical antibiotic review | ✓ | ✓ | ✓ | ▲ |
| Reduction in antibiotic consumption per 1,000 admission | N/A | N/A | N/A | ▲ |
| Improving services for people with mental health needs who present to A&E | ✓ | ✓ | ✓ | ● |
| Advice & Guidance | ✓ | ✓ | ✓ | ● |
| E-referrals | ✓ | ✓ | ! | ▲ |
| Supporting proactive and safe discharge | ✓ | ✓ | ! | ● |
| Tobacco screening | N/A | N/A | N/A | N/A |
| Tobacco brief advice | N/A | N/A | N/A | N/A |
| Tobacco referral and medication | N/A | N/A | N/A | N/A |
| Alcohol screening | N/A | N/A | N/A | N/A |
| Alcohol brief advice or referral | N/A | N/A | N/A | N/A |
| **Community** | | | | |
| Improving the assessment of wounds | ✓ | ✓ | ✓ | ● |
| Personalised care and support planning | N/A | N/A | ✓ | ● |
| Tobacco screening | ✓ | ✗ | ✓ | ▲ |
| Tobacco brief advice | ✓ | ✗ | ✓ | ▲ |
| Tobacco referral and medication | ✓ | ✗ | ✓ | ▲ |
| Alcohol screening | ✓ | ✗ | ✓ | ▲ |
| Alcohol brief advice or referral | ✓ | ✗ | ✓ | ▲ |
| **Commissioner: NHS England - Specialised Services** | | | | |
| Hospital Pharmacy Transformation and Medicines Optimisation | ✓ | ✓ | ✓ | ● |
| Optimising Palliative Chemotherapy Decision Making | ✓ | ✓ | ✓ | ● |
| Nationally Standardised Dose Banding for SACT | ✓ | ✓ | ✓ | ● |
| Data Quality - Secondary Care Dental | ✓ | ✓ | ✓ | ● |
| Public Health - Health Inequalities | ✓ | ✓ | ✓ | ● |
| **Commissioner: Local Authority** | | | | |
| Follow up Procedure for Specialist Weight Management | ✓ | ✓ | ✓ | ● |
| School Lead Resource Service (Oral Health Promotion) | ✓ | ✓ | N/A | ● |

| | Actual | Forecast |
|---|---|---|
| Achieved or expected to achieve | ✓ | ● |
| Part achievement or risk to part achievement | ! | ▲ |
| Non achievement or expected non achievement | ✗ | ◆ |

## Information on registration with the Care Quality Commission (CQC)

The Mid Yorkshire Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is "registered without conditions".

The CQC carried out a comprehensive inspection of the Trust's hospital and community services in spring 2017. The planned inspection took place 16-19 May 2017 and further unannounced visits carried out on 11, 22 May and 05 June 2017. The inspection covered eight acute core services and three community services.

The final Quality Reports detailing the inspection findings and ratings were published on 13 October 2017. The Trust received an overall provider rating of "Requires Improvement". Importantly, the Trust rating against the safe key question improved from "inadequate" to "requires improvement".

| Ratings | |
|---|---|
| Overall rating for this trust | Requires improvement |
| Are services at this trust safe? | Requires improvement |
| Are services at this trust effective? | Requires improvement |
| Are services at this trust caring? | Good |
| Are services at this trust responsive? | Requires improvement |
| Are services at this trust well-led? | Requires improvement |

A detailed action plan has been developed to address the areas for improvement identified in the inspection reports. A total of 87 unique actions for improvement were identified across the seven inspection reports, 7 "must do" actions and 80 "should do" recommendations for improvement.

These are detailed in **Appendix 1**. Progress against the plan will be monitored regularly through the Trust's internal governance arrangements, overseen by the Quality Committee and Trust Board.

The CQC has taken enforcement action against The Mid Yorkshire Hospitals NHS Trust during 2017/18. Following the comprehensive inspection in May, the Trust was served a Section 29A Warning Notice on 19 June 2017 under the Health and Social Care Act 2008. The Notice formally informed the Trust that significant improvement was required in the quality of healthcare provided across its' medical care wards, and in particular in the following areas:

- Nurse staffing
- Monitoring and escalation of the deteriorating patient
- Privacy and dignity of patients in additional capacity bed areas
- Assessment and management of patient risk for nutrition and hydration and falls
- Robust assessment of mental capacity

In response to the Warning Notice, a focused improvement plan was developed and implemented in July 2017, progress against which was monitored weekly. To check on progress made against the Warning Notice concerns, the CQC carried out an unannounced focused inspection on 30 October 2017, which focused on medical wards across Pinderfields Hospital and Dewsbury and District Hospital. The inspectors found improvements in the quality of healthcare had been implemented on our medical wards and that plans were in place to ensure further improvements were made and sustained.

As detailed in the inspection report published on 25 January 2018, the CQC noted significant improvement with regards to the assessment and management of risks in relation falls, care of the deteriorating patient and the use of additional capacity bed spaces which had significantly reduced. Although improvement had been made, it was identified that further improvements were still required, particularly in relation to nurse staffing, nutrition and hydration, and robust assessment of patients' mental capacity. Based on the findings of the unannounced inspection, the Warning Notice was revoked and the Trust has not been subject to any further enforcement activity in 2017/18.

In line with the CQC revised approach to regulation, the Trust actively participates in routine engagement meetings with CQC inspectors; the purpose of which is to facilitate more timely and manageable exchange of information and therefore response to risk, in addition to supporting openness and transparency in relation to challenges and concerns.

The Mid Yorkshire Hospitals NHS Trust has participated in two special reviews by the CQC relating to the following areas during 2017/18.

### Joint inspection of local area services for children and young people with special educational needs and/or disabilities (SEND) in Wakefield

In June 2017, Ofsted and the CQC carried out a joint inspection of the local area of Wakefield to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The overall comments were very positive in most areas however, a written statement of action was required due to the area's position with regards to Autism Assessments- there was more than a 2 year wait. This was already well known to us and a recovery action plan was already in place prior to the inspection.
This recovery plan remains in place and is now demonstrating improvements. Currently the wait stands at 18 months but is falling quickly and by October 2018 it is expected to be at approximately 9 months.

The work with SEND children is multi agency and a joint action plan was drawn up for the whole authority which encompassed all health recommendations within it. The health recommendations have now been extracted from the large document and are all in progress with a view to completion within the next 6 months. All the recommendations and actions are being monitored through the SEND transformation Board.

### Review of services for looked after children and safeguarding (CLAS) in Kirklees

In January 2018, the CQC conducted a review of safeguarding children and services for looked after children within the geographical boundaries of Kirklees. The review, which took place 22 to 26 January 2018 focused on the quality of health services for looked after children and the effectiveness of safeguarding arrangements for all children in the area, in addition to the experiences and outcomes for children, young people and their families who receive health services within the boundaries of Kirklees. Included within the scope of the review were roles of a number of commissioning and provider organisations, including the Trust.

The findings of the review have not yet been published. The Trust is developing a draft action plan based on informal feedback received during the review and this will be finalised following publication of the review. Progress against the CLAS Action Plan will be monitored internally by the Trust's Safeguarding Group and externally by the CQC and locally by NHS North Kirklees CCG.

### Information Governance Toolkit attainment levels

The Trust has an Information Governance Steering Group (CIGSG) which meets every eight weeks chaired by the Trusts Caldicott Guardian*. The Group takes an active role in overseeing the delivery of Information Governance within the Trust to ensure that all information used, especially that relating directly or indirectly to patient care, is managed carefully, responsibly, within current law and with due regard to considerations of privacy such as those defined in the Data Protection Act 1998 (to be replaced by the General Data Protection Regulation (GDPR) in May 2018) and the Caldicott Principles.

The NHS Information Governance Toolkit for Acute Trusts, via its 45 requirements, provides an annual, mandatory assessment of the Trusts standards (current scores in brackets) in: Information Governance Management (100%), Confidentiality and Data Protection (87%), Information Security (93%), Clinical Information (86%), Secondary Use (79%) and Corporate Information (77%).

The toolkit is completed by our specialist "requirement owners" and is audited by internal audit prior to the 31st March final submission.

The Mid Yorkshire Hospitals NHS Trust Information Governance Toolkit Assessment report score for 2017/18 currently stands at 87% and was graded Green.

Each NHS organisation is required to have a Caldicott Guardian. This was mandated for the NHS by Health Service Circular: HSC 1999/012. The mandate covers all organisations that have access to patient records, so it includes acute trusts, ambulance trusts, mental health trusts, primary care trusts, strategic health authorities, and special health authorities.

*A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information-sharing. In accordance with the Caldicott Guardian Manual, this is a position held by a senior clinician

### Clinical coding

The Mid Yorkshire Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

### Information on the quality of data

Comprehensive accessible information is an asset of fundamental value to the NHS. It is a critical factor to support decision making in clinical and management settings. Accurate and timely information is essential to ensure high quality patient care, to improve patient safety and thus ensure a safe environment and to protect patients from avoidable harm.

Improving data quality remains one of the Trust's key strategic priorities. The Mid Yorkshire Hospitals NHS Trust will take the following actions to improve data quality.

- All clinical and administrative staff (where appropriate) are given training and guidance on how to input data onto the hospital systems. No staff

member is allowed to use the systems until they have received this training.

- The Trust is continually promoting the use of the Summary Care Records (SCR) to trace and confirm patient demographic information.
- The Trust routinely uses the Spine Demographic Service to automatically trace patients; this is to ensure the optimal accuracy of demographic information, in particular patient NHS Numbers.

The Mid Yorkshire Hospitals NHS Trust submitted records from April 2017 to September 2017 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) that are included in the latest published data.

The percentage of records in the published data with valid NHS Numbers and valid General Medical Practice Codes are as follows:

| Valid NHS number Patient Type | 2014/15 Target | Trust 2015/16 | 2015/16 Target | Trust 2016/17 | 2016/17 Target | *Trust 2017/18 | 2017/18 Target |
|---|---|---|---|---|---|---|---|
| **Admitted patient care** | 99% | 99.8% | 99% | 99.9% | 99% | 99.8% | 99% |
| **Outpatient care** | 99% | 99.9% | 99% | 99.9% | 99% | 99.9% | 99% |
| **Accident and emergency care** | 95% | 99.2% | 95% | 99.4% | 95% | 99.4% | 95% |
| **Valid General Medical Practice Code** | | | | | | | |
| **Admitted patient care** | 99% | 100% | 99% | 100% | 99% | 100% | 99% |
| **Outpatient care** | 99% | 100% | 99% | 100% | 99% | 100% | 99% |
| **Accident and emergency care** | 99% | 100% | 99% | 100% | 99% | 100% | 99% |

***Months April 2017 – September 2017**

## Learning from Deaths

During the reporting period April 2017 and March 2018, 2129 of Mid Yorkshire Hospitals NHS Trust patients died as in-patients. This comprised the following number of deaths per quarter:

| 2017/18 | Deaths |
|---|---|
| Q1 | 484 |
| Q2 | 471 |
| Q3 | 541 |
| Q4 | 633 |

The crude mortality rate was 3.4% and the relative risk of mortality (12 month rolling) has been reduced from 109 to 99.

A new methodology has been introduced into The Mid Yorkshire Hospitals Trust from January 2018. The Structured Judgement Review (SJR) is now the tool used for the review of deaths.

Therefore there is not a complete data set for 2017/18; however for the purposes of 17/18 reporting, the Trust will use the number of serious incidents where a death has occurred and where care has been implicated as a potential contributing factor as a proxy for the learning from deaths metric.

By year end 2017/18, 11 Serious Incident investigations had been completed in year relating to inpatient deaths.

The number of deaths in each quarter for which an SI investigation was completed was:

| | |
|---|---|
| Q1 | 0 |
| Q2 | 1 |
| Q3 | 1 |
| Q4 | 9 |

Of the 1938 deaths within 2017/18 there were 10 were identified for investigation and SIs were completed, of these, 6 implicated care as a potential factor in the patient's death. This would represent 0.3% of the total deaths.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 1 representing 100% for the third quarter;
- 6 representing 0.95% for the fourth quarter

These numbers have been estimated using the number of serious incident investigations and the comprehensive outcome report from these where care has been implicated as a potential factor in the death of patients.

The Trust uses a variety of mechanisms to communicate to staff the lessons that can be learned from patient deaths. These include: a fortnightly Patient Safety Bulletin; specific communications to medical staff via email; a regular blog and; circulation of standard presentations for use at specialty governance meetings. Some of the learning that has been identified from the reviews includes:

- Gastroenterology: One out of eight DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms was signed but not countersigned by a Consultant, two patients had "crash calls" despite having DNACPR forms completed
- Oncology: Identified timelier need for rapid treatment for sepsis
- Urology: Patients having aggressive intervention, despite likely fatal outcome, should be considered for palliative care/end of life care earlier
- Anaesthetics: Requirement for adjustment of paracetamol doses in low body weight adults
- General Surgery: Importance of endocrinology support in patients with hypokalaemia (low Potassium levels)
- Fractured Neck of Femur: Need for surgery in less than 36 hours. Need for 7-day access to physiotherapy/occupational therapy
- Coronary Atherosclerosis/Other Heart Disease: Of the 13 patients, none were thought to have been preventable deaths. Several patients had Myocardial Infarction (not angina) and therefore were potentially incorrectly coded.

Overall mortality for myocardial infarction AND angina (Coronary Atherosclerosis/Other heart disease) is low.

There have been two areas subject to Rapid Process Improvement Workshops (RPIW). The areas chosen for the improvement workshops were: fractured neck of femur pathway and; care of the deteriorating patient at Dewsbury District Hospital. These were identified as key areas from internal mortality reviews.

The Stroke Team are reviewing three areas of practice: incidence of Pneumonia (in part a function of access to Speech and Language Therapy – SALT - assessment and treatment); use of palliative care input to the sickest patients for symptomatic relief and; weekend access to physiotherapy.

The sepsis group has actioned a number of initiatives including education - appointing a Quality Improvement Sepsis/AKI nurse; introducing sepsis trolleys; redesigning/ relaunching the Sepsis Screening tool and; making stronger links with the newly-appointed consultant antimicrobial pharmacist.

Having previously been an outlier for relative risk of death from septicaemia (leading to an alert from Dr Foster), Mid Yorkshire Hospitals NHS Trust now has average mortality from septicaemia. The Trust has seen an improving 12-month position for relative risk of death in septicaemia over 3 consecutive 1-year periods.

The proportion of episodes and of deaths coded as having specialist care input has improved. A co-ordinated action plan between clinical coding and the palliative care coding team including investment to support increased availability of advice over the weekend has supported this improvement.

The RPIW into care of the deteriorating patient care on the Dewsbury site occurred in November 2017. Tracking has shown improved proportions of patients having their observations on time and a reduction in the number of cardiac arrest on the Dewsbury Hospital site in the 4-weeks after the RPIW compared to the 4-weeks before. This is very early data and the improvement cycle is being monitored on an ongoing basis.

The mortality associated with stroke remains high. The areas of interest to the clinical team at present are: the provision of speech and language therapy access 7-days; exploration of provision of physiotherapy 7-days and; exploring the higher incidence of pre-existing stroke in Mid Yorkshire patients (31.9% vs 26.1% nationally) and the associated higher level of pre-existing disability in the Mid Yorkshire population at presentation of the index stroke (30.6% modified Rankin performance status 3,4,5 vs 20.1% nationally).

12 investigations completed after 01/04/2017, which related to deaths, which took place before the start of the reporting period.

7 representing 0.58% of the patient deaths before the reporting period are judged to be more likely than not to have been impacted by problems in the care provided to the patients. This number has been estimated using the total number of deaths in Q3 and Q4 of 2016/17 (1213) and the number of SI reports that implicated care as a potential factor in the death of the patient (7).

Applying the percentage of deaths, above, to the total number of deaths in 2016/17 (2254) the Trust estimates that 13, representing 0.58%, of the patient deaths during 2016/2017 are judged to be more likely than to have potentially been due to problems in the care provided to the patient.

## Review of other quality performance

### MY Quality Improvement System (MYQIS)

The Mid Yorkshire Trust's Quality Improvement System (MYQIS) is designed to continually improve quality, and eliminate waste using the approach developed by the Virginia Mason Health System based in turn on the Toyota Production System. It is central to the MYHT approach to building quality improvement and capacity and capability. The Kaizen Promotion Office (KPO) facilitates and supports MYQIS.

MYQIS is used to improve the quality and value of services by looking at existing ways of working, removing waste from processes and maximising activities that add value. Processes are observed, analysed and are redesigned by operational staff using the best ideas and concepts to ensure high quality service delivery.

This is driven by Rapid Process Improvement Workshops (RPIWs). The ethos of the RPIW is that staff involved develop and find their own solutions to the problems being addressed, and are empowered, with the full support of the organisation, to implement change using improvement cycles or Plan, Do, Study, Act (PDSA). The legacy of each RPIW will be staff that have learned new skills and participated in driving and taking control of improvement, participants then take this learning back to their own areas and can drive improvement in their own environment as well of course resolving or reducing the problem that was the focus of the RPIW.

### MYQIS Training

To complement the RPIWs and build capacity and capability within the organisation, the Trust has developed a training plan. There are a number of levels to this training:

- **Certified Leader training**
  This intensive training comprises of 5 day classroom training and execution of two improvement events. This training is for staff who will lead Trust wide rapid process improvement events in the organisation and is focused at senior staff including Executive Directors, Clinical Directors and Heads of Service. 37 staff have completed Certified Leader training and must maintain their certified leader status through an annual recertification process to maintain their knowledge and skills.

- **MYQIS Leader training**
  This training comprises of 6 days over 6 months with classroom training followed up with application in the workplace. MYQIS Leader is designed for service and department changes and aimed at staff at Ward Manager and Team Manager level to understand the QIS toolkit and run small scale improvement projects. This group of staff can also provide support to Certified Leaders during rapid improvement events.

- **MYQIS Admin training**
  This training comprises of 2 days over 2 months with classroom training followed by application in the workplace and is suitable for any administrative staff within the organisation wanting to make improvements at team level.

## Rapid Process Improvement Workshops

During 2017/18, there have already been some real successes stories, as a result of over 170 staff taking part in 16 RPIWs as of February 2018. In the RPIWs, staff have implemented their ideas to make improvements to their service, reducing waste and improving outcomes for patients and colleagues. These include:

### End of Life Fast Track Discharge

- This RPIW required collaborative working with MacMillan Cancer Support, patients, Intensive Care Team, Palliative Care Nurses, IM & T, Matrons, Consultants, Pharmacy, Continuing Health Care, Local Authority, Community Nursing and Intermediate Care.
- There were no standard target time to effect a safe and appropriate discharge for patients at end of life who had chosen to leave hospital
- Consequently there was variability in the time to discharge patients sometimes taking 2 weeks or more. On some occasions the patient passes away in hospital and does not die in their preferred place of death.

### Results of the RPIW

- Funding for equipment of care packages were put in place for patient's preferred place of care.
- A fast track discharge process was formulated and implemented.
- Where previously a patient's family was expected to find a nursing home, changes were made so that nursing homes provide the Trust with daily vacancy updates so options can be provided to families.
- As of March 2018 30 patients moving through this process have died in their preferred place of care.
- Current time to discharge is within 24 hours, including discharge to a nursing home. Time to discharge to patients own home is within 15 hours.

### Emergency Department Stepdown

- There are processes for stepping down patients from Resuscitation so they are cared for in the right place, at the right time by the right person which has resulted with patients being discharged from Resuscitation 50% quicker
- There is multi-speciality engagement and guidelines for referral to specialities to ensure the person is referred to the right speciality

### #Neck of Femur patient

- 44% increase of #NOF theatre start time being met
- A significant decrease in cancellation of theatre time for #NOF patient, increasing patient confidence in the service and an increase in NOF theatre utilisation, which has positively impacted on productivity
- Since January every patient met the 36 hour best practice standard

### Non-Medical Recruitment

- There has been a significant reduction in time from 58 days from the receipt of resignation to advert going live on NHS jobs to 1 day
- 100% customer satisfaction rating from Recruiting Managers for the new process

### Deteriorating patient at DDH

- 100% patients at have an appropriate frequency of observations prescribed
- The team improved the time from recording a patients high NEWS to having a management plan and care interventions by 50%.

### Moving forwards into 2018/19:

Education will be delivered by a variety of methods and in settings relevant to the target groups, at a time and place that will encourage participation and produce maximum benefit.

- **Certified Leader Training**, Cohort 4 is underway commencing in April 2018, with a further 16 attendees**.**
- **MYQIS Leaders,** cohort 1 commencing March 2018
- **MYQIS Admin,** 1st cohort currently underway
- **RPIWs** will continue at the current pace with topics being agreed at executive level in line with trust strategic goals and priorities.

### Duty of Candour

During 2017, the Trust reviewed and published the Duty of Candour / Being Open Policy. This document provides staff with information in relation to providing written notification to the 'relevant person' following a patient safety incident (known as a notifiable incident) which has resulted in moderate, or above moderate, harm.

Following completion of the verbal duty of candour, staff are asked to complete the template for the written notification within ten working days. This captures the information provided when the verbal notification was given.

The Trust has also developed information leaflets to help patients and staff understand duty of candour.

There has been no duty of candour breaches in 2017/18.

### Number of Never Events

A never event is defined as a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented.

There have been 2 never events in the Trust during 2017/18 which is comparable with 2016/17 when there were 3 reported never events.

Using the National Never Event criteria, the two never events reported in 2017/18 were both:

- Wrong Site Surgery - Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block.

### Number of serious incidents (SIs)

There have been 104 serious incidents reported in 2017/18 which is a slight increase from 2016/17 where there were 103 serious incidents.

The main themes remain pressure ulcers, falls and diagnostic incidents including delay (including failure to act on test results).

All category 3 and 4 pressure ulcers are reported as serious incidents. Falls, which result in fractured neck of femur, cerebral bleed and severe harm/death are reported as serious incidents. Pressure ulcers accounted for 45 of reported serious incidents and falls were reported in 22 episodes. The number of serious incidents per 1,000 bed days was 0.17 (excluding pressure ulcers).

There were:

- 35 serious incidents reported in Quarter1
- 32 serious incidents reported in Quarter 2
- 20 serious incidents reported in Quarter 3
- 17 serious incidents reported in Quarter 4

So that learning from each individual serious incident is adopted, it is fed back to the Patient Safety Panel and the minutes are submitted to the Patient Safety and Clinical Effectiveness Sub-Committee each month.

The key learning messages are cascaded via the Patient Safety Bulletin to all staff in the Trust and 'learning lessons posters' distributed from the pressure ulcer and falls panels. 'Risky Business' is a Trust newsletter to share more detailed information and learning from serious incident themes. Scenarios and themes from incidents are also used in training sessions and there is a range of opportunities for face-to-face discussions where learning is shared.

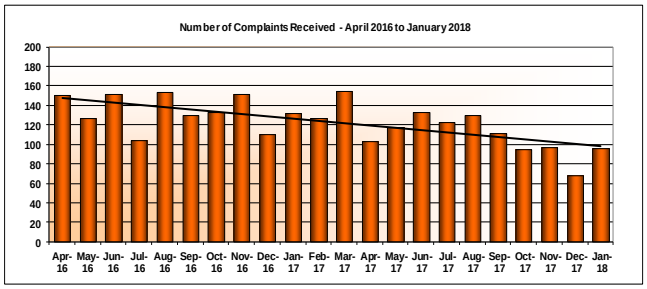
## Learning from complaints

The Trust recognises that sometimes things can go wrong and people wish to raise a concern or a complaint. The Trust has a duty to investigate and learn from such complaints. The complaints process is an important mechanism for patients to provide feedback regarding the quality of our services. This feedback is highly valuable the Trust works hard to use this to improve services.

Considerable effort has been made to improve how complaints are managed, to ensure that any complaints which can be resolved quickly and informally. In August 2017, a new post, Complaints & PALS Improvement Lead was introduced, to manage and lead quality improvements within the Complaints and PALS service.

During the period 1 April 2017 to **31 March 2018**, 1,267 formal complaints were received. The Trust is pleased to report that this represents an overall 22% improvement compared with the same period in 2016/17.

The graph below shows the number of complaints received from April 2016 to March 2018. The figures clearly show that there continues to be a downward trend in the number of complaints received. This can be attributed to the PALS Team being pro-active in the early resolution of informal concerns and low graded complaints.




A robust process is in place to monitor all complaints and concerns closely, noting any recurring themes and trends.

The top categories of formal complaints received have continued to be:

- Clinical Treatment (in particular, pain management)
- Staff Attitude/Behaviour

In response to these themes, task and finish group and projects were established, across divisions and led by matrons, to address these areas of concerns. The groups established include:

- Pain Management Task & Finish Group (to address clinical treatment)
- Supporting Emotional Needs Project (to address staff attitude/behaviour)
- Compassion in Care Project (to address staff attitude/behaviour)

The Pain Management Task & Finish Group aims to co-design improvements in the management of patient's pain. Areas of work will include reviewing patient feedback relating to pain, identifying specific areas of concern then co-designing and testing out a number of small changes in pilot sites which are as follows.

- Gate 45 highlighted delays around patients receiving controlled drugs. As part of the project, the team is currently piloting the distribution of controlled drugs prior to the regular medications round. This will be trialled for three months and then evaluated.
- Maternity Services are piloting self-administration of analgesia for inpatients. This will be evaluated through FFT data.
- Ophthalmology Services will consider feasible options to explain to patients what to expect from their appointment. This is designed to manage their expectations regarding the pain they will experience when eye drops are administered.

The project established to address Supporting Emotional Needs was established to consider the best way to ensure that people's care preferences are understood and honoured. The aim will be to support development of a culture where services routinely engage meaningfully with patients to improve their experience of care. This will extend significantly beyond the simple involvement of patients and families to test out new models of care that shift the conversation from "What's the matter?" to "What matters most to you?"

The project to address Compassion in Care aims to co-ordinate and lead a number of improvement initiatives focussing on supporting our workforce to be compassionate.

Work in this area will consider the merits of:

- Assessing the benefits of implementing a process for self-assessment of organisational culture.
- Recognising excellence and best practice in the delivery of compassionate care.
- Show casing examples of good practice.
- Identifying missed opportunities for compassion in care through observations.
- Support for staff to raise concerns.
- Highlighting the different methods in which the Trust is listening to and engaging patients and staff
- Considering how improvements to public perception of staff can be made.

## National Patient Safety Alerts

The Department of Health and its agencies have systems in place to receive reports of adverse incidents and to issue Alert Notices and other guidance where appropriate. These alerts provide the opportunity for Trusts to identify deficiencies in their systems and to correct them by learning lessons from identified risks.

All NHS bodies have a duty to promptly report adverse incidents and take prompt action on receipt of Alert Notices.

For the period 1 April 2017 to 31 March 2018 the Trust has been issued with a total of 6 Patient Safety Alerts (PSA) from the Central Alerting System.

4 of these alerts have been completed in line with the stipulated completion periods.

A remaining PSA has a completion date of 9 August 2018: this alert is still to be completed and the relevant leads will work towards completion within the timescale.

There is one outstanding alert – the completion date was 20 February 2018 – all actions have not yet been completed.

## Quality Improvement Strategy

The Trust has a Quality Improvement Strategy, which encompasses the requirements of the 'Sign up to Safety' campaign. This strategy is currently under review and a new Quality Strategy will be launched later this year following approval at April 2018 Trust Board meeting.

The current strategy focuses on promoting an open culture, strong professional practice and clinical leadership to deliver:

- Positive patient experience
- Patient safety
- Clinical effectiveness

In early 2017, a new Quality Governance Framework for the Trust was developed and was approved at Trust Board. The purpose of this new framework is to further strengthen the direct sight between frontline provision and the Trust Board and to strengthen assurance and exceptions from frontline services to the Trust Board.

This governance framework involved the establishment of two new committees, Patient Safety and Clinical Effectiveness and the Patient Experience Committee.

Both these committee are chaired by Clinical Executive Directors and these committees report by exception to the Quality Committee.

## Nursing Quality Governance Framework

The Nursing Quality Governance Framework was developed as a means of improving standards on wards and for the assurance of quality from ward to board. The outcomes of ward accreditations are discussed at divisional governance meetings and at a Trust Committee level via the Patient Safety and Clinical Effectiveness Committee, providing a means of assurance and as a measure of continuous improvement.

The information gained from the many aspects of data collated utilising the nursing governance framework is embedded into nursing practice, providing useful ways for ward managers to develop and monitor improvements as well as divisional and trust level management. This information also directs the Quality Improvement Team to areas that may require more assistance than others, so that those resources are distributed more effectively.

## Patient Safety Walkabout Visits

Both Wakefield and North Kirklees CCGs visit the Trust on a monthly basis to assess standards of care in clinical services and assist the achievement of continuous improvement. As in all patient safety walkabout visits, initial feedback is provided to the visited areas and the division so that appropriate immediate action can happen. Once the formal report is received from the CCG it is disseminated to the appropriate areas and divisions. The expectation is that the reports are reviewed and that practice is improved based on any issues identified.

The improvements made are reported at a Trust level to the Patient Safety and Clinical Effectiveness Committee via the Quality Improvement Lead. In addition, clinical divisions report required actions and evidence of improvement directly to the same committee. Patient safety walkabout visit reports are discussed at divisional governance meetings and at a Trust Committee level via the Patient Safety and Clinical Effectiveness committee every three months to ensure the appropriate level of oversight.

### Mortality Review Process

The Mortality Steering Group is active and has representation on the Regional Mortality Group (coordinated by the Yorkshire and Humber Academic Health Science). There is representation from CCGs and the group reviews the mortality dashboard, peer benchmarks, HSMR, crude mortality rate and other indicators monthly.

The Trust has a multi-disciplinary cohort of trainers in Structured Judgment Case Note review and has trained 99 clinicians in the methodology and continues to deliver its roll-out programme of training. The Trust Mortality Policy has been reviewed and revised to introduce a new Learning from Deaths Policy which includes identification of the Structured Judgement Review as the Trust tool of choice.

### Implementation of priority clinical standards for 7 day services

Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities based on their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The Trust has completed the twice-yearly seven-day services survey since its introduction in March 2016. Despite subtle changes to the survey methodology, the Trust continues to demonstrate relatively strong performance when compared to regional and national averages.

For Clinical Standard 2, the results of the September 2017 survey showed that, overall, 71% of patients were seen and assessed by a suitable consultant within 14 hours of admission. The latest reported data for Clinical Standard 8 shows that:

- The overall proportion of patients who required twice-daily consultant reviews and were reviewed twice by a consultant was 100%.
- The overall proportion of patients who required a daily consultant review and were reviewed by a consultant was 87%

The Trust continues to improve the activity challenges in demand, capacity and workforce it faces to improve performance against clinical standards 2 and 8.

Recent changes to the configuration of the Trust's services through the Acute Hospital Reconfiguration should assist with performance against these standards.

## Access to care

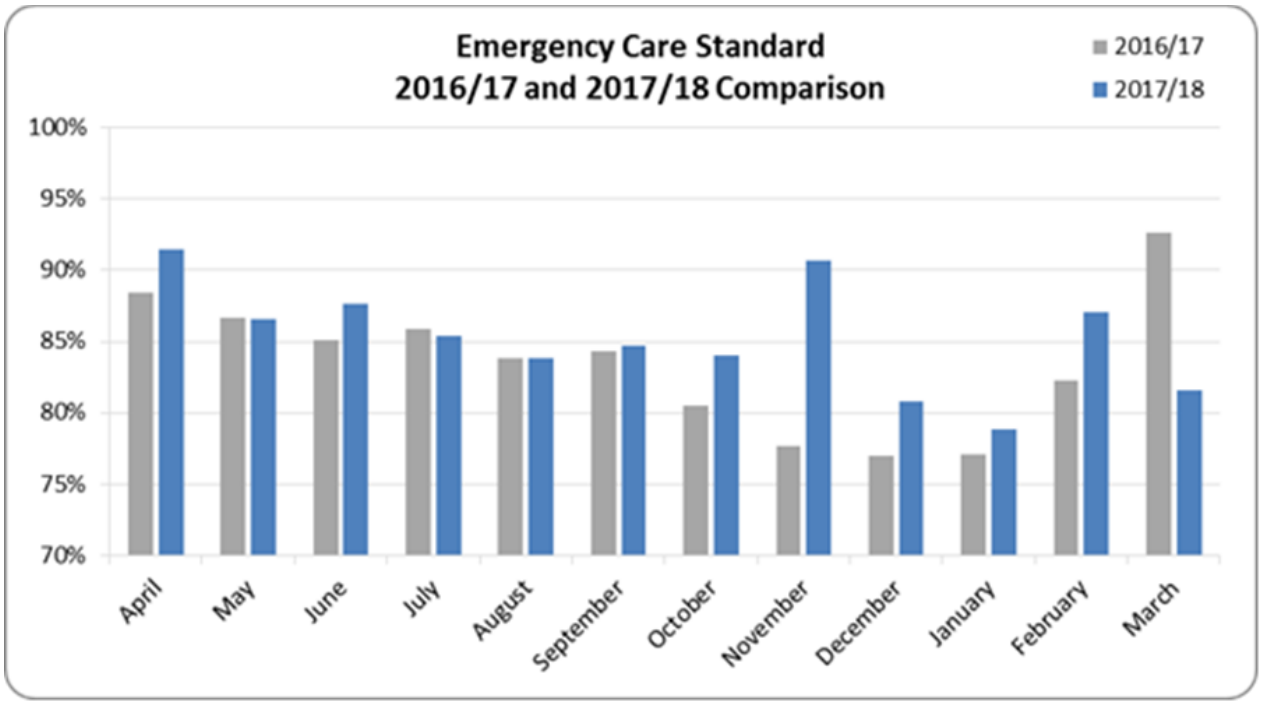
The Trust is committed to improving access to services either in line with constitutional targets or in line with guidance from regulators and commissioners on expectations for 2017/19; however, there continue to be risks related to continued demand pressure (urgent and planned) and workforce gaps.

To mitigate these risks the Trust is working closely with commissioners (clinical and managerial), regulators and other local providers of healthcare to improve the delivery of access to care for patients. This joint working is largely (but not entirely) coordinated through the Urgent Care Board and the Planned Care Improvement Group. The Trust has also developed internal governance to manage internal transformation and improvements outside of those being worked jointly with external partners.

## The Emergency Care Standard (ECS)

The Emergency Care Standard states that 95% of patients are required to be seen treated and discharged within 4 hours of attendance at an Emergency Department (ED). This target is a challenge nationally but is a key indicator of patient experience and safety, and reflects the hospital's ability to deal with patients in the ED and also to manage the flow of patients through the hospital to discharge.

In November 2017, the Winter Room (open 12 hours a day, 7 days a week) was established which brought together key individuals, led by a director, to aid with the flow of patients in and out of the Trust's three Emergency Departments as well as through the wider hospital by ensuring patients were discharged as soon as they were medically fit. There has been noted improvement in the Trust's overall Emergency Care Standard position compared to last year's performance.



The Trust continues to engage with the wider health economy recognising that the delivery of this standard is an endeavour that spans outside our organisational boundaries. Collective effort has and continues to go into the management of 'stranded patients' (over seven days in hospital), Delayed Transfers of Care (DTOC) requiring social input for discharge and other complex discharge-related matters.

Following improvement work that commenced at the end of the previous financial year, the Trust has and continues to see significant improvement in its ambulance turnaround performance. In June 2016 performance was approximately 56% whereas this year performance is regularly above 80% with the Trust regularly outperforming other regional Trusts on this indicator.

In September 2017, the Children's Emergency Department (ED) at Pinderfields became a 24/7 ED. This was a pivotal development for the service as it offered our younger patients a more suited environment to receive their care.

The Trust continues to progress its internal plans to support patient flow. This year, this has included among other initiatives:

- The delivery of a Primary Care Stream in the EDs at Pinderfields and Dewsbury. Patients of lower complexity are now seen by a GP allowing clinical staff to focus on treating more complex patients.
- Work continues with Primary Care to ensure that GP referrals are directed to appropriate assessment units unless they need urgent care or resuscitation in the ED.
    - Emergency Hot Clinics for surgical patients who do not need to be seen on the day of attendance. This has reduced over-crowding in the Surgical Assessment Unit
- Further extension of the Ambulatory Care Service at Pinderfields.
- Established Frailty Units at both Pinderfields and Dewsbury Hospitals

The Unplanned Care Programme is an ongoing programme of change for the Trust and new initiatives are currently being reviewed for consideration in the Trust's 18/19 plans.

### Cancer Services

The Trust's performance in Cancer Services has been an area of success in 2017/18. The Trust has achieved the two-week wait standard, the 31-day standard and the 62-day standard in Quarters 1 to 3, however missed the target by 2.8% in Quarter 4.

The Cancer Services Team has worked hard to recover performance and deliver sustainable services. In addition, focussed work has taken place to reduce the volume of the longest waiting patients. This is in the context of growing demand for cancer services.

During quarters 1-3 the Trust consistently outperformed the English average in achieving the 2 week-wait standard, 62 day referral to treatment standard and 31 day standard in Q3 - remaining close in the other quarters.

### Referral to Treatment Time (RTT)

The RTT standard states that at least 92% of patients are treated within 18 weeks of their referral to hospital. This standard has been difficult to achieve at Mid Yorkshire, mainly due to a significant imbalance between capacity and demand.

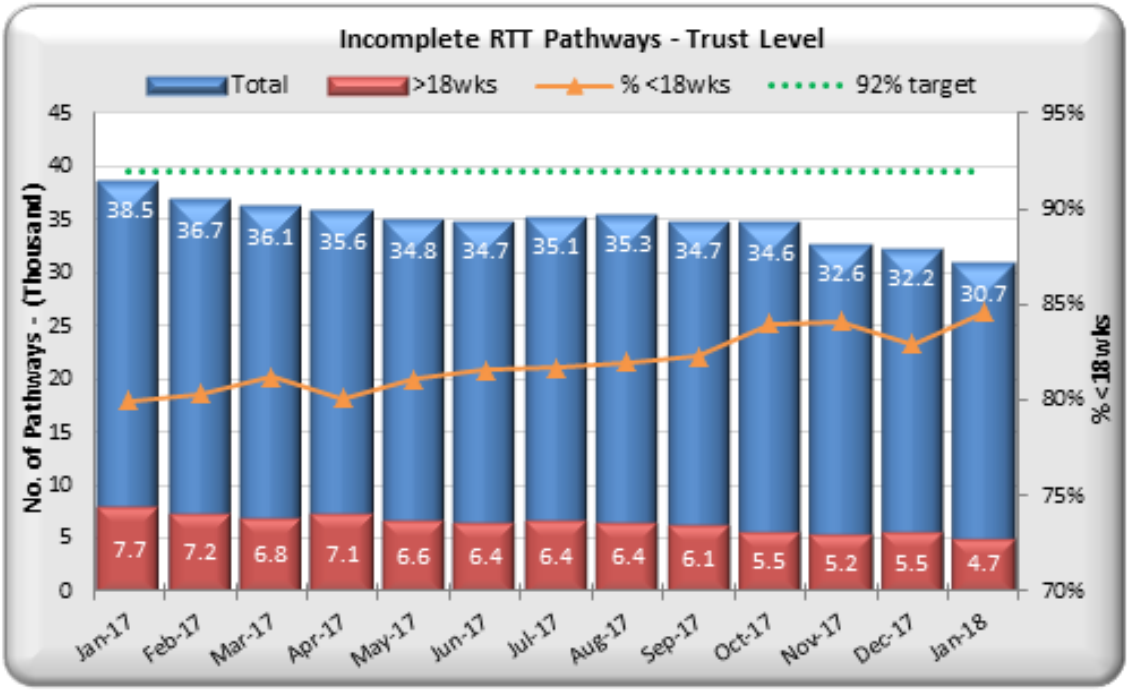
A collaborative improvement plan, in partnership with commissioners and GPs, was launched in November 2016 and has covered an extensive remit of work to support sustainable delivery of routine elective work.

During 2017/18, our focus has been on:

- Improving efficiencies and productivity in outpatients and theatres.
- Increasing use of alternative providers over a long period of time to redirect demand.
- Increasing internal capacity (particularly at weekends and at the Pontefract Hospital site).
- Working with CCGs on demand management interventions including an online advice and guidance service (OSCAR) and a referral support service TRISH (The Referral Information Support Hub).
- In-depth service review of Ophthalmology, which was identified as the service with the most clinical risk and challenges to performance delivery.
- Modernising processes and systems, with a project to switch off paper referrals from GPs to consultant led services and an increase of the Electronic Referral Service.
- Specialty level sustainable recovery plans to deliver performance improvement.
- Validation of waiting lists and learning lessons to improve data quality at point of entry.
- Increased provision of Advice and Guidance services using e-consultation.

The result of this programme of work has been a steady reduction in the overall waiting list size, as demonstrated in the graph below. Performance against the incomplete 92% standard has improved, although the national standard is still not being met. The Trust remains committed to ensuring that patients are treated fairly in clinical and chronological order and as such monitor this compliance on a weekly basis.

At specialty level there has been significant improvement in the performance against the 92% referral to treatment (RTT) standard. In April 2017 only 3 specialties were achieving ≥92%, at the end of 2017/18 this had increased to 5. Most notably Dermatology has improved their performance by over 24%.




## Focus on Patient Experience

During the year, the Trust has worked with service users, stakeholders and staff to review and update the Trust's Patient, Family & Carer Experience Framework in line with the Trust's Vision '*To achieve excellent patient experience each and every time.'*

Our patient experience priorities for improvement are identified on an annual basis by undertaking a review of all our key sources of patient experience feedback and are based on what is important to patients.

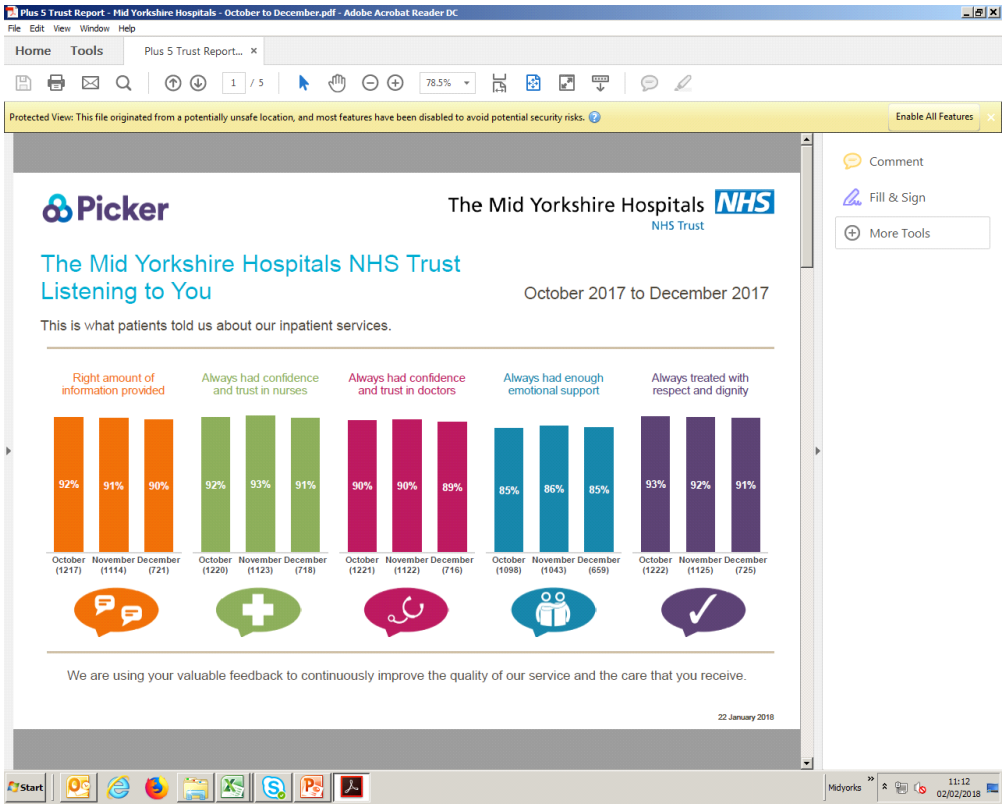
Our patient experience priorities are:

- Patients will be treated with dignity and respect.
- Patients will receive information about their condition and treatment.
- Nurses will communicate effectively with patients and their family/carers to increase confidence
- Doctors will communicate effectively with patients and their family/carers to increase confidence
- Patients' emotional needs will be reviewed and supported appropriately

The Trust's Patient Family & Carer Experience action plan, led and developed by the Patient Experience Sub Committee aims to achieve improvements against the patient experience priorities. The approach is based on the national 'Always Events®' initiative whereby improvements are based on what matters most to patients and achieved by working together with service users. Action plans are also developed and implemented at divisional and service level.

Questions relating to our patient experience priorities have been added to the Inpatient Friends and Family Test (FFT) cards so that we can monitor the impact of any changes on a monthly basis. The Trust set a target to achieve 90% in these priority areas. Work is ongoing making improvements in these key areas.

The following chart shows the results for October 2017 to December 2017.




Survey work during 2017/18 included participation in the national survey programme, which allows us to compare ourselves against other trusts nationally. The Trust uses the results to identify areas of good practice and ideas for improvement

## National Accident and Emergency Department Survey

Areas where we are performing well include cleanliness, privacy when being examined or treated, and patients not feeling threatened. Areas identified for improvement include waiting times, information about condition/ treatment and gaining confidence and trust.

## National Children's Inpatient and Day Case Survey

Areas where we are performing well included friendly staff, explaining how operations or procedures have gone and distracting children during painful procedures. Areas identified for improvement include offering information to support decision-making, supporting those with worries/fears and improvements in pain management.

## National Maternity Survey

Areas where we are performing well include offering choice and giving information about where women can have their babies, speaking in a way mothers can understand. Areas identified for improvement include delays in discharge, treating with kindness and understanding, and prompting women about their postnatal check-ups.

## National Adult Inpatient Survey

Areas where we are performing well included cleanliness, offering drinks, single sex accommodation and not changing planned admission dates. Areas identified for improvement focused around the relational aspects of care including respect

and dignity, information about condition/ treatment and discharge arrangements.

### Initiatives to improve patient experience

Key projects for action have been based around achieving improvements in pain management, caring for patient's emotional needs and increased compassion in care.

A selection includes:

- The Trust has been successful in taking part in a national 'Always Events® initiative led by NHS England. The focus has been on achieving improvements in care based on what matters most to patient on Gate 45 (Respiratory Medicine). An aim was set by patients to improve buzzer response times. A number of changes have been implemented to achieve this e.g. staff are allocated to answering buzzers at peak times such as meal and handovers, the ward has been split in two with staff allocated to each ward, storage and labelling of drawers has been improved to release time having to search for items. The team has featured on an NHS England Always Events® promotional DVD.

- An End of Life drawer initiative has been trialled and rolled out across wards. Items include mouth care products, syringe driver bags, ring pouches, relative welcome items, door posters and patient/relative information. The initiative has been shortlisted for a national patient experience network (PENNA) award.

- The Trust is making improvements in End of Life care as part of a national Gold Standard Framework (GSF) project. Workshops and group meetings have been held to support evidence-based improvements in identifying, documenting and coordinating care to support those patients in the palliative stage of life.

- A pain management project team has tested improvements in pain management to address negative patient experience due to delayed or missed medications. E.g. self-medication project on maternity and giving controlled medications for pain relief at the beginning of the medicine rounds on a medical ward.

- A number of projects have achieved improvements in experience for women being discharged from maternity services. A New-born and Infant Physical Examination clinic was introduced in November 2017 in maternity services which has improved efficiency and oversight of the number of babies requiring neonatal examination. A new administrative clerk/assistant role has also been established which has increased midwives clinical capacity and more timely generation of discharge documents. Postnatal hand held records have been updated to include an introduction to postnatal care which will act as a prompt for more information.

- A project group has been leading improvements and raising the profile of compassion in care. The group has undertaken surveys of frontline staff identifying areas for improvement, and has developed a Compassion in Care card for staff as an approach for recognising excellence and best practice in the delivery of compassionate care. This work is linked to a wider group of health and care providers led by Healthwatch Wakefield in order to establish

evidence based solutions to be implemented across the system.

- Gates 41 and 43 support workers implemented an initiative to increase the opportunity for patient to socialise and interact through activities such as card games, quizzes and a range of arts and craft.

- The volunteer befriender scheme has continued to expand to more areas including Emergency departments where they are able to support more vulnerable patients who may require regular reassurance and assistance.

- The Emergency department at Dewsbury made improvements in the environment and establishing a dedicated family room for breaking bad news to families.

- Many items have been regularly kindly donated by volunteers. Items such as toiletries, clothing, property and syringe driver bags all support our aim to welcome and offer comfort to both our patients and their carers.

- The Parent Room on G46 at Pinderfields was re-furbished providing a kitchen and seating area where parents can make refreshments and have a break from the bedside.

- An Age UK hub has been established at Pinderfields Hospital and will be based on E floor so that it is co-located near the Elderly Care wards. The information hub will offer a range of information and advice services to older people, their carers and professionals on a wide range of issues including housing, social care, residential care and maintaining independence whilst visiting the hospital.

- We have worked in partnership with DisabledGo to launch our own accessibility checker. This offers detailed information about the accessibility of our departments, wards and services such as entrances, toilets, lifts, parking etc. and is accessible via the DisabledGo.com website.

- The family waiting area within Dewsbury Hospital Mortuary has been refurbished to provide a more comfortable and calm environment. Plans have also been approved to refurbish Pinderfields Hospital Mortuary and relatives overnight stay rooms.

### Hospital Reconfiguration

In September 2016 the first major phase of reorganisation of services run by the Mid Yorkshire Hospitals NHS Trust was completed with the opening of two new birth centres and centralisation of the consultant labour ward, neo-natal, children's inpatient care and acute surgery. Between May and September 2017 the Trust implemented the final major phase of the reconfiguration. This focused on changes to Acute Medicine, Critical Care and Complex Surgery.

The Acute Hospitals Reconfiguration was part of a three-year programme which was approved by the Secretary of State for Health in 2014. The aim of the reconfiguration was to enhance safety and secure more sustainable services for the 540,000 people living in North Kirklees and Wakefield district.

Now the reconfiguration is complete key features of the service configuration are:

- Pinderfields Hospital is the main centre for:
  - people with very serious illness

- emergency surgery and critical care
- for children inpatient care
- consultant led obstetrics
- Neo-Natal Intensive Care

- Most people who need an emergency ambulance are taken to Pinderfields Hospital or the nearest appropriate hospital.
- Dewsbury and Pontefract Hospitals continue to have open access to urgent care for people who attend using their own transport.
- Dewsbury and Pontefract Hospitals provide planned care and treat people with less serious illness.

As part of the changes between April and September 2017 the Trust has opened two new Acute Care of the Elderly (ACE) Units, one at Dewsbury Hospital and one at Pinderfields Hospital. These units allow for the rapid diagnosis and treatment of frail patients.

The changes in September 2017 saw the centralisation of Acute Medicine along with Critical Care on the Pinderfields Hospital site which means inpatient care for people with serious, urgent medical conditions are provided centrally at Pinderfields Hospital.

There has been an increase in assessment services at Dewsbury Hospital including more ambulatory care services and dedicated assessment services for frail older people to support patients receiving care closer to home.

Both Pinderfields and Dewsbury Hospitals retain 24/7 consultant led Emergency Departments. The changed configuration is supported by changes to ambulance protocols developed in conjunction with Yorkshire Ambulance Service to ensure patients are taken to the most appropriate Emergency Department.

As part of the reconfiguration the Trust has established inpatient rehabilitation or 'Step Down' services at Dewsbury Hospital. Where appropriate, patients who are close to discharge are transferred to the rehabilitation wards at Dewsbury to continue their rehabilitation prior to discharge.

Outpatients and Elective Surgery is provided on all three hospital sites and the Trust are working to increase the amount of appointments and operations offered at both Pontefract Hospital and Dewsbury Hospitals.

### NHS Staff survey

The Trust participates in the NHS Staff Survey, which is designed to collect the views of staff about their work and the health care organisation they work for. The survey was sent to 7738 staff working at the Trust from the end of September 2017 until 1 December 2017. 3374 members of staff in the Trust responded which equates to 44% of staff and is 1% better than the average response rate for combined acute and community trusts and a 2% increase on 2016.

As in previous years, the detailed content of the questionnaire has been summarised and presented in the form of key findings which are arranged under nine headings such as job satisfaction, patient care and experience. Full results can be found at www.nhsstaffsurveys.com

The five questions where the Trust most improved the 2016 scores were: the percentage of staff saying the last time they experienced an incident of physical violence they reported it (increase from 45% to 60%), the percentage of staff saying feedback from patients is used to make informed decisions within their directorate/department (increase from 48%

to 55%), percentage of staff saying the last time they experienced an incident of harassment, bullying or abuse they reported it (increased from 34% to 41%), percentage of staff reporting good communication between senior management and staff (increase from 33% to 39%) and percentage of staff agreeing they are given feedback about changes made in response to reported errors, near misses and incidents (increased form 56% to 61%).

The Trust's best five ranking scores compared to peers were:

- % of staff working extra hours
- % of staff having adequate materials, supplies and equipment to do their job
- % of staff given feedback about changes made in response to reported errors, near misses and incidents
- % of staff saying the values of the Trust were definitely discussed as part of their appraisal
- % of staff saying they receive regular updates on patient experience feedback in their directorate or department

The five questions for which the Trust compares least favourably with other combined acute and community trusts were:

- % of staff who would be happy with the standard of care provided by the Trust, if a friend or relative needed treatment
- % of staff who would recommend the Trust as a place to work
- % of staff who agree the Trust acts on concerns raised by patients
- % of staff saying the last time they experienced an incident of physical violence, they or a colleague reported it
- % of staff agreeing the care of patients is the Trust's top priority

The Trust is required to report against the following indicators:

- 11% of staff said they experienced discrimination in the last 12 months (11% in 2016/17)
- 83% of staff said they believed the organisation offers equal opportunities for career progression (86% in 2016/17)
- 26% of staff said they had experienced bullying or harassment by patients, relatives or members of the public (28% in 2016/17)
- 24% of staff said they had experienced bullying or harassment by staff (22% in 2016/17)
- 41% of staff said they had reported their most recent experience of bullying or harassment (35% in 2016/17)

Overall, the results show a trend of improvement with increased scores in 52 out of the 88 questions in the survey with 31 showing a statistically significant improvement. In addition, the gap between the Trust's scores and its peer group average has decreased. However, on a number of key questions the Trust ranks at the bottom or near the bottom compared to its peers. The Trust therefore must make improvements to make it the place to work which it wants it to be. Action plans will be developed with staff in the coming year to address the key issues.

### Freedom to Speak Up

The Freedom to Speak Up Guardian role was established on a part-time basis in November 2016, in response to a directive from the Department of Health, to fulfil a key recommendation of the Francis Review 2015 and became a full-time role from January 2018.

The Guardian offers a face to face meeting with all colleagues wishing to speak up, to establish the full details of the issues and to agree the necessary 'next steps' towards escalation.

Where the reporter feels it is appropriate, concerns are referred to senior managers for investigation and further action. Feedback on actions taken by managers is provided for those reporting concerns, and feedback from the reporters is then gathered to establish their level of satisfaction with the support provided by the Guardian.

In the context of organisational governance, the Guardian meets monthly with the Chief Executive, allowing oversight at senior level of the issues which are causing anxiety for members of staff across the Trust. During this discussion the Guardian is able to highlight issues of particular concern. The regular contact between Guardian and Chief Executive is in line with the recommendation of the National Freedom to Speak Up Guardian.

The Guardian also contributes to a regular monthly report to the Trust Board, submitting anonymised details of all concerns raised within the reporting period. A comprehensive 'stand-alone' Freedom to Speak Up report is delivered to the Trust Board every six months. This report focuses on demonstrating progress towards achieving defined priorities in the context of Freedom to Speak Up service developments. Fundamentally, however, it serves the operational function of enabling Board members to review the nature of concerns, to explore emerging themes and patterns. In line with the principles outlined in the Freedom to Speak Up Review (Francis, 2015) this reporting mechanism enables prompt and necessary action at the highest level, to ameliorate organisational risk.

The Freedom to Speak Up Guardian has two key functions:

- To receive and manage concerns raised by staff, to ensure that issues of patient safety are effectively addressed.
- To drive a programme of cultural change, to promote an open and transparent ethos within the organisation so that colleagues can have confidence that the concerns they raise will be well received, and that meaningful investigations will be undertaken to achieve best outcomes for patients.

For this reporting period, 169 staff members have made contact with the Guardian to raise concerns, across a wide range of issues including:

- Concerns over the quality of care delivered on a ward
- Bullying behaviour by colleagues
- Recruitment practice
- Inappropriate administration of medication to a patient
- Concerns over the safe implementation of the Trust Full Capacity Plan

The Trust is pleased to report that in October 2017 The Trust Freedom to Speak Up Guardian was successful in winning the award for 'Leading the Change' at the National Guardian inaugural awards ceremony which demonstrates the significant progress that has been made in this area during 2017/18.

## Statements from our stakeholders

**The following statement was provided by Mr Bryan Denson, lead member of the MYHT Stakeholder Forum.**

"The Quality accounts were a thorough indication as to the direction of travel for the Mid Yorkshire Hospital Trust. The areas for improvement and those targeted for the specific needs of the service that is to be delivered were clearly outlined in the report. The accounts were a demonstration as to the challenges faced by the Trust given the limited resources in terms of money and staffing levels and relies heavily on the goodwill and cooperation of the dedicated staff that work within the Trust. It highlighted the current and future demands that will be placed upon us during the coming 5 years. There is always room for improvement but the Trust is well placed to rise to the challenge ahead. The current quality accounts are just a snapshot in time as the targets, priorities and future legislation will inevitably change during the period and lifetime of the accounts and so the ability of the management team to adapt the future changes is of paramount importance."

**Healthwatch Wakefield Commentary on the Quality Account of the Mid Yorkshire Hospitals NHS Trust**

Healthwatch Wakefield is pleased once again to comment on the Quality Account of the Mid Yorkshire Hospitals NHS Trust ('the Trust') for the year 2017/2018. We are pleased to report that the Trust has continued to involve Healthwatch Wakefield on a number of issues.

The Healthwatch Wakefield Quality Account Task and Finish Group have collected information and intelligence over the year via a variety of methods, including:

- An ongoing programme of face-to-face meetings and discussions with colleagues within the Trust;
- Feedback received by Healthwatch Wakefield from service users;
- Our engagement work across the District with community groups and voluntary organisations;
- Our volunteer activities including visiting our hospitals and other services.

General Commentary

The opening statement on quality from the Chief Executive provides an honest reflection on the Trust's progress in improvement against safety and quality indicators over the course of 2017/18, whilst recognising that the Trust continues to face challenges particularly regarding matching capacity to demand. This is a summary that Healthwatch Wakefield are in agreement with, and would take this opportunity to commend the Trust on their continued provision of healthcare services to the people of Wakefield District and surrounding area.

It is heartening to see that the Trust has successfully implemented its Quality Improvement System, with a people centred approach aimed at driving quality improvement, and as a result we note that a recent CQC inspection upgraded the Trust from 'inadequate' to 'requires improvement' in the patient safety realm. Whilst we recognise there is still work to be done. Healthwatch Wakefield is happy to see steps being taken in the right direction.

Review of 2016/17 Quality Priorities

Whilst it is encouraging to see a good result against the target to reduce cases of healthcare associated Clostridium Difficile cases (35 reported cases compared to 45 in 2016/17) especially considering this was an area for concern last year. It is slightly disappointing to note that the equivalent target for Methicillin susceptible Staphylococcus Aureus infections has been exceeded, albeit only just. Healthwatch Wakefield is however, pleased to see that

the Infection Prevention and Control Team react quickly to address the causes and issues identified.

We are pleased to now see high rates of screening for Sepsis, as recommended last year, but are concerned that similar rates in relation to Acute Kidney Injury are significantly low. From discussion with the Trust about this, however, we note that a new recording system may have affected these figures. Nevertheless, this needs to improve urgently and implementing the same processes as for Sepsis will go a long way to achieve this.

Delivering harm free care for all patients is a key national priority and Healthwatch Wakefield support the Trust in their efforts to improve this in our region. We are pleased to see the initiatives taken already have had a positive impact, and particularly commend the Trust on their achievement in reducing the number of people who have a fall which results in harm per 1,000 bed days to 1.71 (compared with the 2016/17 baseline of 1.89).

Reducing the consumption of antibiotics and optimising prescribing practice has proved to be a challenging area for the Trust during 2017/18, not least due to a reported national shortage of particular drugs – this has had an obvious effect on Defined Daily Dose metrics, as the Trust has been forced to use combinations of other antibiotics in order to treat patients who normally would have received a single equivalent dose of the unavailable drug. Healthwatch Wakefield will be interested to see how this performance develops over 2018/19 and will hope to see ongoing improvements in this area.

In discussions with the Trust, Healthwatch Wakefield have been made aware that reducing the incidence of pressure ulcers has proved a challenging area, particular as many of the factors that affect this are beyond the Trust's direct control. We have noted that improvements have been noted for patients in a hospital setting, whereas incidence is rising in a community setting and we would recommend that it may be worth splitting this metric in 2018/19 to monitor performance in each area separately. We are pleased to see, however, that the Trust continues to review and reflect on how its Tissue Viability Team can be used most effectively.

Staff engagement continues to yield disappointing results; this year particularly reflected in vacancy rates, although we note this is partially affected by the increase of permanent bed base. The fact that retention rates are strong remains good to see and if this can be maintained should hopefully translate into an equivalent improvement in staff morale. Other initiatives being taken, including setting up an onsite school of nursing, are also warmly welcomed.

We are pleased to again see improvements in the Friends and Family Test, both staff and patient related, and hope that this can be maintained throughout 2017/18. We are also

encouraged to note the significant improvements to the pathway for patients with a hip fracture, and hope to see this continue throughout 2018/19.

Healthwatch Wakefield is concerned to note that there has been 1 'Never Events' during the course of 2017/18, and whilst this is a reduction on last year, when there were three, we strongly urge the Trust to take steps to ensure such incidents do not occur at all. We will continue to hold the Trust to account in this area.

Priorities for Improvement 2017/18

Healthwatch Wakefield welcomes the fact that, given performance against all 2016/17 priorities has not been completely successful, several priorities are being rolled over into next year. We also agree that retaining last year's additional priority relating to Reducing the Incidence of Pressure Ulcers is necessary and worthwhile. Amending the metrics in relation to hospital attributable infections and antibiotic usage, and adding a new priority relating to electronic discharge summaries are changes to be welcomed.

Overall Summary

The draft document that was presented to Healthwatch Wakefield for review is well designed and comprehensive. We particularly like the clear summary of performance against 2017/18 priorities which is then followed by a section with further detail for those who need it.

However, Healthwatch Wakefield Task and Finish Group members have raised concerns regarding the accessibility of this document. All NHS and Adult Social Care organisations are required to have an Accessible Information and Communications policy within which they should identify when and how they will provide information and communicate in alternative formats.

The Quality Account annual report needs to be made available to the public, and the Trust should decide what actions they wish to take to proactively or reactively publish documents in alternative formats. Good practice would be that an accessible summary of the account should be made available in at least one other format: indeed, we are aware that other Trusts produce the information in easy read alongside the original report, and we would recommend that Mid Yorkshire Hospitals NHS Trust take at least the same approach.

Nevertheless, there is evidence of strong performance against most of the priorities the Trust set for itself, and although many of the targets were missed, we are encouraged by the efforts already made, the future plans, and the dedication of the team to continue driving through improvements despite the continuing challenges in the healthcare macro and micro environments.

Healthwatch Wakefield commends the Trust on its performance in delivering quality healthcare services to the people of Wakefield District and surrounds, and we look forward to

continuing to support and work with the Trust to help ensure continuous improvements are sustained.

**Statement from Wakefield MDC Adults Services, Public Health and the NHS Overview and Scrutiny Committee - Mid Yorkshire Hospitals NHS Trust Quality Account 2017/18**

Through the Quality Accounts process the Adults Services, Public Health and the NHS Overview and Scrutiny Committee have engaged with the Trust to review and identify quality themes and the Trust has sought the views of the Overview and Scrutiny Committee with the opportunity to provide pertinent feedback and comments.

This has included discussions on progress against the areas for improvement identified in the 2016/17 Quality Account, including a dedicated session with the Trust on the 12 April 2018. This allowed consideration of any potential issues that may have been of concern and has helped the OSC build up a picture of the Trust's performance in relation to the Quality Account.

In addition, the Committee has worked with the Trust over the last year and has challenged those areas most visibly under pressure – with particular focus on quality, patient experience, safety and clinical effectiveness – the three aspects of the Quality Account. Consequently, the Committee believes that the Trust's priorities identified in the Quality Account broadly match those of the public.

The Committee would still like to see a more challenging approach to the setting of priority areas for improvement. Whilst the Committee accepts that the continuum of improvement should be sustained, specifically by retaining the majority of priority areas for improvement from 2016/17, members believe the public would want to see more ambition in setting challenging but realistic targets for improvement.

The Committee accepts that the content and format of the Quality Account is nationally prescribed. The Quality Account is therefore, having to provide commentary on a wide range of services to a broad range of audiences and is also attempting to meet two related, but different, goals of local quality improvement and public accountability.

In order for the public to make sense of information presented requires the provision of standard, consistent and comparable measures, published in a format that enables interpretation and comparison. Priorities for improvement should then be given benchmark or trend information to provide some context for interpretation. The Committee therefore welcomes the intention of the Trust to provide a reader friendly summary document which hopefully will provide public clarity and relevance to the Quality Account.

The Committee is aware that the Trust has experienced difficulty in delivering key constitutional access standards and, as a result, to provide assurance of long term improvement. Access to services is a fundamental indicator of patient experience and improved outcomes. This is the most prevalent concern raised by member constituents.

The challenge of matching the Trust's capacity to demand for services is clearly reflected in the Quality Account and this is supported through the Committee's anecdotal evidence from patients,

particularly in relation to the number of patients seen and treated within the 4-hour standard, together with the number of patients waiting longer than the 18-week standard.

The Committee cited a number of examples from member constituents of poor patient care and lack of response to various individual concerns, particularly in relation to older adults. It is accepted that such cases may be isolated but any and all examples of poor care should be fully investigated and appropriate and acceptable responses given.

The Committee welcomes the sustained improvement in sepsis awareness leading to better practice and reduced mortality. It is encouraging to see successful examples resulting from the Trust's Quality Improvement System, particularly the impressive improvements in the pathway for patients with a hip fracture.

The Committee remains committed to a zero tolerance approach to pressure ulcers amongst inpatients with a focus on prevention in the first instance; thereby reducing the incidence of pressure ulcers, both new and inherited. Members firmly believe that pressure ulcer prevention is a fundamental part of ensuring high quality patient care, promotion of patient safety and health service efficiency.

It is acknowledged that the Trust is treating more patients than ever before but the objective of significant and sustained improvement in the reduction of pressure ulcers has not met the overall aim of eliminating this avoidable harm to patients.

The Committee welcomes the inclusion of the Quality Improvement Priority related to electronic discharge summaries being sent to GPs with 24 hours.

The Committee has continued to consider actions to reduce hospital-acquired harms which disproportionately affect the frail and elderly, which can lead to rapid decompensation, higher mortality and longer hospital stays. The Committee therefore welcomes the continuation of 'Harm Free Care' as a national and Trust Priority and the commitment to build on work undertaken in 2016/17 to prevent avoidable harm.

Overall the Committee would like to see improvement priorities more explicitly aligned to the Trust's core values that reinforce behaviours and ways of working in order to underpin a culture of service improvement and better quality care.

Finally, the Committee believes that the Quality Account is a fair reflection of the Trust's performance, challenges and achievements during 2017/18.

**NHS Wakefield Clinical Commissioning Group**
**NHS North Kirklees Clinical Commissioning Group**

**MYHT Quality Account 2017/18**

**Commissioning CCG Written Statement**

Commissioners welcome the opportunity to comment on the Trust's 2017/18 Quality Account. Throughout the year we have had access to a wealth of information on the quality and safety of care provided to patients accessing the Trust's services. We are assured that this information is carefully assessed by the Trust Board, it informs our regular dialogue with the Trust, and is used to identify areas for improvement. We are confident that the Quality Account provides an accurate and balanced summary of the quality of care provided by MYHT.

The Trust has accurately described the progress made against the quality priorities which aim to reduce harm, improve experience and ensure delivery of effective care. We have worked with the Trust throughout the year on these key areas and on other issues such as reducing waiting times for appointments, improving performance against the cancer targets, and ensuring more timely discharge from hospital. Of particular note is the system-wide working which was established in response to the warning notice following the Trust's CQC inspection to improve patient flow and timely discharge from hospital. Our partnership working has been strengthened further in the context of our shared financial challenge and managing increasing demand on the services the Trust provides.

The Trust has been transparent in describing the reasons they have not met a number of the quality priorities, and as commissioners, these are areas we will continue to influence. It is disappointing that the initiatives implemented to support a reduction of pressure ulcers have not yet impacted on the number or severity, particularly in the community services the Trust provides. We are supporting the Trust to understand the reasons why pressure ulcers develop and deteriorate, to influence the actions they are taking and to ensure all services we commission, such as local care homes, are supporting this work.

We are confident that the Trust has a full understanding of the quality of care it provides to patients, and has established the new MYQIS structure as a comprehensive and consistent approach to quality improvement. It is apparent from the findings shared in the document, that this inclusive and structured approach is empowering staff to implement improvements in their service which will improve outcomes for patients. We particularly welcome the focus on care for patients with hip fractures, where the Trust has previously performed poorly against the best practice standards compared to other Trusts in the region.

We fully support the Trust's decision to continue to focus on pressure ulcers, acute kidney injury, sepsis and staffing. We are pleased that the Trust has identified an additional priority about the timeliness of sending discharge summaries to GPs following feedback from commissioners. We often receive negative feedback from our GP colleagues about the late receipt of discharge letters, particularly where medication has been changed while the patient was in hospital, or there are follow-up arrangements to be made for the patient. We will continue to work with the Trust to support this work.

As in previous years, the report is largely focused on the quality of services provided in hospitals. We are aware that the Trust is undertaking work to improve the quality of care in community services, as part of our system-wide Connecting Care programme and would have liked to have seen more information in the Quality Account.

## INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF THE MID YORKSHIRE HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of The Mid Yorkshire Hospitals NHS Trust's Quality Account for the year ended 31 March 2018 ("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 2018 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents resulting in severe harm or death; and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as "the indicators".

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from the Commissioners;
- feedback from Local Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, for the six months to September 2017;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey dated 2017;
- the latest national staff survey dated 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 24/05/2018;
- the annual governance statement dated 24/05/2018;
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015; and
- the CQC inspection reports for the Trust published in year, dated 13 October 2017 and 25 January 2018.

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 Mid Yorkshire 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 Mid Yorkshire 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;
- testing key management controls;
- analytical procedures;
- 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 Mid Yorkshire Hospitals NHS Trust.

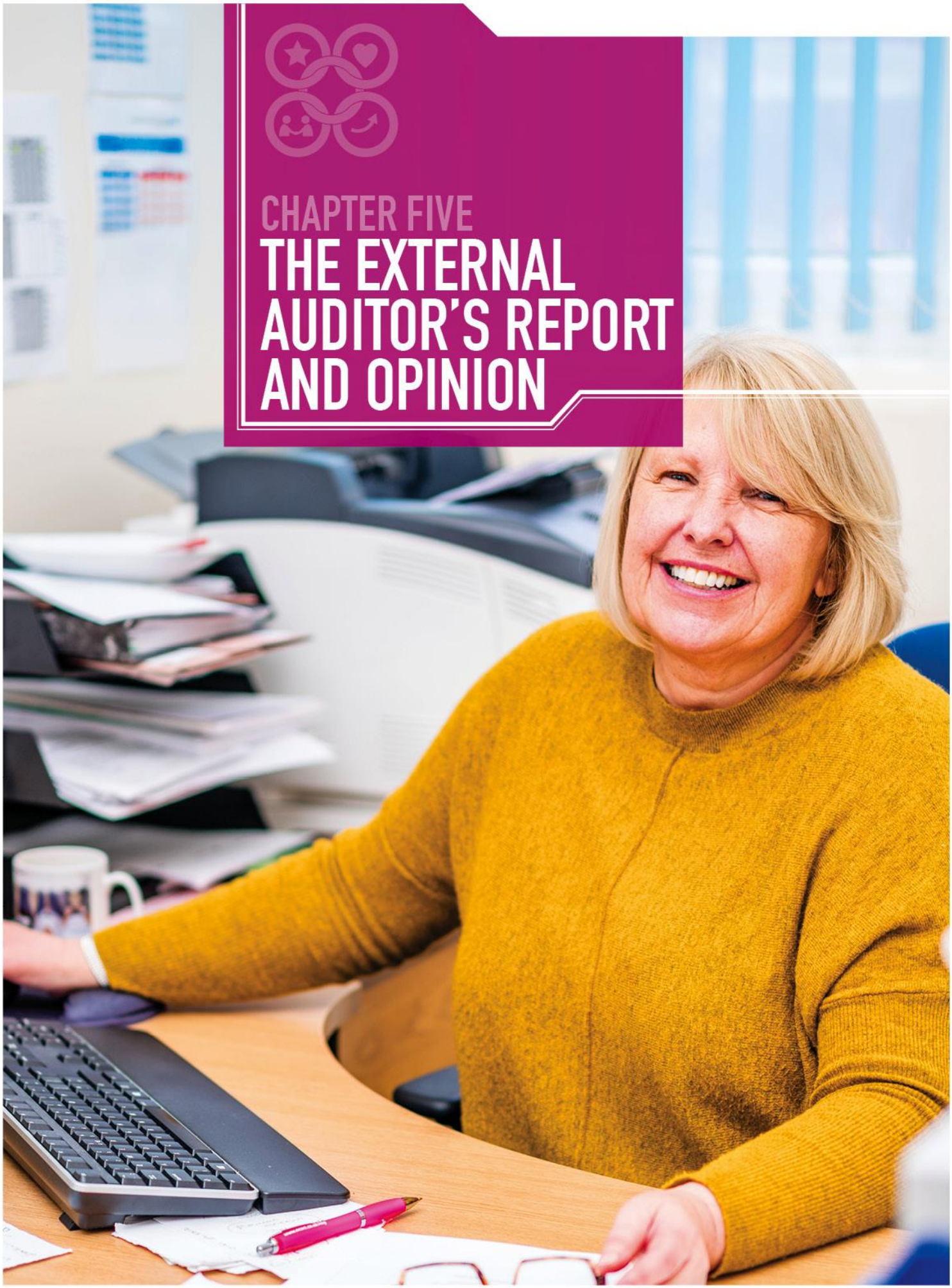
**Conclusion**
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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.

KPMG LLP
Chartered Accountants
Leeds

25 May 2018



CHAPTER FIVE

# THE EXTERNAL AUDITOR'S REPORT AND OPINION

## INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE MID YORKSHIRE HOSPITALS NHS TRUST REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

### Opinion

We have audited the financial statements of the Mid Yorkshire Hospitals NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1. In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

### Material uncertainty related to going concern.

We draw attention to note 2 to the financial statements which indicates that the Trust has incurred a significant deficit in year of £15.854m (2016/17: £19.888m). Loan borrowing has increased at the Trust, with loans from the Department of Health now totalling £73.674m (2016/17: £55.013m), with £19.650m due for repayment in the 2018/19 period. The Trust delivered £17.3m of Cost Improvement Programme (CIP) savings in 2017/18 against a plan of £24.7m. The Trust has submitted a financial plan for 2018/19 that forecasts a deficit of £5.41m with a CIP delivery of £24.0m required in order to meet this target.

These events and conditions, along with the other matters explained in note 2 constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

### Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

### Annual Governance Statement
We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

### Remuneration and Staff Report
In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

### Directors' and Accountable Officer's responsibilities
As explained more fully in the Statement of Directors' Responsibilities the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

### Auditor's responsibilities
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report.

Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

### Report on other legal and regulatory matters

### Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.
Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

### Adverse conclusion
As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects Mid Yorkshire Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

### Basis for adverse conclusion
In considering the Trust's arrangements for securing financial resilience and its arrangements for challenging how it secures economy, efficiency and effectiveness in the use of its resources we identified the following:

- the Trust incurred a deficit of £15.854m in 2017/18 and has a cumulative deficit against its breakeven duty of £140.3m as at 31 March 2018;
- the Trust has set a deficit budget of £5.4m for 2018/19, which includes cost improvement programme target of £24.0m;
- the Trust does not have sufficient cash to meet its commitments without receiving further external funding;
- current borrowing (over and above PFI related borrowing) totals £73.7m at 31 March 2018 (£55.0m at 31 March 2017), with £19.7m of this falling due prior to 31 March 2019; and
- the Trust received two Care Quality Commission inspection reports in the year to 31 March 2018 both of which reached an overall conclusion that the Trust 'requires improvement' including around the 'Well Led' strand of their inspection. These reports noted ongoing concern with regards the 'pace of change' and whether this was occurring quickly enough to fully address the issues identified within their report.

## Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement of the Chief Executive's responsibilities, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

## Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

On 18 May 2017 a referral was made to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 in respect of the Trust's failure to achieve its statutory break even duty.

## The purpose of our audit work and to whom we owe our responsibilities

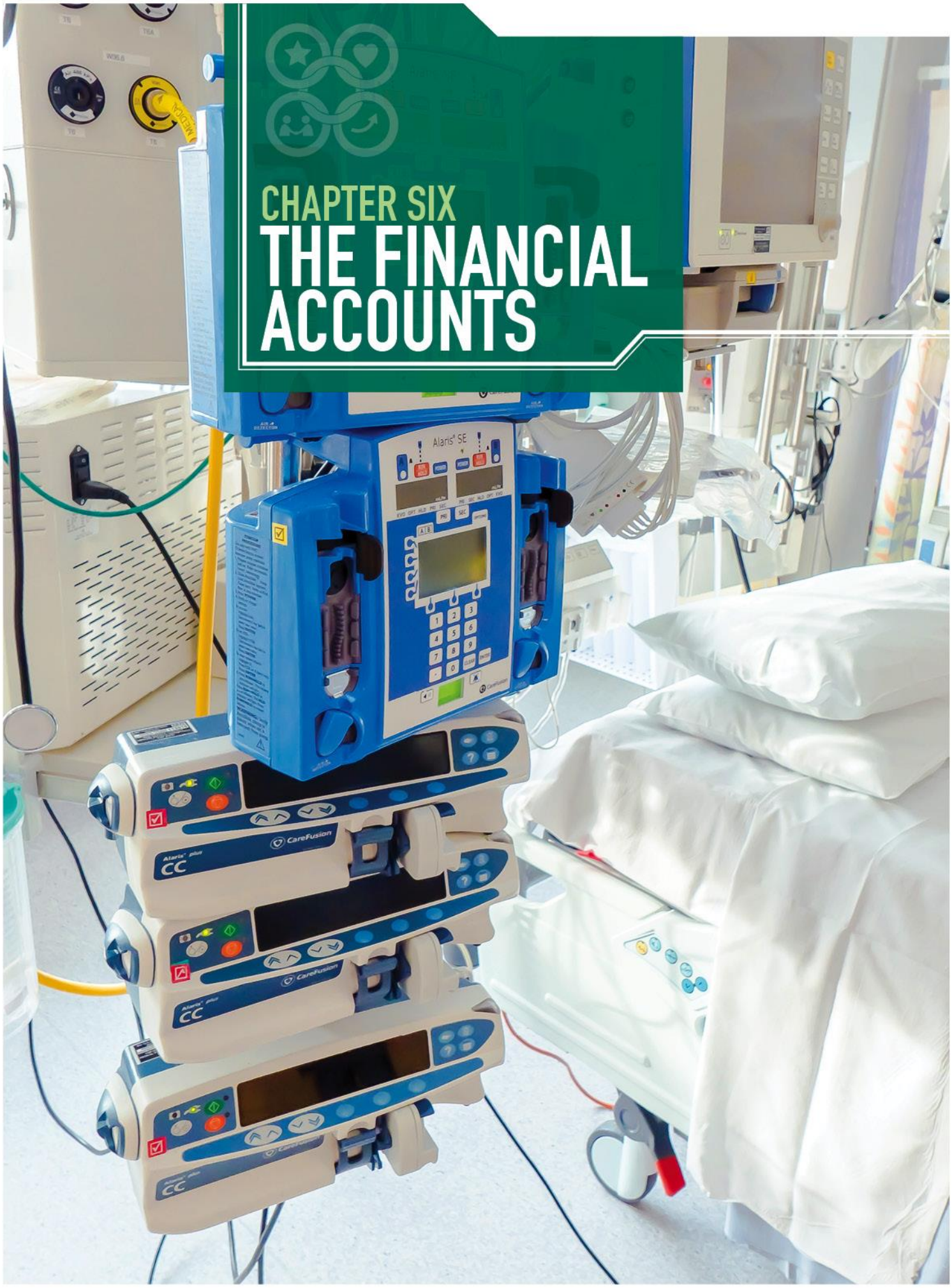
This report is made solely to the Board of Directors of Mid Yorkshire Hospitals NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

## Certificate of completion of the audit

We certify that we have completed the audit of the accounts of Mid Yorkshire Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Clare Partridge
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 Sovereign Square,
Leeds
LS1 4DA

25 May 2018




# CHAPTER SIX
# THE FINANCIAL ACCOUNTS

# Financial Overview 2017/18

In 2017/18, we agreed a plan with NHS Improvement which provided for a deficit of £2.3m, which included £13.5m of Sustainability and Transformation Funding (STF).

Within this plan we provided for a cost improvement programme (CIP) of £24.7m which equates to around 5% of the Trust's turnover.

2017/18 was a very challenging year, and the Trust fell short of making the required level of CIP which resulted in the Trust failing to meet the NHS Improvement target, and a year on year increase in the Trust's deficit.

## Financial Position in 2017/18

The Trust planned for an income and expenditure deficit of £2.3m, which included £13.5m of STF income.
For 2017/18 the Trust has reported a deficit of £18.4m which is £16.1m worse than planned. The main reason for this was the £7.4m shortfall on efficiency savings where the Trust delivered £17.3m against the target of £24.7m, and also a £6.1m shortfall in the amount of STF income available.

The impact of changes to the valuation of our assets resulted in a net reversal of impairment of £2.5m which is excluded from the reported break even financial performance as a technical adjustment.

The table summarises how the position has changed between 2016/17 & 2017/18.

| | | Position at 31/3/18 | | |
|---|---|---|---|---|
| | Position at 31/3/17 | Plan | Actual | Variance |
| | £m | £m | £m | £m |
| **Surplus/ (deficit) excl. STF** | **(19.7)** | **(15.8)** | **(25.8)** | **(10.0)** |
| Add STF | 11.9 | 13.5 | 7.4 | (6.1) |
| **Surplus/ (deficit) incl. STF** | **(7.8)** | **(2.3)** | **(18.4)** | **(16.1)** |

## Revenue

The total revenue in 2017/18 amounted to £505.6m, an increase on the prior year total of £504.5m. Revenue in 2017/18 includes £7.4m STF income, which is a £4.4m reduction on the £11.8m in 2016/17. Around £462m (91%) of our income is received from NHS commissioning bodies for the purchase of clinical activity. Similar to the previous year we also received £2.5m in respect of local health economy support.

## Expenditure

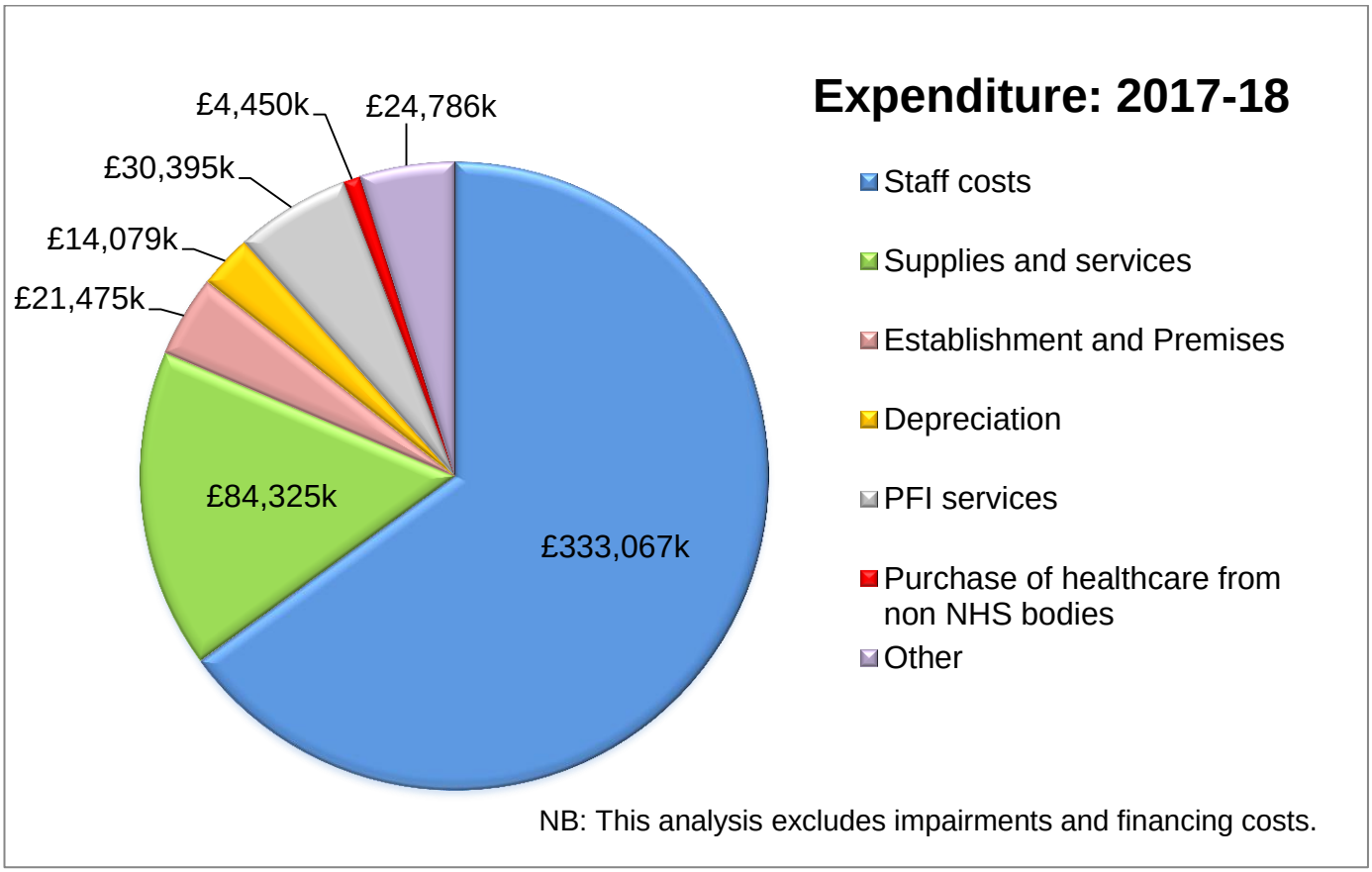
Our operating expenditure excluding financing costs and impairments was £512.6m and the largest element of this was the pay bill for our staff cost of £333.0m (65%). Other significant components of the Trust's expenditure baseline were supplies and service costs of £41.1m (8%) and establishment and premise costs of £20.9m (4%).

In 2017/18 and 2016/17 the Trust revalued its land and buildings as at the 1 April and 31 March.

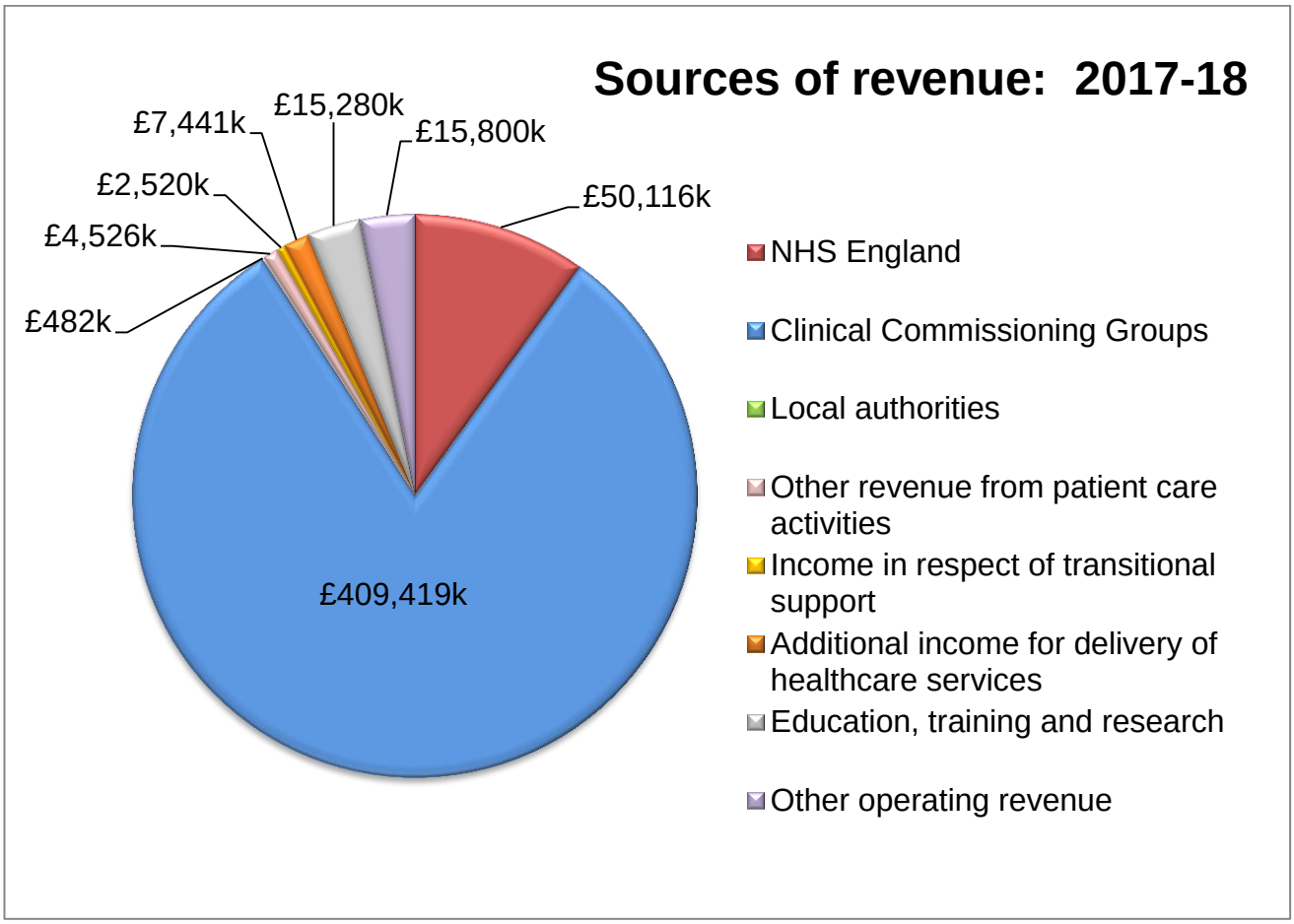
The valuations are on a modern equivalent asset basis with the revalued assets having the same service potential as the existing ones. The valuations resulted in a net reversal of impairments of £2.5m in 2017/18 and impairment in 2016/17 of £12.0m.

## Capital Expenditure

In 2017/18 we invested £8.3m in capital expenditure, including £2.6m invested in our healthcare facilities, £1.7m in replacing our information technology and £4m on new medical equipment. In 2018/19 we plan to spend a further £11.8m on developing our healthcare facilities and equipment.




NB: This analysis excludes impairments and financing costs.


Sources of revenue: 2017-18
£7,441k
£15,280k
£15,800k
£2,520k
£50,116k
£4,526k
£482k
£409,419k
NHS England
Clinical Commissioning Groups
Local authorities
Other revenue from patient care activities
Income in respect of transitional support
Additional income for delivery of healthcare services
Education, training and research
Other operating revenue

## Looking Forward to 2018/19

Our financial challenge will continue into 2018/198 and we have agreed a financial plan with NHS Improvement which provides a £5.4m deficit including Provider Sustainability Funding (PSF) income of £14.5m.

The receipt of PSF will be dependent on the Trust delivering its emergency care target and delivering on the financial target set by NHS Improvement. This will be a significant challenge for the Trust and we are already working very hard to deliver the plan.

The financial target we have been set will mean we have to make a further £24.0m of cost improvements and efficiencies. This forecast takes into account the 2% efficiency target that all Trusts are required to deliver and to address the underlying deficit position brought forward from 2017/18. All of our cost improvement schemes will be assessed for the impact on patient safety and patient experience by our Medical Director and Chief Nurse.

We continue to work with our stakeholders and we are supporting initiatives to drive efficiencies and transform healthcare services across the health economy to enable us to provide safe, quality and sustainable care for our patients.
In 2018/19 we will commence the Dewsbury Hospital Reconfiguration Strategy which will address backlog maintenance as well as optimising the quality of clinical accommodation at this site.

## External Auditors

KPMG LLP UK were the Trust's external auditors in 2017/18. The cost of the work undertaken by KPMG LLP UK was £0.1m (inclusive of VAT).

This includes the fees for audit services in relation to the statutory audit and the quality accounts.

Auditing standards require the Directors to provide the external auditors with representations on certain matters material to their audit opinion.

The Board has confirmed and provided assurance via a statement of representation to its auditors that there is no information relevant to the audit that they are aware of that has not been made available to the auditors. Directors have taken all steps necessary to make themselves aware of any relevant audit information and established that the auditors are aware of that information.

## Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum.

These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- Value for money is achieved from the resources available to the Trust
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

**Signed:** .

**Chief Executive and Accountable Officer:** Martin Barkley
**Date: 24 May 2018**

## Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.
-

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

**Signed:**

**Chief Executive and Accountable Officer:** Martin Barkley
**Date: 24 May 2018**

**Signed:**

**Director of Finance:** Jane Hazelgrave
**Date: 24 May 2018**

## Statement of Comprehensive Income for the year ended 31 March 2018

| | 2017-18 | 2016-17 |
|---|---|---|
| | £000s | £000s |
| Operating income from patient care activities | 464,543 | 458,158 |
| Income in respect of legacy financial support | 2,520 | 3,900 |
| Other operating income | 38,521 | 42,396 |
| Employee benefits | (332,982) | (323,953) |
| Other operating expenses | (179,595) | (177,366) |
| Reversal of impairments/(impairments) | 2,503 | (11,963) |
| Operating surplus/(deficit) from continuing operations | (4,490) | (8,828) |
| Finance income | 46 | 56 |
| Finance expenses | (11,385) | (11,399) |
| PDC dividends payable | 0 | 0) |
| Net finance costs | (11,339) | (11,343) |
| Other gains/(losses) | (25) | 283 |
| Surplus/(deficit) for the year from continuing operations | (15,854) | (19,888) |
| Other comprehensive income | | |
| Reversal of impairments/(impairments) | 265 | (38,544) |
| Revaluations | 0 | 17,005 |
| Total comprehensive income / (expense) for the period | (15,589) | (41,427) |

A NHS Trust's reported financial performance is assessed on its retained surplus/deficit adjusted for items that the Department of Health and Social Care does not consider to be part of the organisation's performance.

## Breakeven duty financial performance

| | 2017-18 | 2016-17 |
|---|---|---|
| | £000s | £000s |
| Surplus / (deficit) for the year | (15,854) | (19,888) |
| Add back all I&E impairments / (reversals) | (2,503) | 11,963 |
| Remove capital donations / grants I&E impact | (48) | 52 |
| Breakeven duty financial performance surplus / (deficit) | (18,405) | (7,873) |

In 2017/18, the Trust was required to adjust for reversal of impairments of £2,503k (2016/17: impairments of £11,963k) and the impact of eliminating the donated asset reserve of £48k credit (2016/17: £52k debit) net income (2016/17: £52k net expenditure).

Sustainability and Transformation Fund income of £7,441k (2016/17: £11,864k) is included in the reported financial performance.

## Statement of Financial Position as at 31 March 2018

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000s | £000s |
| Non-current Assets | | |
| Intangible assets | 1,910 | 2,402 |
| Property, plant and equipment | 379,649 | 381,956 |
| Total non-current assets | 381,559 | 384,358 |
| Current Assets | | |
| Inventories | 7,654 | 8,229 |
| Trade and other receivables | 22,148 | 19,985 |
| Non-current assets held for sale | 0 | 1,250 |
| Cash and cash equivalents | 8,194 | 11,286 |
| Total current assets | 37,996 | 40,750 |
| Current Liabilities | | |
| Trade and other payables | (34,228) | (34,507) |
| Borrowings | (27,973) | (8,971) |
| Provisions | (1,586) | (1,608) |
| Other liabilities | (2,013) | (1,623) |
| Total current liabilities | (66,800) | (47,709) |
| Total current assets less current liabilities | 352,755 | 377,399 |
| Non-current Liabilities | | |
| Borrowings | (330,974) | (340,110) |
| Provisions | (6,691) | (7,030) |
| Total non-current liabilities | (337,665) | (347,140) |
| Total assets employed | 15,090 | 30,259 |
| Financed by | | |
| Public dividend capital | 203,139 | 202,719 |
| Revaluation reserve | 35,481 | 37,107 |
| Other reserves | 2,685 | 2,685 |
| Income and expenditure reserve | (226,215) | (212,252) |
| Total taxpayers' equity | 15,090 | 30,259 |

The financial statements were approved by the Board on 24 May 2018 and signed on its behalf by:

**Signature:**

**Chief Executive and Accountable Officer:** Martin Barkley
**Organisation:** The Mid Yorkshire Hospitals NHS Trust

## Statement of Changes in Taxpayers' Equity for the year ended 31 March 2018

| | Public Dividend Capital | Revaluation reserve | Other reserves | Income and expenditure reserve | Total reserves |
|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s |
| **Taxpayers' equity at 1 April 2017 - brought forward** | 202,719 | 37,107 | 2,685 | (212,252) | 30,259 |
| Surplus/(deficit) for the year | | | | (15,854) | (15,854) |
| Other transfers between reserves | | (654) | | 654 | 0 |
| Reversal of impairments/(impairments) | | 265 | | | 265 |
| Transfer to retained earnings on disposal of assets | | 1,237 | | (1,237) | 0 |
| Public dividend capital received | 420 | | | | 420 |
| Taxpayers' equity at 31 March 2018 | 203,139 | 35,481 | 2,685 | (226,215) | 15,090 |

In 2017/18, the Trust received £220k of permanent Public Dividend Capital (PDC) for cyber security and £200k for West Yorkshire and Humber Cancer Alliance digital pathology scheme.

| | Public Dividend Capital | Revaluation reserve | Other reserves | Income and expenditure reserve | Total reserves |
|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s |
| **Taxpayers' equity at 1 April 2016 - brought forward** | 196,144 | 59,569 | 2,685 | (193,287) | 65,111 |
| Surplus/(deficit) for the year | | | | (19,888) | (19,888) |
| Other transfers between reserves | | (923) | | 923 | 0 |
| Impairments | | (38,544) | | | (38,544) |
| Revaluations | | 17,005 | | | 17,005 |
| Public dividend capital received | 6,575 | | | | 6,575 |
| Taxpayers' equity at 31 March 2017 | 202,719 | 37,107 | 2,685 | (212,252) | 30,259 |

In 2016/17, the Trust received £5,000k of permanent Public Dividend Capital (PDC) in return for the revenue to capital transfer in 2015-16, £975k for the acute hospital reconfiguration and £600k for West Yorkshire Acceleration Zone.

.

## Statement of Cash Flows for the Year ended 31 March 2018

| | 2017-18 | 2016-17 |
|---|---|---|
| | £000s | £000s |
| Cash flows from operating activities | | |
| Operating surplus/(deficit) | (4,490) | (8,828) |
| Non-cash income and expense: | | |
| Depreciation and amortisation | 14,079 | 13,729 |
| Net impairments | (2,503) | 11,963 |
| Income recognised in respect of capital donations | (263) | (146) |
| (Increase)/decrease in receivables and other assets | (2,178) | (3,386) |
| (Increase)/decrease in inventories | 575 | 662 |
| Increase/(decrease) in payables and other liabilities | (949) | (6,640) |
| (Increase)/decrease in provisions | (379) | 1,051 |
| Net cash generated from / (used in) operating activities | 3,892 | 8,405 |
| Cash flows from investing activities | | |
| Interest received | 61 | 56 |
| Purchase of intangible assets | (619) | (786) |
| Purchase of property, plant, equipment and investment property | (6,599) | (12,469) |
| Sales of property, plant, equipment and investment property | 1,226 | 712 |
| Receipt of cash donations to purchase capital assets | 263 | 146 |
| Net cash generated from / (used in) investing activities | (5,668) | (12,341) |
| Cash flows from financing activities | | |
| Public dividend capital received | 420 | 6,575 |
| Movement on loans from the Department of Health and Social Care | 18,661 | 26,863 |
| Capital element of finance lease rental payments | (422) | (328) |
| Capital element of PFI, LIFT and other service concession payments | (8,633) | (9,031) |
| Interest paid on finance lease liabilities | (24) | (30) |
| Interest paid on PFI, LIFT and other service concession obligations | (9,664) | (9,954) |
| Other interest paid | (1,654) | (1,390) |
| PDC dividend (paid) / refunded | 0 | 1,435 |
| Net cash generated from / (used in) financing activities | (1,316) | 14,140 |
| | | |
| Increase / (decrease) in cash and cash equivalents | (3,092) | 10,204 |
| Cash and cash equivalents at 1 April - brought forward | 11,286 | 1,082 |
| Cash and cash equivalents at 31 March | 8,194 | 11,286 |

**A full set of the Trust's Financial Accounts 2017/18 is available at www.midyorks.nhs.uk**

# APPENDICES

# Appendix I: Summary of findings - CQC Report published October 2017

The Trust must:

- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels
- Ensure that there is effective escalation and monitoring of deteriorating patients
- Ensure that there is effective assessment of the risk of patients falling
- Ensure that the privacy and dignity of patients being nursed in bays where extra capacity beds are present is not compromised
- Ensure that there is effective monitoring and assessment of patients nutritional and hydration needs to ensure these needs are met
- Ensure that there is a robust assessment of patients' mental capacity in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards
- Ensure that mandatory training levels are meeting the trust standard

The Trust should:

- Ensure that all staff have annual appraisals
- Continue to focus on achieving A&E standards and ensure that improved performance against standard is maintained
- Ensure that records are completed fully and that records are stored securely
- Ensure that staff triage training is robust and that staff carrying out triage are experienced ED clinicians
- Continue to address issues of non-compliance with referral to treatment indicators and the backlog of patients waiting for appointments
- Ensure work to improve the completion of consent forms in line with trust expectations
- Review the risk registers and remove or archive any risks that no longer apply
- Increase local audit activity to encourage continuous improvement
- Ensure it continues to address capacity and demand across all outpatient services
- Consider ways of ensuring team meetings in main outpatients are regular and consistent
- Consider ways of ensuring environmental compliance issues with carpets in departments
- Improve the assessment and recording of patient pain scores
- Ensure there are appropriately qualified or experienced children's nurses in ED
- Undertake clinical audit in ED to ensure that national and local standards of care are being met
- Improve the reliability of the blood diagnostic service
- Ensure that robust recruitment and retention policies continue, to improve staff and skill shortages; with particular emphasis on theatre recruitment
- Ensure staff are aware of the duty of candour regulations
- Ensure prescribers detail the indications for antimicrobials and ensure review dates are adhered to
- Ensure it reviews the compliance with Guidelines for the Provision of Intensive Care Services and the plans to meet the standards
- Ensure appropriate precautions are taken for patients requiring isolation and that the need for isolation is regularly reviewed and communicated to all staff

- Ensure reported incidents are investigated in a robust and timely manner and the current backlog of outstanding incidents are managed safely and concluded
- Ensure staff are informed of lessons learnt from patient harms and patient safety incidents
- Ensure patient bed moves after 10pm are kept to a minimum to avoid unnecessary distress to the patient
- Ensure escalation initiatives and governance processes to support nurse staffing requirements are effective
- Ensure work is undertaken to reduce the number of patients requiring endoscopies being cancelled on the day of their procedure
- Ensure quality and performance is measured effectively
- Ensure it develops and shares with staff a longer term critical care strategy beyond the acute hospital reconfiguration
- Ensure risks are identified and reviewed appropriately
- Ensure staff in maternity services are trained and competent in obstetric emergencies, to include a programme of skills and drills held in all clinical areas
- Ensure visible assurance that all electronic equipment has been safety checked and assurance that staff are competent in the use of all medical devices
- Ensure that all appropriate staff have undergone APLS training
- Work with the non-medical prescribing governance group to ensure that all non-medical prescribers are supported to prescribe within their competencies
- Ensure patients have access to leaflets in alternative formats such as large print, Braille or other languages
- Ensure it completes the outstanding actions remaining from RCEM audits to ensure the quality of care in the department is meeting the RCEM standards
- Ensure that the cross site governance processes introduced in January 2017 become embedded in practice
- Consider an analysis of the increased reporting of clostridium difficile cases across the division
- Ensure all relevant staff are informed of oxygen prescribing standards
- Apply the trust wide pain assessment documentation consistently on wards
- Ensure whiteboards being used at the patient bed head contain the correct information
- Ensure all patients and family members are fully informed and involved in all discharge arrangements and future care discussions at the earliest opportunity
- Consider an analysis of the processes involved in obtaining timely social care assessments for patients on divisional wards
- Consider a review of the current governance processes for the Regional Spinal Unit
- Continue with improvement in staff engagement activity specifically around the acute healthcare reconfiguration and current service demands
- Ensure divisional meetings are quorate and all agenda items are discussed/minuted accordingly
- Improve the proportion of patients having hip fracture surgery on the day or day after admission

- Continue to monitor and improve compliance with the 'Five steps to safer surgery'
- Reduce the management of medical patients on surgical wards
- Reduce the number of patients boarding on PACU and discharging home directly from PACU
- Reduce the usage of extra capacity beds on surgical wards
- Ensure there is evidence of appropriate local induction for agency staff
- Ensure their safeguarding children policy is up to date
- Ensure that staff have regular safeguarding supervision
- Ensure that children have access to child friendly menus
- Consider limiting access to their milk rooms and fridges, to prevent unauthorised access to feeds
- Ensure that staff are following the medicines management policy and that fridge and room temperatures are appropriately recorded
- Ensure that resuscitation equipment is checked daily and appropriately recorded
- Ensure plans for clinical validation across specialties where there are waiting list backlogs are progressed and risks are managed and mitigated
- Audit and report the implementation of the end of life care plan and performance in fast track discharge
- Ensure regular internal performance reporting on End of Life care to directorate or board management to demonstrate improvement in areas such as quality of care, preferred place of death, referral management and rapid discharge of end of life patients
- Ensure VTE risk assessments are completed and the target of 95% is achieved
- Ensure care plans are individualised and reflect the needs of their patients
- Ensure that families who had been discussed at the multi-agency risk assessment panel. (MARAC) are flagged on the electronic system so they can be identified as being at risk of domestic abuse
- Ensure that there is a specific mental health assessment room that meets the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983
- Ensure staff are aware of the NHS Protect guidance on distressed patients to ensure that patients with mental health problems would be treated appropriately
- Ensure a risk assessment is undertaken with regards to access to the staircase via the fire exit on ward 2
- Consider relocating the resuscitation trolley on ward 4 to ensure it can be easily access in an emergency
- Improve the rate of missed medicines doses
- Ensure the use of cameras in critical care is reviewed and in line with trust policy and national guidance
- Ensure that children are recovered from day case surgery in a child friendly environment
- Ensure there are systems in place for the recording of transfer bag checks
- Ensure that emergency drugs are stored in tamper evident containers in resuscitation bags in line with the recommendations of the Resuscitation Council UK
- Ensure that patients receive skin integrity checks in a timely manner
- Ensure that nursing staff at the Wakefield Intermediate Care Unit receive three monthly supervision as per trust policy

- Consider giving further support and training to staff in the application of the Mental Capacity Act
- Continue to work towards nursing records moving from paper to electronic
- Continue to explore facilities that are more suitable from which to provide community health inpatient services
- Ensure that the correct information is extracted from the IT system to record the correct percentage of response times for adult community services
- Ensure that IT systems are available to be able to upload wound photography and wound templates to share with specialists that can review the patient care
- Ensure that the trust completes a transcribing policy for staff to follow when administering prescribed medication
- Ensure that the trust reviews the medication sheets used for administration and adopts one system for all the networks
- .

# Appendix II: Mandatory indicators

Each year, the NHS identifies a range of indicators that all providers of hospital services must report on in the Quality Account. The indicators below are those that we are required to report on in 2017/18.

## Summary Hospital Level Mortality Indicators

The Trust considers this data is as described for the following reasons:

- The Trust Mortality Review Group continues to meet and reports regularly to the Trust's Quality Committee. The Group's function is to monitor and analyse mortality data in order to fully understand the basis for the results. This group has carried out a number of deep dive analyses of mortality rates within specific conditions and have tasked operational services with identifying improvement actions to meet the findings of these analyses.

- The Trust has taken a number of actions to improve the accuracy of data submitted from which mortality rates are calculated including improving palliative care coding rates. A number of other actions have also been taken including continuing to roll out Structured Judgement Review training to clinicians, strengthening palliative care services and improving the response to deteriorating patients. The Trust continues to use VitalPac as the system for recording and tracking nursing observations.

| Core indicator | Mid Yorkshire Hospitals NHS Trust<br><br>April 16 – March 17 | Mid Yorkshire Hospitals NHS Trust<br><br>June 16 – June 17 | National Average | Other trusts- best | Other trusts - worst |
|---|---|---|---|---|---|
| Summary Hospital level Mortality Indicator (SHMI) value | 99.36 | 98.27 | - | 72.61 | 122.77 |
| SHMI banding | As expected | As expected | - | Lower than expected | Higher than expected |
| Percentage of patient deaths with palliative care coded at either diagnosis or specialty level | 22.8% | 24.2% | 31.1% | 11.2% | 58.6% |

## Patient Reported Outcome Measures (PROMS)

**The patient reported outcome score for groin hernia**
Provisional data for April 2016 to March 2017 shows an improvement in PROMs score from 2015/16 for groin hernia based on the EQ-5D Index metric and the Trust is reporting a score at the national average. The Mid Yorkshire Hospitals NHS Trust will continue to review the patient pathway to improve this score and so the quality of its services.

**The patient reported outcome measures scores (PROMS) for varicose vein surgery**
Provisional data for April 2016 to March 2017 shows an improvement in scores from 2015/16 although below national average performance. The Mid Yorkshire Hospitals NHS Trust will continue to review the patient pathway to improve this score and so the quality of its services.

**The patient reported outcome measures scores (PROMS) for hip replacement surgery.**
Provisional data for April 2016 to March 2017 shows a decrease in scores from 2015/16 and remains below national average performance. The Mid Yorkshire Hospitals NHS Trust will continue to review the patient pathway to improve this score and so the quality of its services.

**The patient reported outcome measures scores (PROMS) for knee replacement surgery.**
Provisional data for April 2016 to March 2017 shows the Trust's PROMs scores for knee replacement surgery have decreased from the 2015/16 reported figures but are still above national average. The Mid Yorkshire Hospitals NHS Trust will continue to review the patient pathway to improve this score and so the quality of its services.

## Patient Reported Outcome Measures (PROMS)

| Core indicator | Mid Yorkshire Hospitals NHS Trust April 15 – March 16 | Mid Yorkshire Hospitals NHS Trust April 2016 – March 17* | National Average | Other trusts - Best | Other trusts - Worst |
|---|---|---|---|---|---|
| **Adjusted average health gain: groin hernia surgery** | | | | | |
| EQ - 5D Index | 0.08 | 0.09 | 0.09 | 0.14 | -0.01 |
| EQ VAS | -1.67 | 0.91 | -0.25 | 3.32 | -6.55 |
| **Adjusted average health gain: varicose vein surgery** | | | | | |
| EQ – 5D Index | 0.15 | 0.11 | 0.09 | 0.15 | 0.02 |
| EQ VAS | -2.23 | 0.59 | 0.21 | 5.91 | -4.59 |
| Aberdeen score | -13.34 | -12.46 | -8.26 | 1.54 | -18.01 |
| **Adjusted average health gain: hip replacement surgery** | | | | | |
| EQ VAS | 12.73 | 10.43 | 13.4 | 20.43 | 8.37 |
| EQ – 5D Index | 0.46 | 0.40 | 0.44 | 0.54 | 0.3 |
| Oxford Hip Score | 21.60 | 20.73 | 21.77 | 54.89 | 16.45 |
| **Adjusted average health gain: knee surgery** | | | | | |
| EQ VAS | 3.96 | 5.06 | 6.98 | 14.68 | 2.02 |
| EQ – 5D Index | 0.32 | 0.31 | 0.32 | 0.4 | 0.25 |
| Oxford Knee Score | 17.10 | 16.63 | 16.52 | 19.86 | 12.06 |

*Provisional data published by NHS Digital

## Percentage of Patients aged 0-15 and 16 or over readmitted within 28 days

The latest information available through NHS Digital for the percentage of patients readmitted to a hospital within 28 days of discharge remains as 2011/12, the same as last year. The Trust has therefore taken a decision to use and publish data made available through Dr Foster Intelligence. This shows that for the 0-15 age range 9.9% of patients were readmitted during the 28 days period post-discharge which represents and improvement in performance from data reported last year. It is still felt that this performance relates slightly to the coding of patients seen with the Children's Assessment Unit and the coding of activity within this unit will be reviewed. For patients aged 16 and over the Trust performance has improved throughout the year and now is very close to national average.

| Core indicator | Mid Yorkshire Hospitals NHS Trust 2016/17 | Mid Yorkshire Hospitals NHS Trust April 2017 – July 2017 | National Average | Other trusts – Best | Other trusts - Worst |
|---|---|---|---|---|---|
| Percentage of patients **aged 0-15** readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period | 9.9% | 10.0% | 8.6% | 3.2% | 14.5% |
| Percentage of patients **aged 16 or over** readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period | 8.5% | 8.5% | 8.4% | 6.3% | 11.0% |

## Responsiveness to the personal needs of patients

| Core indicator | MYHT 2015/16 | MYHT 2016/17 | National Average | Other Trusts - Best | Other Trusts - Worst |
|---|---|---|---|---|---|
| Trust's responsiveness to the personal needs of patients (score out of 100) | 73.0% | 73.4% | 76.7% | 88.0% | 70.7% |

The data shown is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals. The Trust is supported in carrying out the survey by The Picker Institute which is approved by the CQC to undertake this survey work. The Trusts score shows a slight improvement but remains below the national average.

The Patient, Family and Carer Experience action plan, developed by the Patient Experience Sub Committee, aims to achieve improvements against the Trust's priorities for improvement. The focus is on further developing skills in understanding and improving the relational experience of patients, families and carers. Questions relating to these priorities have been added to the Inpatient Friends and Family Test (FFT) in order to identify information on a monthly basis and monitor the impact of change over time.

## Staff who would recommend the Trust to their Friends and Family

| Core indicator | Mid Yorkshire Hospitals NHS Trust 2016 | Mid Yorkshire Hospitals NHS Trust 2017 | National average | Other Trusts – Best | Other Trusts - Worst |
|---|---|---|---|---|---|
| Staff Friends and Family – Staff who would recommend the Trust as a provider of care to their family or friends | 49.2% (unweighted) | 49.6% (unweighted) | 68.4% (unweighted) | 89.3% (unweighted) | 48.1% (unweighted) |

**NB. National average and Other Trusts Best and Worst for Combined Acute and Community Trusts**

### Patients who would recommend the Trust to their family or friends

| Core indicator | Mid Yorkshire Hospitals NHS Trust November 2017 | Mid Yorkshire Hospitals NHS Trust December 2017 | National average | Other trusts – Best | Other trusts - Worst |
|---|---|---|---|---|---|
| A & E Friends and Family Test - Percentage of patients who would recommend the Trust as a provider of similar treatment or care to their family or friends | 95% | 93% | 85% | 100% | 57% |

This data is based on patients attending the Trust Emergency Department services. The Trust is supported in carrying out the survey by The Picker Institute and reported by NHS England. The data shows that the Trust score remains well above the national average. This is the Trust's score based on a single question in the Friends and Family survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The Trust continues to monitor and encourage participation in the national Friends and Family Test (FFT). Actions identified within service, Divisional and Trust level actions plans aim to achieve improvements in patient experience against priorities for improvement, which will be reflected in the Trust's FFT 'recommend' score.

## Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

The Trust has consistently reported achievement on a monthly and quarterly basis the performance standards set out in the NHS Standard Contract relating to the risk assessment for VTE of patients admitted to our hospitals. The Trust has a reporting system in place, which allows analysis of performance at divisional, and ward level. Work continues to ensure that systems and processes remain fit for purpose and a number of improvement actions have been identified.

| Core indicator | Mid Yorkshire Hospitals NHS Trust Q1 2017/18 | Mid Yorkshire Hospitals NHS Trust Q2 2017/18 | National average | Other trusts – Best | Other trusts - Worst |
|---|---|---|---|---|---|
| Percentage of patients admitted to hospital and who were risk assessed for VTE during the reporting period | 95.5% | 95.38% | 95.25% | 100% | 71.88% |

## Rate of C Difficile Infections (CDI)

The national objective for CDI for 2017/18 remains at no more than 27 Trust attributed cases. At the end of December 2017 the Trust had reported 25 Trust attributed CDI cases. This is a decrease of 7 cases from the previous reporting year. 17 of the cases were deemed not preventable, 6 preventable cases and 2 cases remained in the review process at the end of December 2017. A post infection review (PIR) is undertaken on all cases of CDI and reviewed with Health Economy colleagues, on behalf of the Wakefield and Kirklees Clinical Commissioning Groups (CCG). It is at this review where a decision on preventable/not preventable is made dependent upon whether a lapse in care has been identified and contributed to the development of the infection. Learning from cases has been shared through the divisional infection prevention and control meeting. In addition, 2 CDI summits have been held within the Trust where learning has been shared and improvement pledges made.

| Core indicator | Mid Yorkshire Hospitals NHS Trust 2015/16 | Mid Yorkshire Hospitals NHS Trust 2016/17 | National average | Other trusts – Best | Other trusts - Worst |
|---|---|---|---|---|---|
| Rate per 100,000 bed days of cases of C.Difficile infections reported within the Trust amongst patients aged two years and over during the reporting period | 11.1 | 13.3 | 13.2 | 0.0 | 82.7 |

## Patient Safety incidents

The Trust considers that this data is as described for the following reasons: The data reflects incidents reported to the National Patient Safety Agency over a given period. The Trust has a dedicated Quality and Safety team that is responsible for the identification and investigation of Serious Incidents (SI's) that occur within the Trust. The guidance for such investigations is the NHS England Serious Incident Framework (2015) which stipulates best practice for investigations – the Trust policy reflects this. The Trust Policy was updated in 2018. There is no definitive list of events/incidents that constitute a serious incident, each must be considered on an individual case-by-case basis. Outcome alone is not always enough to delineate what counts as a serious incident. The exception is the Trust has locally agreed that the following will be reported as serious incidents:

- All category three and four pressure ulcers
- Falls resulting in fractured neck of femur, cerebral haemorrhage or death

Patient safety incidents are reported via Datix (electronic incident reporting system) and these incidents are reviewed by the relevant clinical governance team. The Quality and Safety Team also produce a daily report which highlights any moderate and above incidents that have occurred.

| Related NHS outcomes framework domain | Prescribed information | Mid Yorkshire Hospitals NHS Trust Oct 16 – Mar 17 | Mid Yorkshire Hospitals NHS Trust Apr 17 – Sept 17 | National average | Other trusts – Best | Other trusts - Worst |
|---|---|---|---|---|---|---|
| Treating and caring for people in a safe environment and protecting them from avoidable harm | Patient safety incidents and those that resulted in severe harm or death | | | | | |
| | Number of incidents reports (all harm) | 8,294 | 8,218 | - | - | - |
| | Rate per 1,000 occupied bed days (all harm) | 48.63 | 48.04 | 42.23 | 23.47 | 111.69 |
| | Number that resulted in severe harm or death | 26 | 22 | - | - | - |
| | Percentage that resulted in severe harm or death | 0.31% | 0.27% | 0.35% | 0.00% | 1.98% |

**N.B National average and Other Trusts Best and Worst for Acute (Non Specialist) Trusts**

# Appendix III: Statement of director's 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 (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality Account, directors should take steps to assure themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the reporting period.
- 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 they are working effectively in practice.
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with any Department of Health guidance.

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

By order of the Board,

Jules Preston
Chairman

Martin Barkley
Chief Executive

## Appendix IV: Glossary of terms

**Board / Board of Directors:** The trust is run by the Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services it manages.

**Care Quality Commission (CQC):** the independent regulator of health and social care in England who regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, local authorities, private companies and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

**Clinical Commissioning Groups (CCGs):** NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

**Clostridium Difficile:** a species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

**Commissioners:** The organisations that have responsibility for buying health services on behalf of the population of the area work for.

**Commissioning for Quality and Innovation (CQUIN):** is a payment framework such that a proportion of NHS providers' income is conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle**.**

**Data Protection Act 1998:** The law that regulates storage of and access to data about individual people.

**DATIX:** electronic system for collecting data about clinical, health and safety and information governance incidents.

**Duty of Candour:** From 27 November 2014 all NHS bodies are legally required to meet the Duty of Candour. This requires healthcare providers to be open and transparent with those who use their services in relation to their care and treatment, and specifically when things go wrong

**Emergency readmissions:** unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission.

**Freedom of Information Act 2000:** A law that outlines the rights that the public have to request information from public bodies (other than personal information covered by the Data Protection Act), the timescales they can expect to receive the information, and the exemptions that can be used by public bodies to deny access to the requested information.

**Friends and Family Test:** A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend of family member if they needed that kind of treatment.

**General Medical Practice Code:** is the organisation code of the GP Practice that the patient is registered with. This is used to make sure that our patients' GP practice is recorded correctly.

**Health and Wellbeing Boards:** The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way.

**Healthwatch:** local bodies made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

**Hospital Episode Statistics (HES):** is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

**Hospital Standardised Mortality Ratio (HSMR)** – an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for.

**Information Governance Toolkit & Assessment Report:** is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

**Methicillin-resistant Staphylococcus aureus (MRSA):** is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is especially troublesome in hospitals, prisons and nursing homes, where patients with open wounds, invasive devices, and weakened immune systems are at greater risk of infection than the general public.

**Multi-agency:** this means that more than one provider of services is involved in a decision or a process.

**National Confidential Inquiries (NCI) and National Clinical Audit:** research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. Supported by a national programme of audit.

**National Institute for Clinical Excellence (NICE):** NHS body that provides guidance, sets quality standards and manages a national database to improve 83

**National Institute for Health Research (NIHR):** an NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of patients and the public.

**National Reporting and Learning System (NRLS):** The National Reporting and Learning System (NRLS) is a central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously 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.

**NHS Digital**: the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care**.**

**NHS Staff Survey:** an annual survey of staffs' experience of working within NHS Trusts.

**Overview & Scrutiny Committees (OSCs):** These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area.

**Patient Advice & Liaison Team (PALs):** The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

**Patient reported outcome measures (PROMs**): tools we use to measure the quality of the service we provide for specific surgical procedures. They involve patients completing two questionnaires at two different time points, to see if the procedure has made a difference to their health.

**Patient safety incident:** any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care as defined by the National Patient Safety Agency.

**Payment by Results (PBR):** a new system being implemented across the NHS, and piloted in mental health Trusts, to provide a transparent, rules-based system for paying NHS Trusts. The system aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity, adjusted for case-mix, and outcomes. Importantly, this system aims to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

**PPI:** Patient and Public Involvement.

**Pressure ulcer:** a type of injury that affect areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

**Project:** A one-off, time limited piece of work that will produce a product (such as a new building, a change in a service or a new Strategy / policy) that will bring benefits to relevant stakeholders.

**Quality Account:** A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider.

**Quality Committee:** sub-committee of the Trust Board responsible for quality and assurance.

**Quality Improvement Strategy:** This is a Trust Strategy. The current Strategy covers 2015 – 2019. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps the Trust continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable

**Quality Risk Profile Reports:** The Care Quality Commission's (CQC) tool for providers, commissioners and CQC staff to monitor provider's compliance with the essential standards of quality and safety.

**Root Cause Analysis (RCA):** a technique employed during an investigation that systematically considers the factors that may have contributed to the incident and seeks to understand the underlying causal factors.

**Safety thermometer:** a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. It provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time. The safety thermometer records pressure ulcers, falls, catheters with urinary tract Infections and venous thromboembolisms (VTEs).

**Serious Untoward Incidents (SUIs):** defined as an incident that occurred in relation

**Stakeholder:** a person, group, organisation, member or system who affects or can be affected by an organisation's actions.

**Trust Board:** See 'Board / Board of Directors'.

**Trust wide:** This means across the whole geographical area served by the Trust.

**Unexpected Death:** a death that is not expected due to a terminal medical condition or physical illness.

**Urinary tract infection (UTI):** an infection that can happen anywhere along the urinary tract. Urinary tract infections have different names, depending on what part of the urinary tract is infected. They are caused by bacteria entering the urethra and then the bladder which can lead to infection.

**Venous thromboembolism (VTE):** a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood. A blood clot can occur anywhere in the body's bloodstream. There are two main types; venous thromboembolism (VTE) which is a blood clot that develops in a vein; and arterial thrombosis which is a blood clot that develops in an artery.

**WHO checklist:** The World Health Organization Surgical Safety Checklist was introduced in 2008 to increase the safety of patients undergoing surgery. The checklist ensures that surgical teams have completed the necessary listed tasks to ensure patient safety before proceeding with surgery.

The Mid Yorkshire Hospitals
NHS Trust

# Mid Yorkshire Hospitals NHS Trust

## Annual accounts for the period

## 1 April 2017 to 31 March 2018

Chairman - **Jules Preston MBE**

Chief Executive - **Martin Barkley**

# Statement of Comprehensive Income

| | Note | 2017/18 £000 | 2016/17 £000 |
|---|---|---|---|
| Operating income from patient care activities | 4 | 464,543 | 458,158 |
| Income in respect of legacy financial support | 4 | 2,520 | 3,900 |
| Other operating income | 5 | 38,521 | 42,396 |
| Employee Benefits | 6, 8 | (332,982) | (323,953) |
| Other Operating expenses | 6 | (179,595) | (177,366) |
| Reversal of impairments/(impairments) | 6 | 2,503 | (11,963) |
| **Operating surplus/(deficit) from continuing operations** | | **(4,490)** | **(8,828)** |
| Finance income | 11 | 46 | 56 |
| Finance expenses | 12 | (11,385) | (11,399) |
| PDC dividends payable | | - | - |
| **Net finance costs** | | **(11,339)** | **(11,343)** |
| Other gains / (losses) | 13 | (25) | 283 |
| **Surplus / (deficit) for the year from continuing operations** | | **(15,854)** | **(19,888)** |
| **Surplus / (deficit) for the year** | | **(15,854)** | **(19,888)** |
| **Other comprehensive income** | | | |
| Reversal of impairments/(impairments) | 7 | 265 | (38,544) |
| Revaluations | 17 | - | 17,005 |
| **Total comprehensive income / (expense) for the period** | | **(15,589)** | **(41,427)** |

A NHS Trust's reported financial performance is assessed on its retained surplus/deficit adjusted for items that the Department of Health and Social Care does not consider to be part of the organisation's performance and is included in note 38.

The notes on pages 5 to 44 form part of this account.

# Statement of Financial Position

| | Note | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 14 | 1,910 | 2,402 |
| Property, plant and equipment | 15 | 379,649 | 381,956 |
| **Total non-current assets** | | **381,559** | **384,358** |
| **Current assets** | | | |
| Inventories | 19 | 7,654 | 8,229 |
| Trade and other receivables | 20 | 22,148 | 19,985 |
| Non-current assets held for sale | 21 | - | 1,250 |
| Cash and cash equivalents | 22 | 8,194 | 11,286 |
| **Total current assets** | | **37,996** | **40,750** |
| **Current liabilities** | | | |
| | 23 | (34,228) | (34,507) |
| Borrowings | 25 | (28,973) | (9,971) |
| Provisions | 27 | (1,586) | (1,608) |
| Other liabilities | 24 | (2,013) | (1,623) |
| **Total current liabilities** | | **(66,800)** | **(47,709)** |
| **Total assets less current liabilities** | | **352,755** | **377,399** |
| **Non-current liabilities** | | | |
| Borrowings | 25 | (330,974) | (340,110) |
| Provisions | 27 | (6,691) | (7,030) |
| **Total non-current liabilities** | | **(337,665)** | **(347,140)** |
| **Total assets employed** | | **15,090** | **30,259** |
| **Financed by** | | | |
| Public dividend capital | | 203,139 | 202,719 |
| Revaluation reserve | | 35,481 | 37,107 |
| Other reserves | | 2,685 | 2,685 |
| Income and expenditure reserve | | (226,215) | (212,252) |
| **Total taxpayers' equity** | | **15,090** | **30,259** |

The notes on pages 5 to 44 form part of these accounts.

The financial statements were approved by the Board on 24th May 2018 and signed on its behalf by

Chief Executive Martin Bolsley Date: 24/5/18

## Statement of Changes in Equity for the year ended 31 March 2018

| | Public dividend capital £000 | Revaluation reserve £000 | Other reserves £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|---|
| **Taxpayers' equity at 1 April 2017 - brought forward** | **202,719** | **37,107** | **2,685** | **(212,252)** | **30,259** |
| Surplus/(deficit) for the year | - | - | - | (15,854) | **(15,854)** |
| Other transfers between reserves | - | (654) | - | 654 | **-** |
| Reversal of impairments/(impairments) | - | 265 | - | - | **265** |
| Transfer to retained earnings on disposal of assets | - | (1,237) | - | 1,237 | **-** |
| Public dividend capital received | 420 | - | - | - | **420** |
| **Taxpayers' equity at 31 March 2018** | **203,139** | **35,481** | **2,685** | **(226,215)** | **15,090** |

In 2017/18, the Trust received £220k of permanent Public Dividend Capital (PDC) for cyber security and £200k for West Yorkshire and Humber Cancer Alliance digital pathology scheme.

## Statement of Changes in Equity for the year ended 31 March 2017

| | Public dividend capital £000 | Revaluation reserve £000 | Other reserves £000 | Income and expenditure reserve £000 | Total £000 |
|---|---|---|---|---|---|
| **Taxpayers' equity at 1 April 2016 - brought forward** | **196,144** | **59,569** | **2,685** | **(193,287)** | **65,111** |
| Surplus/(deficit) for the year | - | - | - | (19,888) | **(19,888)** |
| Other transfers between reserves | - | (923) | - | 923 | **-** |
| Impairments | - | (38,544) | - | - | **(38,544)** |
| Revaluations | - | 17,005 | - | - | **17,005** |
| Public dividend capital received | 6,575 | - | - | - | **6,575** |
| **Taxpayers' equity at 31 March 2017** | **202,719** | **37,107** | **2,685** | **(212,252)** | **30,259** |

In 2016/17, the Trust received £5,000k of permanent Public Dividend Capital (PDC) in return for the revenue to capital transfer in 2015/16, £975k for the acute hospital reconfiguration and £600k for West Yorkshire Acceleration Zone.

**Information on reserves**

**Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to the DHSC as the PDC dividend.

**Revaluation reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

**Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

**Other Reserves**
This represents the net value of assets transferred from the reconfiguration of healthcare trusts in 2002/2003.

# Statement of Cash Flows

| | Note | 2017/18 £000 | 2016/17 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus / (deficit) | | (4,490) | (8,828) |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 6 | 14,079 | 13,729 |
| Net impairments | 7 | (2,503) | 11,963 |
| Income recognised in respect of capital donations | 5 | (263) | (146) |
| (Increase) / decrease in receivables and other assets | | (2,178) | (3,386) |
| (Increase) / decrease in inventories | | 575 | 662 |
| Increase / (decrease) in payables and other liabilties | | (949) | (6,640) |
| Increase / (decrease) in provisions | | (379) | 1,051 |
| **Net cash generated from / (used in) operating activities** | | **3,892** | **8,405** |
| **Cash flows from investing activities** | | | |
| Interest received | | 61 | 56 |
| Purchase of intangible assets | | (619) | (786) |
| Purchase of property, plant, equipment and investment property | | (6,599) | (12,469) |
| Sales of property, plant, equipment and investment property | | 1,226 | 712 |
| Receipt of cash donations to purchase capital assets | | 263 | 146 |
| **Net cash generated from / (used in) investing activities** | | **(5,668)** | **(12,341)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 420 | 6,575 |
| Movement on loans from the Department of Health and Social Care | | 18,661 | 26,863 |
| Capital element of finance lease rental payments | | (422) | (328) |
| Capital element of PFI | | (8,633) | (9,031) |
| Interest paid on finance lease liabilities | | (24) | (30) |
| Interest paid on PFI | | (9,664) | (9,954) |
| Other interest paid | | (1,654) | (1,390) |
| PDC dividend (paid) / refunded | | - | 1,435 |
| **Net cash generated from / (used in) financing activities** | | **(1,316)** | **14,140** |
| **Increase / (decrease) in cash and cash equivalents** | | **(3,092)** | **10,204** |
| **Cash and cash equivalents at 1 April - brought forward** | | **11,286** | **1,082** |
| **Cash and cash equivalents at 31 March** | 22 | **8,194** | **11,286** |

## Notes to the Accounts

### 1 Accounting policies and other information

#### 1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

#### 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

#### 1.1.2 Going concern

These accounts have been prepared on a going concern basis. See Note 2.

#### 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Pinderfields and Pontefact Hospitals, constructed under the Private Finance Initiative (PFI), meet the criteria for inclusion in the financial statements as Finance Leases as the Trust bears the risks and rewards of ownership. See paragraphs 1.13 Leases and 1.7.5 PFI transactions.

#### 1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Plant, Property and Equipment - Paragraph 1.7 and Note 15.1
- PFI - Paragraph 1.7.5 and Note 30.2
- Provision for Impairment of Receivables - Note 20.2
- Provisions - Paragraph 1.14 and Note 27.1

#### 1.3 Interests in other entities

**Joint operations**

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

### 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred. Maternity pathways and incomplete spells are recognised in the year of receipt.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

**Revenue grants and other contributions to expenditure**
Government grants are from government bodies other than commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

### 1.5 Expenditure on employee benefits

**Short-term employee benefits**
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust provides certain employees, who are not enrolled into the NHS Pensions Scheme, with cover from the defined contributions scheme which is managed by the National Employment Savings Trust (NEST). The cost to the Trust is taken as equal to the contributions payable to the scheme for the accounting period.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

### 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

**1.7 Property, plant and equipment**

**1.7.1 Recognition**
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

**1.7.2 Measurement**
**Valuation**
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- land and non-specialised buildings – market value for existing use
- specialised buildings – depreciated replacement cost, modern equivalent asset basis

PFI assets are valued net of VAT and in accordance with the Trust's approach for each relevant asset class.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

**Subsequent expenditure**
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Depreciation**
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

**Revaluation gains and losses**
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

**Impairments**
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

**1.7.3 Derecognition**
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**1.7.4 Donated and grant funded assets**
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

**1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions**
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary, the payment for the:

- fair value of services received
- PFI asset, including finance costs
- replacement of components of the asset during the contract 'lifecycle replacement'

**Services received**

The cost to the Trust of services received in the year is recorded within 'operating expenses' under 'other'.

**PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

**PFI liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

**Lifecycle replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are not expected to meet the Trust's criteria for capital expenditure. Lifecycle replacement costs are recognised as an expense as a proxy to depreciation.

**Assets contributed by the Trust to the operator for use in the scheme**

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

**Other assets contributed by the Trust to the operator**

Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

### 1.7.6 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Land | - | - |
| Buildings, excluding dwellings | 2 | 90 |
| Dwellings | 30 | 80 |
| Plant & machinery | 3 | 25 |
| Transport equipment | 5 | 10 |
| Information technology | 2 | 10 |
| Furniture & fittings | 5 | 15 |

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

### 1.8 Intangible assets

### 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

**Internally generated intangible assets**

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset, and
- the Trust can measure reliably the expenses attributable to the asset during development.

**Software**

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

**1.8.2 Measurement**
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

**Amortisation**
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

**1.8.3 Useful economic lives of intangible assets**
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Software licences | 2 | 10 |

**1.9 Inventories**
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method or the weighted average cost method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

**1.10 Cash and cash equivalents**

Cash is 'cash in hand' and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

**1.11 Carbon Reduction Commitment scheme (CRC)**
The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme and is required to surrender to the Government an allowance for every tonne of CO2 emitted during the financial year. A liability and a related expense are recognised in respect of this obligation as CO2 emissions are made.

**1.12 Financial instruments and financial liabilities**

**Recognition**
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial liabilities in respect of assets acquired through finance leases are recognised and measured in accordance with the accounting policy for leases described above

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

**De-recognition**
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

**Classification and measurement**

**Financial Assets**
Financial assets are categorised receivables. Receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

**Financial liabilities**
Financial liabilities are classified as other financial liabilities. All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

**Impairment of financial assets**
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Trade receivables are reviewed for impairment on an individual basis, depending on the size of the receivable and the period for which it is overdue. Where trade receivables are estimated to be less than their carrying values, provisions have been made to write them down to their estimated recoverable amounts.

### 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

#### 1.13.1 The Trust as lessee

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is derecognised when the liability is discharged, cancelled or expires.

**Operating leases**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

### 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

**Clinical negligence costs**

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 27.2 but is not recognised in the Trust's accounts.

**Non-clinical risk pooling**

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

**1.15 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

**1.16 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:
• donated assets (including lottery funded assets)
• average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
• any PDC dividend balance receivable or payable

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

**1.17 Value added tax**

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

**1.18 Foreign exchange**

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**1.19 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

**1.20 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

**1.21 Early adoption of standards, amendments and interpretations**
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

**1.22 Standards, amendments and interpretations in issue but not yet effective or adopted**
The following standards have been issued but are not yet effective or adopted for the public sector:

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. Most contract income is for commisioned services with the Trusts local CCGs, Wakefeld CCG and North Kirklees CCG. Due to the fixed nature of these contracts and the fact the relate to the same financial year, it is not anticipated this standard will have a material effect
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted

**2 Going concern**
The accounting concept of Going Concern refers to the basis on which an organisations assets and liabilities are recorded and included in the accounts. If an organisation is a going concern, it is expected to operate indefinitely and not go out of business or liquidate its assets in the foreseeable future.

Under International Financial Reporting Standards, management are required to assess, as part of the accounts process, the Trust's ability to continue as a going concern. For public sector entities, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern. DH group bodies must prepare their accounts on a going concern basis unless informed by the relevant national body or DH sponsor of the intention for dissolution without transfer of services or function to another entity.

In preparing the financial statements on a going concern basis the directors have considered the Trust's overall financial position and expectations of future financial support. The Trust is in regular dialogue with NHS Improvement, the Board receives and reviews financial reports in respect of the financial position, cashflow and statement of financial position.

The Trust closed the year with a cash balance of £8.2m and positive net assets of £10.2m. The classifications of borrowings are stated within current and non-current liabilities based on the contractual terms of the current agreements and not the expected dates of repayment.

Further areas considered by the Trust in demonstrating it is a going concern were:

- NHS Improvement's support in the Trust's financial plan for 2018/19 to deliver a deficit of £5.4m.
- the continuation of services included within aligned incentive contracts agreed with the lead commissioners including, Wakefield CCG and North Kirklees CCG.
- the Trust's commitment to deliver cost improvement savings of £24.0m, a Programme Management Office is established to support the delivery of this target.
- cash support from the Department of Health and Social Care in 2018/19 to maintain in-year liquidity included within the plan.

The matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate. Based on these indications the directors believe that it remains appropriate to prepare the financial statements on a going concern basis.

**3 Operating Segments**

All of the Trust's activities are in the provision of healthcare, which is an aggregate of the individual specialty components included therein. The majority of the Trust's revenue originates from the UK Government and expenditure mainly relates to staff costs, supplies and overheads. The activities which earn revenue and incur expenses are of one broad, combined nature to deliver healthcare.

The Trust's chief operating decision maker is deemed to be the Board. The finance report considered monthly by the Board contains summary figures for the whole Trust together with divisional budgets and their cost improvement plans. The statement of financial position, statement of comprehensive income and cash flow statement are considered for the Trust as a whole. Therefore one segment of healthcare is considered in its decision making process.

The single segment of 'healthcare' is deemed appropriate and is consistent with the core principles of IFRS8 to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

## 4 Operating income from patient care activities

### 4.1 Income from patient care activities (by nature)

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| **Acute services** | | |
| Elective income | 68,658 | 66,100 |
| Non elective income | 146,453 | 144,057 |
| First outpatient income | 29,281 | 28,858 |
| Follow up outpatient income | 38,536 | 38,567 |
| A & E income | 28,899 | 26,303 |
| High cost drugs income from commissioners (excluding pass-through costs) | 26,823 | 28,859 |
| Other NHS clinical income | 96,202 | 100,381 |
| **Community services** | | |
| Community services income from CCGs and NHS England | 25,500 | 23,071 |
| Income from other sources (e.g. local authorities) | 172 | 542 |
| **All services** | | |
| Private patient income | 16 | 85 |
| Other clinical income | 6,523 | 5,235 |
| **Total income from activities** | **467,063** | **462,058** |

### 4.2 Income from patient care activities (by source)

| Income from patient care activities received from: | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| NHS England | 50,116 | 44,472 |
| Clinical commissioning groups | 409,419 | 399,939 |
| Department of Health and Social Care | - | - |
| Other NHS providers | 754 | 628 |
| NHS other | - | 104 |
| Local authorities | 482 | 8,321 |
| Non-NHS: private patients | 16 | 85 |
| Non-NHS: overseas patients (chargeable to patient) | 103 | 187 |
| NHS injury scheme | 2,485 | 2,409 |
| Non NHS: other | 1,168 | 2,013 |
| **Total income from activities before support** | 464,543 | 458,158 |
| Income in respect of legacy financial support | 2,520 | 3,900 |
| **Total income from activities** | **467,063** | **462,058** |
| **Of which:** | | |
| Related to continuing operations | 467,063 | 462,058 |
| Related to discontinued operations | - | - |

Revenue from patient care activities includes £2,520k (2016/17: £3,900k) of legacy financial support from local commissioners.

Injury cost recovery income is subject to a provision for impairment of receivables of 22.8% (2016/17: 22.9%) to reflect expected rates of collection.

### 4.3 Overseas visitors (relating to patients charged directly by the provider)

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Income recognised this year | 103 | 187 |
| Cash payments received in-year | 50 | 51 |
| Amounts added to provision for impairment of receivables | 47 | 100 |
| Amounts written off in-year | 3 | 29 |

### 5 Other operating income

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Research and development | 1,678 | 1,845 |
| Education and training | 13,602 | 13,105 |
| Receipt of capital grants and donations | 263 | 146 |
| Charitable and other contributions to expenditure | 287 | 315 |
| Non-patient care services to other bodies | 5,034 | 4,110 |
| Sustainability and transformation fund income | 7,441 | 11,864 |
| Rental revenue from operating leases | 607 | 505 |
| Income in respect of staff costs where accounted on gross basis | 353 | 258 |
| | 9,256 | 10,248 |
| **Total other operating income** | **38,521** | **42,396** |
| **Of which:** | | |
| Related to continuing operations | 38,521 | 42,396 |
| Related to discontinued operations | - | - |

Sustainability and Transformation Fund was available in 2017/18 and 2016/17 for the NHS. These funds were linked to the achievement of financial and performance targets. The Trust failed to meet its financial target and some elements of the performance fund and did not receive its full allocation of £13,515k (2016/17: £16,700k)

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. Income generation activities are not considered to be material and no one activity had a full cost over £1m.

## 6 Operating expenditure

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| **6.1 Operating expenses - other** | | |
| Purchase of healthcare from NHS and DHSC bodies | 402 | 257 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 4,450 | 1,896 |
| Remuneration of non-executive directors | 85 | 84 |
| Supplies and services - clinical (excluding drugs costs) | 37,076 | 37,324 |
| Supplies and services - general | 4,048 | 4,112 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 43,201 | 44,549 |
| Inventories written down | 70 | 37 |
| Consultancy costs | 433 | 1,841 |
| Establishment | 4,252 | 4,570 |
| | 16,671 | 18,339 |
| Transport (including patient travel) | 378 | 257 |
| Depreciation on property, plant and equipment | 13,245 | 12,804 |
| Amortisation on intangible assets | 834 | 925 |
| Increase/(decrease) in provision for impairment of receivables | 817 | 731 |
| Change in provisions discount rate(s) | 81 | 585 |
| Audit fees payable to the external auditor- statutory audit | 85 | 85 |
| Internal audit costs | 137 | 138 |
| Clinical negligence | 19,065 | 17,332 |
| Legal fees | 515 | 779 |
| Insurance | 499 | 491 |
| Education and training | 889 | 904 |
| Rentals under operating leases | 495 | 399 |
| Charges to operating expenditure for on-SoFP IFRIC 12 schemes - PFI | 30,395 | 27,676 |
| Hospitality | 37 | 49 |
| Other | 1,435 | 1,202 |
| **Other Operating Expenses** | **179,595** | **177,366** |
| **Employee Benefits** | **332,982** | **323,953** |
| **Net impairments** | **(2,503)** | **11,963** |
| **Total** | **510,074** | **513,282** |
| **Of which:** | | |
| Related to continuing operations | 510,074 | 513,282 |
| Related to discontinued operations | - | - |

In 2017/18 Trust revalued its land and buildings as at 31 March (2016/17: at 1 April 2016 and 31 March 2017). The valuations are on a modern equivalent asset basis with the revalued assets having the same service potential as the existing ones. The valuations resulted in a net reversal of impairments of £2,503k in 2017/18 and an impairment in 2016/17 of £11,963k, see note 7.

### 6.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

## 7 Impairment of assets

| 7.1 Analysis of Impairments and reversal of impairments | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| **Net impairments charged to operating surplus / deficit resulting from:** | | |
| Loss or damage from normal operations | 4 | 23 |
| Changes in market price | (2,507) | 11,940 |
| **Total net impairments charged to operating surplus / deficit** | **(2,503)** | **11,963** |
| (Reversal of impairments)/impairments charged to the revaluation reserve | (265) | 38,544 |
| **Total net impairments** | **(2,768)** | **50,507** |

### 7.2 Events and circumstances giving rise to impairments and reversal of impairments

| 2017/18 | Total £000s | (Reversed) /Charged to revaluation £000s | (Reversed) /Charged to expenditure £000s |
|---|---|---|---|
| Land, buildings and dwellings were revalued by a professional valuer as at 31 March 2018 | (2,772) | (265) | (2,507) |
| Impairment resulted from evidence of physical damage to an asset - this affected an asset classified as plant and machinery | 4 | | 4 |
| **Total** | (2,768) | (265) | (2,503) |

| 2016/17 | Total £000s | (Reversed) /Charged to revaluation £000s | (Reversed) /Charged to expenditure £000s |
|---|---|---|---|
| Land, buildings and dwellings were revalued by a professional valuer as at 1 April 2016 and 31 March 2017 | 50,484 | 38,544 | 11,940 |
| Impairment resulted from evidence of physical damage to an asset - this affected an asset classified as plant and machinery | 23 | 0 | 23 |
| **Total** | 50,507 | 38,544 | 11,963 |

## 8 Employee benefits

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Salaries and wages | 244,582 | 238,486 |
| Social security costs | 22,166 | 21,349 |
| Apprenticeship levy | 1,198 | - |
| Employer's contributions to NHS pensions | 28,310 | 27,768 |
| Pension cost - other | 35 | 742 |
| Termination benefits | - | 60 |
| Temporary staff (including agency) | 36,890 | 35,933 |
| **Total gross staff costs** | **333,181** | **324,338** |
| Recoveries in respect of seconded staff | - | - |
| **Total staff costs** | **333,181** | **324,338** |
| **Of which** | | |
| Costs capitalised as part of assets | (199) | (385) |
| **Total employee benefits charge to SOCI** | **332,982** | **323,953** |

### 8.1 Retirements due to ill-health

During 2017/18 there were 9 early retirements from the Trust agreed on the grounds of ill-health (8 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £773k (£485k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

**9 Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

**c) Pension Costs Other Schemes**

Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme.

NEST is a defined contribution scheme managed by a third party organisation. It carries no possibility of actuarial gain or loss to theTrust and there are no financial liabilities other than payment of the 2% employers contribution of qualifying earnings. This contribution will increase to 3% in 2018/19. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly.

## 10 Operating leases

### 10.1 Mid Yorkshire Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Mid Yorkshire Hospitals NHS Trust is the lessor.

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| **Operating lease revenue** | | |
| Minimum lease receipts | 507 | 413 |
| Contingent rent | 100 | 92 |
| Other | - | - |
| **Total** | **607** | **505** |

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Future minimum lease receipts due:** | | |
| - not later than one year; | 200 | 204 |
| - later than one year and not later than five years; | 399 | 399 |
| **Total** | **599** | **603** |

### 10.2 Mid Yorkshire Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Mid Yorkshire Hospitals NHS Trust is the lessee.

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| **Operating lease expense** | | |
| Minimum lease payments | 495 | 399 |

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Future minimum lease payments due:** | | |
| - not later than one year; | 645 | 685 |
| - later than one year and not later than five years; | 599 | - |
| **Total** | **1,244** | **685** |

The Trust leases equipment, vehicles and short term property lets. None of these are individually significant.

## 11 Finance income

Finance income represents interest received on assets and investments in the period.

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Interest on bank accounts | 46 | 56 |

## 12 Finance expenditure

### 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **Interest expense:** | | |
| Loans from the Department of Health and Social Care | 1,678 | 1,328 |
| Finance leases | 25 | 30 |
| Main finance costs on PFI and LIFT schemes obligations | 9,664 | 9,954 |
| **Total interest expense** | **11,367** | **11,312** |
| Unwinding of discount on provisions | 18 | 87 |
| **Total finance costs** | **11,385** | **11,399** |

### 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

Interest of £68 ( 2016/17: £523) was paid for late payments under The Late Payments of Commercial Debts (interest) Act 1998.

## 13 Other gains / (losses)

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Gains on disposal of assets | 5 | 304 |
| Losses on disposal of assets | (30) | (21) |
| **Total gains / (losses) on disposal of assets** | (25) | 283 |
| Gains / (losses) on foreign exchange | - | - |
| **Total other gains / (losses)** | **(25)** | **283** |

## 14 Intangible assets

### 14.1 Intangible assets - 2017/18

| | Software licences | Development expenditure | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2017 - brought forward** | **7,478** | **-** | **7,478** |
| Additions | 342 | - | **342** |
| **Gross cost at 31 March 2018** | **7,820** | **-** | **7,820** |
| | | | |
| **Amortisation at 1 April 2017 - brought forward** | **5,076** | **-** | **5,076** |
| Provided during the year | 834 | - | **834** |
| **Amortisation at 31 March 2018** | **5,910** | **-** | **5,910** |
| | | | |
| **Net book value at 31 March 2018** | **1,910** | **-** | **1,910** |
| **Net book value at 1 April 2017** | **2,402** | **-** | **2,402** |

### 14.2 Intangible assets - 2016/17

| | Software licences | Development expenditure | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2016 - as previously stated** | **6,620** | **83** | **6,703** |
| Prior period adjustments | 87 | (83) | **4** |
| **Valuation / gross cost at 1 April 2016 - restated** | **6,707** | **-** | **6,707** |
| Additions | 771 | - | **771** |
| **Valuation / gross cost at 31 March 2017** | **7,478** | **-** | **7,478** |
| | | | |
| **Amortisation at 1 April 2016 - as previously stated** | **4,064** | **83** | **4,147** |
| Prior period adjustments | 87 | (83) | **4** |
| **Amortisation at 1 April 2016 - restated** | **4,151** | **-** | **4,151** |
| Provided during the year | 925 | - | **925** |
| **Amortisation at 31 March 2017** | **5,076** | **-** | **5,076** |
| | | | |
| **Net book value at 31 March 2017** | **2,402** | **-** | **2,402** |
| **Net book value at 1 April 2016** | **2,556** | **-** | **2,556** |

Purchased computer software is amortised and charged to the income statement on a straight line basis over the shorter of the term of the licence and their useful lives.

The remaining lives for purchased computer software are 2 to 10 years. Amortisation periods and methods are reviewed annually and adjusted if appropriate to reflect fair value.

The Trust has no internally generated intangible assets or intangible assets acquired through Government grants.

## 15 Property, plant and equipment

### 15.1 Property, plant and equipment - 2017/18

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2017 - brought forward** | **18,386** | **333,040** | **2,653** | **1,473** | **62,236** | **24** | **26,467** | **3,696** | **447,975** |
| Additions | - | 1,610 | - | 853 | 4,105 | - | 1,603 | - | **8,171** |
| Impairments | - | (4,126) | - | - | - | - | - | - | **(4,126)** |
| Reversals of impairments | - | 2,971 | - | - | - | - | - | - | **2,971** |
| Revaluations | - | (1,440) | (2) | - | - | - | - | - | **(1,442)** |
| Reclassifications | - | 688 | (1) | (948) | 261 | - | - | - | **-** |
| Disposals / derecognition | - | - | - | - | (2,139) | - | - | - | **(2,139)** |
| **Valuation/gross cost at 31 March 2018** | **18,386** | **332,743** | **2,650** | **1,378** | **64,463** | **24** | **28,070** | **3,696** | **451,410** |
| **Accumulated depreciation at 1 April 2017 - brought forward** | **-** | **-** | **-** | **-** | **43,759** | **22** | **20,029** | **2,209** | **66,019** |
| Provided during the year | - | 5,315 | 54 | - | 5,363 | 2 | 2,155 | 356 | **13,245** |
| | - | - | - | - | 4 | - | - | - | **4** |
| Reversals of impairments | - | (3,875) | (52) | - | - | - | - | - | **(3,927)** |
| Revaluations | - | (1,440) | (2) | - | - | - | - | - | **(1,442)** |
| Disposals / derecognition | - | - | - | - | (2,138) | - | - | - | **(2,138)** |
| **Accumulated depreciation at 31 March 2018** | **-** | **-** | **-** | **-** | **46,988** | **24** | **22,184** | **2,565** | **71,761** |
| **Net book value at 31 March 2018** | **18,386** | **332,743** | **2,650** | **1,378** | **17,475** | **-** | **5,886** | **1,131** | **379,649** |
| **Net book value at 1 April 2017** | **18,386** | **333,040** | **2,653** | **1,473** | **18,477** | **2** | **6,438** | **1,487** | **381,956** |

Impairments and reversal of impairments on land and buildings relate specifically to a revaluation as at 31 March 2018. Note 7.2 and 17 provide further information.

**15.2 Property, plant and equipment - restated - 2016/17**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2016 - restated** | **53,702** | **330,337** | **2,405** | **1,707** | **61,319** | **27** | **24,145** | **3,564** | **477,206** |
| Additions | - | 4,474 | 31 | 1,312 | 2,923 | - | 2,520 | 144 | **11,404** |
| Impairments | (35,371) | (19,789) | (152) | (62) | - | - | - | - | **(55,374)** |
| Reversals of impairments | - | 4,552 | - | - | - | - | - | - | **4,552** |
| Revaluations | 57 | 11,989 | 369 | - | - | - | - | - | **12,415** |
| Reclassifications | - | 1,477 | - | (1,478) | 15 | (3) | 1 | (12) | **-** |
| Disposals / derecognition | (2) | - | - | (6) | (2,021) | - | (199) | - | **(2,228)** |
| **Valuation/gross cost at 31 March 2017** | **18,386** | **333,040** | **2,653** | **1,473** | **62,236** | **24** | **26,467** | **3,696** | **447,975** |
| **Accumulated depreciation at 1 April 2016 - restated** | **-** | **-** | **-** | **-** | **40,504** | **20** | **17,945** | **1,856** | **60,325** |
| Provided during the year | - | 4,876 | 52 | - | 5,238 | 2 | 2,283 | 353 | **12,804** |
| Impairments | - | - | - | - | 23 | - | - | - | **23** |
| Reversals of impairments | - | (338) | - | - | - | - | - | - | **(338)** |
| Revaluations | - | (4,538) | (52) | - | - | - | - | - | **(4,590)** |
| Disposals/ derecognition | - | - | - | - | (2,006) | - | (199) | - | (2,205) |
| **Accumulated depreciation at 31 March 2017** | **-** | **-** | **-** | **-** | **43,759** | **22** | **20,029** | **2,209** | **66,019** |
| **Net book value at 31 March 2017** | **18,386** | **333,040** | **2,653** | **1,473** | **18,477** | **2** | **6,438** | **1,487** | **381,956** |
| **Net book value at 1 April 2016** | **53,702** | **330,337** | **2,405** | **1,707** | **20,815** | **7** | **6,200** | **1,708** | **416,881** |

Property plant and equipment has been restated to clear the cummulative depreciation on formal revalutation as at 31 March 2017. There has been no change to the net book value.

**15.3 Property, plant and equipment financing - 2017/18**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2018** | | | | | | | | | |
| Owned - purchased | 18,386 | 109,536 | 2,650 | 1,378 | 17,011 | - | 4,647 | 1,063 | **154,671** |
| Finance leased | - | - | - | - | 105 | - | 1,042 | 23 | **1,170** |
| On-SoFP PFI contracts | - | 220,917 | - | - | - | - | - | - | **220,917** |
| Owned - government granted | - | 138 | - | - | - | - | - | - | **138** |
| Owned - donated | - | 2,152 | - | - | 359 | - | 197 | 45 | **2,753** |
| **NBV total at 31 March 2018** | **18,386** | **332,743** | **2,650** | **1,378** | **17,475** | **-** | **5,886** | **1,131** | **379,649** |

**15.4 Property, plant and equipment financing - 2016/17**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2017** | | | | | | | | | |
| Owned - purchased | 18,386 | 108,559 | 2,653 | 1,473 | 17,887 | 2 | 5,093 | 1,407 | **155,460** |
| Finance leased | - | - | - | - | 200 | - | 1,113 | 27 | **1,340** |
| On-SoFP PFI contracts | - | 222,399 | - | - | - | - | - | - | **222,399** |
| | - | 2,082 | - | - | 390 | - | 232 | 53 | **2,757** |
| **NBV total at 31 March 2017** | **18,386** | **333,040** | **2,653** | **1,473** | **18,477** | **2** | **6,438** | **1,487** | **381,956** |

**16 Donations and Grants of property, plant and equipment**

Donated assets are from grants provided by the Trust's related charity Mid Yorkshire Hospitals NHS Trust Charitable Fund and other local charities. No conditions or restrictions are imposed by the donors.

The Trust received a grant £138k 2017-18 from the City of Wakefield Metropolitan District Council to extend the childcare facility to support the provison of 30 hours free nursery childcare. There is seven year claw back period. There is a reducing percentage of capital funds repayable should there be change in use of the facilities or a disposal of the property.

**17 Revaluations of property, plant and equipment**

In 2017/18 and 2016/17, land and buildings were revalued by a professional independent valuer as at 31 March (and at 1 April 2016/17). The Valuer used the independent index issued by the Building Cost Information Service (BCIS) of the Royal Institute of Chartered Surveyors (RICS). Valuations are at depreciated replacement cost using the Modern Equivalent Asset (MEA) approach (Note 1.7). The MEA valuation is based upon maintaining three hospitals within the current localities, not necessarily on the existing sites.

The PFI buildings are valued net of VAT, reflecting the cost at which the service potential would be replaced by the PFI Operator. All other valuations are at replacement cost inclusive of VAT.

The valuers advised changes to asset lives. Building lives vary between 1 to 86 years (2016/17 2 to 90 years). Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the Valuer. Leaseholds are depreciated over the primary lease term. Buildings (excluding dwellings) are depreciated over 1 to 86 years. Dwellings are depreciated over 33 to 73 years.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

| | |
|---|---|
| Software licences | 2 to 10 |
| Plant and machinery | 3 to 25 |
| Transport equipment | 5 to 10 |
| Information technology | 2 to 10 |
| Furniture and fittings | 5 to 15 |

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset held for sale, an impairment is charged to bring the value of the asset to its value at the point of sale.

No property is currently held at existing use value with an open market value which is materially different to its existing use value.

The nature and value of impairments and reversal of impairments are in note 7.

## 18 Disclosure of interests in other entities

From 2013-14, the Trust has been required to consolidate the results of The Mid Yorkshire Hospitals NHS Trust Charitable Fund over which it considers it has the power to exercise control in accordance with IFRS10 requirements. However, the transactions are immaterial in the context of the group and the transactions have not been consolidated. Details of the transactions with the Charity are included in note 33, the related party note.

## 19 Inventories

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Drugs | 2,269 | 2,489 |
| Consumables | 5,302 | 5,634 |
| Energy | 83 | 106 |
| **Total inventories** | **7,654** | **8,229** |
| **of which:** | | |
| Held at fair value less costs to sell | - | - |

Inventories recognised in expenses for the year were £69,097k (2016/17: £73,239k). Write-down of inventories recognised as expenses for the year were £70k (2016/17: £37k).

## 20.1 Trade receivables and other receivables

| | 2018 £000 | 2017 £000 |
|---|---|---|
| **Current** | | |
| Trade receivables | 6,171 | 7,229 |
| Accrued income | 6,068 | 2,114 |
| Provision for impaired receivables | (1,663) | (1,518) |
| Prepayments (non-PFI) | 3,152 | 3,698 |
| Interest receivable | (11) | 4 |
| VAT receivable | 2,733 | 2,626 |
| Other receivables | 5,698 | 5,832 |
| **Total current trade and other receivables** | **22,148** | **19,985** |
| | | |
| **Of which receivables from NHS and DHSC group bodies:** | | |
| Current | 8,427 | 6,407 |
| Non-current | - | - |

£2,739k (2016/17: £5,017k) of receivables are with Clinical Commissioning Groups and NHS England. These organisations are the main commissioners for NHS patient services and as they are funded by Government no credit scoring is deemed necessary.

### 20.2 Provision for impairment of receivables

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **At 1 April** | **1,518** | **1,559** |
| Transfers by absorption | - | - |
| Increase in provision | 959 | 841 |
| Amounts utilised | (672) | (772) |
| Unused amounts reversed | (142) | (110) |
| **At 31 March** | **1,663** | **1,518** |

Trade receivables are reviewed for impairment on an individual basis, depending on the size of the receivable and the period for which it is overdue. Where trade receivables are estimated to be less than their carrying values, provisions have been made to write them down to their estimated recoverable amounts.

### 20.3 Credit quality of financial assets

| | 31 March 2018 Trade and other receivables | 31 March 2017 Trade and other receivables |
|---|---|---|
| **Ageing of impaired financial assets** | **£000** | **£000** |
| | 1 | 25 |
| 30-60 Days | 22 | 41 |
| 60-90 days | 10 | 24 |
| 90- 180 days | 35 | 77 |
| Over 180 days | 828 | 413 |
| **Total** | **896** | **580** |

| | 31 March 2018 Trade and other receivables | 31 March 2017 Trade and other receivables |
|---|---|---|
| **Ageing of non-impaired financial assets past their due date** | **£000** | **£000** |
| 0 - 30 days | - | - |
| 30-60 Days | 616 | 2,130 |
| 60-90 days | 604 | 453 |
| 90- 180 days | 451 | 1,340 |
| Over 180 days | 839 | 2,099 |
| **Total** | **2,510** | **6,022** |

This represents balances past their due date but not impaired within other trade receivables. These balances have been assessed for recoverability and the Trust believes that their credit quality remains intact. The Trust does not hold collateral over these balances.

## 21 Non-current assets held for sale and assets in disposal groups

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **NBV of non-current assets for sale and assets in disposal groups at 1 April** | **1,250** | **1,657** |
| | (1,250) | **(407)** |
| **NBV of non-current assets for sale and assets in disposal groups at 31 March** | **-** | **1,250** |

In 2017/18 and 2016/17 land at non-operational sites were sold.

## 22 Cash and cash equivalents

### 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **At 1 April** | **11,286** | **1,082** |
| Net change in year | (3,092) | 10,204 |
| **At 31 March** | **8,194** | **11,286** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 219 | 50 |
| Cash with the Government Banking Service | 7,975 | 11,236 |
| **Total cash and cash equivalents as in SoFP and SoCF** | **8,194** | **11,286** |

### 22.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

| | 2018 | 2017 |
|---|---|---|
| | £000 | £000 |
| Bank balances | - | - |
| Monies on deposit | 2 | - |
| **Total third party assets** | **2** | **-** |

## 23 Payables

### 23.1 Trade and other payables

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Current** | | |
| Trade payables | 8,381 | 9,401 |
| Capital payables | 4,490 | 3,455 |
| Accruals | 10,836 | 11,790 |
| Receipts in advance (including payments on account) | - | - |
| Social security costs | 3,329 | 3,134 |
| VAT payables | - | 2 |
| Other taxes payable | 2,783 | 2,719 |
| Accrued interest on loans | 66 | 41 |
| Other payables | 4,343 | 3,965 |
| **Total current trade and other payables** | **34,228** | **34,507** |
| **Of which payables from NHS and DHSC group bodies:** | | |
| Current | 2,046 | 2,295 |

Trade payables are generally settled on 30 day terms and are not interest bearing unless a supplier makes a claim and has grounds to under The Late Payment of Commercial Debts (Interest) Act 1998. Accruals and deferred income are not interest bearing.

### 23.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Outstanding pension contributions | 3,967 | 3,829 |

## 24 Other liabilities

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Current** | | |
| Deferred income | 2,013 | 1,623 |
| **Total other current liabilities** | **2,013** | **1,623** |

## 25 Borrowings

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Loans from the Department of Health and Social Care | 19,650 | 1,000 |
| Obligations under finance leases | 436 | 338 |
| Obligations under PFI | 8,887 | 8,633 |
| **Total current borrowings** | **28,973** | **9,971** |
| **Non-current** | | |
| Loans from the Department of Health and Social Care | 54,024 | 54,013 |
| Obligations under finance leases | 356 | 615 |
| Obligations under PFI | 276,594 | 285,482 |
| **Total non-current borrowings** | **330,974** | **340,110** |

## 26 Finance leases

### 26.1 Mid Yorkshire Hospitals NHS Trust as a lessee

Obligations under finance leases where Mid Yorkshire Hospitals NHS Trust is the lessee

| | 2018 £000 | 2017 £000 |
|---|---|---|
| **Gross lease liabilities** | **803** | **980** |
| of which liabilities are due: | | |
| - not later than one year | 447 | 356 |
| - later than one year and not later than five years | 356 | 624 |
| Finance charges allocated to future periods | (11) | (27) |
| **Net lease liabilities** | **792** | **953** |
| of which payable: | | |
| - not later than one year | 436 | 338 |
| - later than one year and not later than five years | 356 | 615 |
| | **792** | **953** |
| Contingent rent recognised as an expense in the period | (406) | (443) |

Details of the PFI basis of accounting are excluded from this note and included in note 30.

The Trust uses finance leases or arrangements containing finance leases to acquire plant and equipment. Where the implicit rate of interest cannot be determined the long term real rate of interest, at the date of inception of the contract, has been applied. The long term real rate of interest has been sourced from Treasury interest rate tables.

## 27 Provisions for liabilities and charges

### 27.1 Provisions for liabilities and charges analysis

| | Pensions - early departure costs | Legal claims | Re-structuring | Other | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **At 1 April 2017** | **4,557** | **785** | **60** | **3,236** | **8,638** |
| Change in the discount rate | 30 | - | - | 51 | **81** |
| Arising during the year | 270 | 234 | - | 80 | **584** |
| Utilised during the year | (407) | (50) | (60) | (198) | **(715)** |
| Reversed unused | (235) | (55) | - | (39) | **(329)** |
| Unwinding of discount | 11 | - | - | 7 | **18** |
| **At 31 March 2018** | **4,226** | **914** | **-** | **3,137** | **8,277** |
| **Expected timing of cash flows:** | | | | | |
| - not later than one year | 408 | 914 | - | 264 | **1,586** |
| - later than one year and not later than five years | 1,633 | - | - | 514 | **2,147** |
| - later than five years | 2,185 | - | - | 2,359 | **4,544** |
| **Total** | **4,226** | **914** | **-** | **3,137** | **8,277** |

Amount included in the provisions of the NHS Resolution in respect of clinical negligence liabilities:

| | £ |
|---|---|
| **As at 31 March 2018** | 234,335 |
| **As at 31 March 2017** | 187,294 |

The early departure provision relates to pension costs for certain staff taking early retirement and is determined by capitalising the cost using a formula agreed by NHS Pensions. The formula assumes that the member of staff will live beyond normal retirement age.

A redundancy provision was recognised in 2016/17 and paid in 2017/18.

Other provisions include injury benefits paid by NHS Pensions £2,960k (2016/17: £3,022k) and pay costs associated with current rebanding claims £176k (2016/17: £213k).

### 27.2 Clinical negligence liabilities

At 31 March 2018, £234,335k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Mid Yorkshire Hospitals NHS Trust (31 March 2017: £187,294k).

## 28 Contingent assets and liabilities

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (165) | (128) |
| Other | - | (250) |
| **Gross value of contingent liabilities** | **(165)** | **(378)** |

Clinical negligence claims are managed by NHS Resolution on behalf of the Trust. The value of contingent liabilities for legal claims is provided by NHS Resolution for cases where the amount and timing remain uncertain.

## 29 Contractual capital commitments

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Property, plant and equipment | 243 | 165 |
| Intangible assets | 6 | 68 |
| **Total** | **249** | **233** |

## 30 On-SoFP PFI

The Trust entered into a PFI contract to provide new hospital facilities and associated support services in Wakefield and Pontefract on 28 June 2007 with a 35 year term. The facilities were phased in and were fully operational from 2012/13.

### 30.1 Imputed finance lease obligations

Mid Yorkshire Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Gross PFI** | **418,040** | **436,470** |
| **Of which liabilities are due** | | |
| - not later than one year | 18,396 | 18,429 |
| - later than one year and not later than five years | 75,835 | 74,761 |
| - later than five years | 323,809 | 343,280 |
| Finance charges allocated to future periods | (132,559) | (142,355) |
| **Net PFI** | **285,481** | **294,115** |
| - not later than one year; | 8,887 | 8,633 |
| - later than one year and not later than five years; | 40,909 | 38,551 |
| - later than five years. | 235,685 | 246,931 |
| | **285,481** | **294,115** |

### 30.2 Total on-SoFP PFI

Total future obligations under these on-SoFP schemes are as follows:

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Total future payments committed in respect of the PFI | **1,490,971** | **1,534,667** |
| **Of which liabilities are due:** | | |
| - not later than one year | 45,277 | 43,697 |
| - later than one year and not later than five years | 192,723 | 188,021 |
| - later than five years | 1,252,971 | 1,302,949 |
| | **1,490,971** | **1,534,667** |

The commitment assumes inflation at 2.5% (2016/17: 2.5%) for the remaining life of the contract. This is the rate used in the contractors model.

### 30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's payments in 2017/18:

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| Unitary payment payable to service concession operator | **48,692** | **46,355** |
| **Consisting of:** | | |
| - Interest charge | 9,664 | 9,954 |
| - Repayment of finance lease liability | 8,633 | 8,725 |
| - Service element and other charges to operating expenditure | 27,944 | 25,779 |
| - Revenue lifecycle maintenance | 2,451 | 1,897 |
| **Total amount paid to service concession operator** | **48,692** | **46,355** |

## 31 Financial instruments

### 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

**Currency risk**

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

**Interest rate risk**

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust drew down a £15m capital loan on 15 December 2010, repayable over 14 years and 9 months. The interest rate is fixed at the National Loans Fund rate applicable on the issue date of the loan documents by the Department of Health and Social Care. The interest rate charged is 2.98%. The Trust received a capital loan of £2.5m in 2017/18 with a fixed interest rate of 1.25% and repayable from 18th September 2019 in six monthly instalments with the last payment due 18th March 2028.

The Trust accessed interim revenue loans from the Department of Health and Social Care. The loans are interest bearing, fixed at 1.5% and are repayable on or before the specified repayment

The Trust has a working capital facility with the Department of Health and Social Care. It is a fixed rate (3.5%) interest bearing facility based on the daily outstanding balance.

The Trust invests cash in other liquid resources at the National Loans Fund rate. The Trust is therefore susceptible to movements in current interest rates.

**Credit risk**

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

**Liquidity risk**

The Trust's operating costs are incurred under contracts with Clinicial Commisioning Groups and NHS England, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its capital resource limit. The Trust is not, therefore, exposed to significant liquidity risks.

### 31.2 Carrying values of financial assets

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | Loans and receivables | Loans and receivables |
| | £000 | £000 |
| **Assets as per SoFP** | | |
| Trade and other receivables excluding non financial assets | 12,788 | 10,165 |
| Cash and cash equivalents at bank and in hand | 8,194 | 11,286 |
| **Total** | **20,982** | **21,451** |

### 31.3 Carrying value of financial liabilities

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| **Other financial liabilities** | £000 | £000 |
| **Liabilities as per SoFP** | | |
| Borrowings excluding finance lease and PFI liabilities | 73,674 | 55,013 |
| Obligations under finance leases | 792 | 953 |
| Obligations under PFI, LIFT and other service concession contracts | 285,481 | 294,115 |
| Trade and other payables excluding non financial liabilities | 30,129 | 30,275 |
| **Total** | **390,076** | **380,356** |

### 31.4 Fair values of financial assets and liabilities

**Comparison of PFI liabitiy at book value (carrying value) to estimate of fair value**

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| Implicit Interest rate | 3.33% | 3.33% |
| Interest rate at 31 March | 1.7% | 1.57% |
| | £000 | £000 |
| Carrying value at 31 March | 285,481 | 294,115 |
| Fair value 31 March | 335,542 | 359,158 |
| Difference between carrying and fair value | **(50,061)** | **(65,043)** |

The fair value has been obtained by applying the National Loans Fund interest rate at 31 March 2018 assuming a fixed repayment amount over 25 years (2016/17: 26 years).

### 31.5 Maturity of financial liabilities

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| In one year or less | 59,102 | 40,246 |
| In more than one year but not more than two years | 10,522 | 29,152 |
| In more than two years but not more than five years | 80,705 | 60,527 |
| In more than five years | 239,747 | 250,431 |
| **Total** | **390,076** | **380,356** |

## 32 Losses and special payments

| | 2017/18 | | 2016/17 | |
|---|---|---|---|---|
| | Total number of cases Number | Total value of cases £000 | Total number of cases Number | Total value of cases £000 |
| **Losses** | | | | |
| Cash losses | 1 | - | 1 | 0 |
| Fruitless payments | - | - | 2 | 3 |
| Bad debts and claims abandoned | 4,459 | 672 | 3,858 | 802 |
| Stores losses and damage to property | 4 | 70 | 287 | 37 |
| **Total losses** | **4,464** | **742** | **4,148** | **842** |
| **Special payments** | | | | |
| Compensation under court order or legally binding arbitration award | - | - | 3 | 140 |
| Ex-gratia payments | 76 | 167 | 104 | 192 |
| **Total special payments** | **76** | **167** | **107** | **332** |
| **Total losses and special payments** | **4,540** | **909** | **4,255** | **1,174** |

There are no cases individually over £300k.

**33 Related parties**

The Department of Health and Social Care is regarded as a related party. During the year, Mid Yorkshire Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The main entities are NHS England, Wakefield CCG, North Kirklees CCG, Leeds South & East CCG and Leeds West CCG.

Services were also purchased from: Yorkshire Ambulance Service NHS Trust, Leeds Teaching Hospitals NHS Trust, National Blood and Transplant Authority, NHS Resolution, NHS Professionals.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Wakefield Metropolitan District Council and Kirklees Council.

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity (The Mid Yorkshire Hospitals NHS Trust Charitable Fund), it effectively has the power to exercise control so as to obtain economic benefits. The transactions are immaterial in the context of the group and transactions have not been consolidated. The transactions with the charity are disclosed in the previous table and the audited accounts of The Mid Yorkshire Hospitals NHS Trust Charitable fund are included in the Trust's Annual Report.

Transactions with related parties are disclosed below. There are no bad debt expenses or provisions in respect of these organisations.

| 2017/18 | Payments to Related Party £000s | Receipts from Related £000s | Amounts owed to Related £000s | Amounts due from Related £000s |
|---|---|---|---|---|
| Julie Charge, Non-Executive Director, Director of Finance to Salford University | 1 | 0 | 0 | 0 |
| Mike Smith, Associate Non-Executive Director to 31 March 2018, Chair and NED to Medipex Ltd | 8 | 0 | 0 | 0 |
| Mike Smith, Associate Non-Executive Director to 31 March 2018, Fellowship with and Advisor at Sheffield | 5 | 0 | 0 | 0 |
| David Melia, Director of Nursing and Quality, Trustee of Wakefield Hospice | 14 | 194 | 5 | 0 |
| Board Members, Corporate Trustee to the Mid Yorkshire Hospitals NHS Trust Charitable Fund | 0 | 550 | 0 | 105 |
| Matt England, Interim Director of Planning and Partnerships to 31 July 2018, partner works at Leeds Teaching Hospital | 3,559 | 1,833 | 920 | 806 |
| | 3,587 | 2,577 | 920 | 916 |

| 2016/17 | Payments to Related Party £000s | Receipts from Related Partv £000s | Amounts owed to Related Partv £000s | Amounts due from Related Partv £000s |
|---|---|---|---|---|
| Dr David Hicks, Associate Non-Executive Director to 31 December 2016, specialist advisor to the Care Quality Commission | 196 | 0 | 0 | 0 |
| Nisreen Booya, Associate Non-Executive Director, specialist advisor to the Care Quality Commission | | | | |
| Nisreen Booya, Associate Non-Executive Director, Associate Consultant to Grant Thornton | 4 | 0 | 0 | 0 |
| Nisreen Booya, Associate Non-Executive Director, Husband is a Consultant Surgeon to the Calderdale and | 875 | 340 | 39 | 112 |
| Julie Bolus, Interim Director of Staff and Patient Engagement to 28 July 2016, Director to Bolus Consulting Limited | 37 | 0 | 0 | 0 |
| Sally Napper, Chief Nurse, sister is an associate at Hempsons Solicitors | 6 | 0 | 0 | 0 |
| Julie Charge, Non-Executive Director, Director of Finance to Salford University | 5 | 0 | 0 | 0 |
| Mike Smith, Associate Non-Executive Director from 1 October 2016, Managing Partner to Harper Keeley LLP | 3 | 0 | 0 | 0 |
| Mike Smith, Associate Non-Executive Director from 1 October 2016, Chair & NED to Medipex Ltd | 9 | 0 | 0 | 0 |
| Mike Smith, Associate Non-Executive Director from 1 October 2016, Partner is Board Member and Trustee to UNICEF | 5 | 0 | 0 | 0 |
| Matt England, Interim Director of Planning and Partnerships from 1 April 2016, partner works for Leeds Teaching Hospital NHS Trust | 3,595 | 1,578 | 541 | 326 |
| Board Members Corporate Trustee to the Mid Yorkshire Hospitals NHS Trust Charitable Fund | 0 | 461 | 0 | 82 |
| | 4,735 | 2,379 | 580 | 520 |

**34 Better Payment Practice code**

| | 2017/18 Number | 2017/18 £000 | 2016/17 Number | 2016/17 £000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total non-NHS trade invoices paid in the year | 74,553 | 203,111 | 81,671 | 212,614 |
| Total non-NHS trade invoices paid within target | 40,425 | 153,469 | 69,873 | 191,018 |
| Percentage of non-NHS trade invoices paid within target | **54.22%** | **75.56%** | **85.55%** | **89.84%** |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 3,083 | 44,745 | 3,449 | 45,550 |
| Total NHS trade invoices paid within target | 1,413 | 29,601 | 2,649 | 38,934 |
| Percentage of NHS trade invoices paid within target | **45.83%** | **66.15%** | **76.80%** | **85.48%** |

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

### 35 Capital absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%. In 2016-17 and 2017-18, the Trust had average relevant net liabilities, resulting in no dividend being payable

### 36 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| Cash flow financing | 13,118 | 13,875 |
| Finance leases taken out in year | | 831 |
| External financing requirement | 13,118 | 14,706 |
| External financing limit (EFL) | 19,580 | 14,706 |
| Under / (over) spend against EFL | **6,462** | **-** |

### 37 Capital Resource Limit

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| Gross capital expenditure | 8,513 | 12,174 |
| Less: Disposals | (1,251) | (429) |
| Less: Donated and granted capital additions | (263) | (146) |
| Plus: Loss on disposal of donated/granted assets | - | - |
| **Charge against Capital Resource Limit** | **6,999** | **11,599** |
| Capital Resource Limit | 7,562 | 11,677 |
| **Under / (over) spend against CRL** | **563** | **78** |

### 38 Breakeven duty financial performance

| | 2017/18 £000 | 2016/17 £000 |
|---|---|---|
| **Surplus / (deficit) for the year** | (15,854) | (19,888) |
| Add back all I&E impairments / (reversals) | (2,503) | 11,963 |
| Retain impact of DEL I&E (impairments)/reversals | (1) | |
| Remove capital donations / grants I&E impact | (48) | 52 |
| CQUIN Risk Reserve - 1617 CT non achievement adjustment | (1,891) | |
| **Adjusted financial performance surplus / (deficit) (control total basis)** | **(20,297)** | **(7,873)** |
| Remove impairments scoring to Departmental Expenditure Limit in 2017/18 | 1 | - |
| Add back CQUIN Risk Reserve - 1617 CT non achievement adjustment | 1,891 | |
| **Breakeven duty financial performance surplus / (deficit)** | **(18,405)** | **(7,873)** |

In 2017/18, the Trust was required to adjust for reversal of impairments of £2,503k (2016/17: impairments of £11,963k) and the impact of donated assets of £48k net income (2016/17: £52k net expenditure).

Sustainability and Transformation Fund income of £7,441k (2016/17: £11,864k) is included in the reported financial performance.

**39 Breakeven duty rolling assessment**

| | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Breakeven duty in-year financial performance | | 871 | 983 | (19,217) | (21,839) | (19,171) | (9,056) | (20,530) | (7,873) | (18,405) |
| Breakeven duty cumulative position | (26,110) | (25,239) | (24,256) | (43,473) | (65,312) | (84,483) | (93,539) | (114,069) | (121,942) | (140,347) |
| Operating income | | 395,875 | 430,417 | 456,954 | 460,792 | 456,810 | 483,428 | 482,792 | 504,454 | 505,584 |
| Cumulative breakeven position as a percentage of operating income | | -6.38% | -5.64% | -9.51% | -14.17% | -18.49% | -19.35% | -23.63% | -24.17% | -27.76% |

The Trust entered into a Financially Challenged Trust agreement in 2008/09 receiving permanent PDC and a loan and met its in-year financial performance in 2009/10 and 2010/11. Since 2009/10 the Trust received support on a non-recurrent basis for the PFI implementation costs and to support the re-configuration of services. The Trust has been unable to meet the significant Cost Improvement Programme challenges in recent years and is currently working on a recovery plan to be agreed with NHS Improvement and the local health economy.

# ANNUAL REPORT AND FINANCIAL ACCOUNTS

2017/2018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