Chief Executive’s quality statement

We are pleased to present the Mid Yorkshire Hospitals NHS Trust Quality Account 2018-2019. This document is an honest reflection of our performance, challenges and achievements during 2018/19 and describes revised quality improvement priorities for 2019-2020. To the best of my knowledge, the information in the Quality Account is accurate.

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 four-hour standard, we nevertheless do not achieve 95%.

Our Urgent Treatment Centre at Pontefract Hospital was opened in April 2018 and has consistently achieved the Emergency Care Standard. Currently 99.2% of patients attending the Urgent Treatment Centre are seen within four hours. Waiting time for our 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 86% of patients are seen and treated within 18 weeks, a 1.6% improvement from March 2018 (85.1%) to March 2019 (86.7%).

In 2018 the Care Quality Commission (CQC) carried out two unannounced inspections of our services in Pinderfields Hospital, Pontefract Hospital and Dewsbury & District Hospital. Whilst we received an overall provider rating of ‘Requires Improvement’ which is unchanged from our previous inspections, there were a great many demonstrated improvements in the quality and safety of our services. The Trust overall ‘Effective’ rating was improved to ‘Good’. There was also notable improvement in core services such as medical care in Pinderfields and Dewsbury & District Hospital, which achieved a rating of ‘Good’. We are proud to say that the Critical Care Unit in Pinderfields Hospital was rated ‘Outstanding’ against the Caring key question. We continue to work hard to achieve an overall rating of ‘Outstanding’ for our Trust. The Trust Board monitors the quality of services against the CQC domains of caring, safe, effective, responsive and well led through monthly reports, which are reviewed in detail by the Quality Committee.

During 2018/19, the Trust has worked in collaboration with the University of Bradford to establish a School of Nursing based at Dewsbury and District Hospital. This is a valuable opportunity for more local people to qualify as a registered nurse whilst being based at a hospital site rather than a university campus. It is hoped that this venture will encourage people from the local area to join the profession. The first cohort is just about to enter their second year of study and the second cohort start their degree course in April 2019.
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.

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 2019/20, 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: 23 May 2019
## Priorities for improvement and statements from the Board

### Review of 2018/19 Quality Priorities

<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority number</th>
<th>Outcome measure/indicator</th>
<th>Metric</th>
<th>2017/18 performance</th>
<th>2018/19 performance</th>
<th>Performance improved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>1</td>
<td>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.</td>
<td>Total number of MRSA bloodstream infections-national objective being a Zero tolerance to preventable infections.</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total number of CDIFF cases-national objective for 2018/19 no more than 26 cases</td>
<td>37</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total number of gram negative blood stream infections-reduction to be determined.</td>
<td>108</td>
<td>101</td>
<td></td>
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<tr>
<td></td>
<td>2</td>
<td>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</td>
<td>≥90% of patients to be screened for Acute Kidney Injury</td>
<td>55%</td>
<td>65%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>≥90% of patients to be screened for sepsis in ED</td>
<td>93%</td>
<td>98%</td>
<td></td>
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<td></td>
<td>3</td>
<td>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</td>
<td>Rate of falls resulting in harm per 1,000 bed days to equate to 1.53</td>
<td>1.59</td>
<td>1.36*</td>
<td></td>
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<tr>
<td></td>
<td>4</td>
<td>Reducing the consumption of antibiotics and optimising prescribing practice</td>
<td>Reducing the use of Carbapenems by 2%</td>
<td>-30.1%</td>
<td>-60%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Reducing overall consumption of antibiotics by 1%</td>
<td>Increase of 14%</td>
<td>16% increase</td>
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<td></td>
<td>5</td>
<td>Reduce the incidence of pressure ulcers</td>
<td>Reduce the incidences of category 2-4 pressure ulcers in the community by 10% from 2017/18 baseline data - presented as a % of the patients held on the community caseloads</td>
<td>18.33%</td>
<td>16.48%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Reduce the rate of incidence of category 2-4 pressure ulcers in the Acute Hospital to 4.23</td>
<td>1.93</td>
<td>2.09</td>
<td></td>
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<tr>
<td>Experience</td>
<td>6</td>
<td>Review all ward nursing models of care to investigate alternatives roles to delegate identified tasks to other roles*</td>
<td>Nurse staffing review for each area twice a year</td>
<td>Annual staffing reviews complete. Bi-annual check and challenge - latest undertaken Oct 18.</td>
<td></td>
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<tr>
<td></td>
<td>7</td>
<td>To provide our patients with the best possible experience demonstrated by better than the national average Friends and Family score.</td>
<td>Inpatient/Daycase</td>
<td>96%</td>
<td>96%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>A&amp;E Services</td>
<td>97.2%</td>
<td>97.3%</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Maternity (Postnatal Ward)</td>
<td>95%</td>
<td>95.2%</td>
<td></td>
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<tr>
<td></td>
<td>8</td>
<td>Improve the understanding of information given to patients at discharge about the effects of their medication</td>
<td>Increasing % of patients reporting being told about medication side effects to watch out for when they go home</td>
<td>44% (Sept 2017)</td>
<td>55% (Sept 2018)</td>
<td></td>
</tr>
<tr>
<td>Effective</td>
<td>9</td>
<td>Electronic discharge summaries will be sent to GPs within 24 hours</td>
<td>90% electronic discharges sent &lt;24 hours.</td>
<td>35.3%</td>
<td>37.70%</td>
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</tbody>
</table>

*Falls rate for 2018/19 reflects the position at time of publication and is subject to change.
What the Trust has done to address the Quality Improvement Priorities

Priority One: 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.

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 educating, supporting and facilitating clinical colleagues in evidence based infection prevention practices.

At the end of March 2019, the Trust had reported 46 Trust-attributed Clostridium Difficile Infection (CDI) cases (37 cases in 2017/18). This is against the nationally set objective to have no more than 26 cases in 2018/19. 40 of the cases were deemed not preventable, whilst two were deemed as preventable (six preventable cases in 2017/18) and four cases remain in the review process.

A comprehensive Clostridium Difficile infection 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.

Colleagues from Public Health England attended the Trust 13 November 2018 to review the Trust CDI position. Recommendations from Public Health England included:

- continue to promote multi-disciplinary review of all CDI cases including doctors
- review testing and diagnostic procedures, particularly in the emergency departments
- look at options for implementing antimicrobial three-day review: stop-start-continue antibiotics
- provide prompts for medical reflection on prescribing behaviour or post infection review, including information to clinicians for immediate patient review
- positive reinforcement for good practice
- develop a robust plan for using HPV post CDI infection
- introducing toxin gene PCR testing to distinguish between toxigenic and non-toxigenic CDI strains to free up space for others needing side rooms.

The above recommendations will be included in an improvement plan.

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 has taken a number of actions including:

- hosting a CDI Summit in May 2018 where learning was shared and improvement pledges made by clinical staff
- feedback on all cases has been given to clinical teams and ward managers so that learning could be shared at their team meeting
- 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 Optimisation Teams
- lessons learned are disseminated through staff communication channels.

Whilst there is no national objective for Methicillin-Susceptible Staphylococcus Aureus (MSSA) bloodstream infection cases, the reduction of cases of MSSA was included as a Quality Improvement Priority in the Trust Quality Account for 2018/19. At the end of March 2019 the Trust had reported 17 Trust attributed cases (26 cases at the end of 2017/18).

There is a national objective to reduce gram negative (E-coli, Klebsiella and Pseudomonas) bloodstream infection cases by 25% by 2021 with an aspiration of 50% reduction by 2023-24. At the end of March 2019 the Trust had reported 70 E-coli cases (72 cases at the end of 2017/18), 18 Klebsiella cases (21 cases at the end of 2017/18) and 13 Pseudomonas cases (15 at the end of 2017/18). The Trust has a comprehensive reduction plan to reduce E-coli bloodstream infections. This plan aligns to the health economy reduction plan; however, the majority of these infections are not thought to be associated with prior healthcare.

**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.

In line with national expectations the aim was that 90% of eligible patients in the Trust’s emergency departments would be screened for sepsis. To date during 2018/19, 98% of eligible patients were screened for sepsis; this is an improvement on 93% the previous year. A number of junior doctors are working in collaboration with the sepsis lead consultant in undertaking quality improvement projects in relation to increased use of the sepsis screening tool, which will be written up and presented on completion.

For AKI the Trust committed to ensuring key information showing that patients had been screened was to be recorded in discharge summaries. Performance during the year is 65% compared to 55% last year showing an upward trend (target is ≥90%). The Trust has not seen the expected improvement and further actions have been identified to deliver this improvement although some improvement has been demonstrated.

This year has seen a number of initiatives and actions that have kept Trust-wide focus on sepsis and AKI and there have been some positive improvements, particularly in relation to antibiotic
administration in sepsis. This is largely due to the collaborative working between the Medical Director’s Office, the Trust sepsis group, Pharmacy and engagement with clinical leaders. The introduction of the national Antibiotic Review Kit (ARK) study, which has changed the process by which antibiotics are reviewed, appears to have had a positive impact on performance in this area with 71% in 2018/19 compared to 63% last year.

Although our hospital standardised mortality ratio (HSMR) for Aug 17- July 18 is 115.9 compared to 103.3 last year, a review of sepsis deaths undertaken by members of the sepsis group revealed that around 50% of deaths coded as sepsis did not have sepsis identified on their death certificate. Work is ongoing in relation to how the Trust can monitor this information as a way of assurance. It is believed that increased awareness and knowledge are linked to increased diagnosis and therefore an increase in clinical coding for sepsis.

Other sepsis work streams delivered throughout 2018/19 have included:

- engagement from the Infection Prevention and Control (IPC) team with community care settings, particularly in relation to urinary tract infections (UTIs), to provide education, awareness and documentation to keep patients out of hospital; a catheter passport has been devised in an attempt to reduce the number of catheter related UTIs
- a pilot in respiratory areas in use of Procalcitonin tests in order to exclude sepsis in patients presenting with exacerbation of chronic obstructive pulmonary disease (COPD)
- consultant-led multidisciplinary team sepsis ward rounds, enabling on the spot microbiology advice
- an annual sepsis campaign week.

From April 2018 to present day, the Trust has seen a total of 1922 patients who have presented with or developed a stage 2 or 3 AKI. These are logged and tracked by the Sepsis/AKI nurse and followed up within the clinical setting, giving advice and input into clinical management and discharge information.

AKI work streams delivered throughout 2018/19 have included:

- a focused fluid balance month concentrating on education for nursing staff
- an AKI/hydration awareness campaign targeted at staff and visitors focusing on healthy kidneys
- a review and update of the fluid balance policy
- approval to trial an AKI care bundle to help guide more timely and appropriate treatment.

The Trust has recently appointed an Associate Medical Director for Quality and Patient Safety whose remit will incorporate working closely with the sepsis and AKI leads, and overseeing the work streams and performance. A more collaborative approach between sepsis and AKI is being adopted, and it is anticipated that further improvements will be made over the next year.

Priority Three: 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.

This Quality Improvement Priority focuses specifically on harm caused by falls and aims to reduce the number of people who have a fall that results in harm per 1,000 bed days by 10%. The Trust position for the year end of 2018/19 showed an overall 11.1% decrease against the total number of falls recorded compared to 2017/18.
The Trust falls prevention programme was developed using evidence and experience from other trusts, the Royal College of Physicians and NICE guidance.

In 2018/19 the Trust has 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 other ‘harm’ 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.

- Trust-wide roll out of the ‘falls risk’ wrist bands.

- ‘Falls February’ was held in February 2019 to promote and to help raise awareness to staff and demonstrate the support available. The month included information stands from Carelink, Age UK and Live Well Wakefield. Activities incorporating PJ Paralysis, Dementia Awareness, including the empathy suit, lie-flat hoist demonstrations and ‘Pimp My Zimmer’ competition.

- Continued expansions of safety huddles alongside the Improvement Academy; the Trust has more coaches trained and able to support more wards. We have also celebrated success through Twitter, with the help of the Communications Team.

A number of other practical falls prevention initiatives were launched across the Trust in 2018/19 to assist all staff, clinical and non-clinical, to help reduce the risk of patients falling whilst in the Trust’s care. Examples include the following.
1. Participating in the National Audit for In-Patient Falls (NAIF).
2. Purchase of five lie flat hoists.
3. Research project on red Zimmer frames.
4. Development of post falls proforma documentation which is now Trust wide.
5. In situ falls prevention training for individual wards.
7. Falls screening tool in Emergency Department has been redesigned.
8. Revision of the Falls Policy has commenced with a working group.
9. Multifactorial Falls Risk Assessment Tool has been redesigned.
10. There has been a trial of the post falls root cause analysis document, which is ongoing.

Priority Four: Reducing the consumption of antibiotics and optimising prescribing practice.

During 2018/19, there has been a concerted effort by Antimicrobial Pharmacy, Infection Prevention and Control (IPC) and Microbiology Teams to lead improvements in antimicrobial use to achieve better experience and health outcomes for patients. Notable activities by the Antimicrobial Stewardship (AMS) Team include the following.

- Introduction of the ARK study (Antibiotic Review Kit), a National Institute for Health Research portfolio study to improve review of antibiotics within 72 hours, which has improved antibiotic review by senior medical staff within 72 hours.
- Influenza point of care testing during the winters 2017/18 and 2018/19 has improved treatment and isolation of patients with influenza. In 2017/18 a positive point of care test was associated with a two-day reduction in antibiotic use per patient.
- Updated local antimicrobial resistance reports on the Trust intranet (antibiograms) to inform guideline development, led by the Information Analyst – Antimicrobials.
- 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.
- Regular antimicrobial ward rounds on the Intensive Care Unit, Gate 21 Haematology, Acute Care of the Elderly Unit, Infection Prevention and Control (Trust wide) and sepsis review (Pinderfields site).
- Improved use of home intravenous antibiotics, led by the Specialist...
Pharmacy Technician - Antimicrobials.

- Emergency department antimicrobial prescribing behaviour project led by the Advanced Clinical Pharmacist - Antimicrobials and HIV.

Targets for 2018/19 and 2019/20 in relation to antimicrobials are as follows.

- A 1% reduction in Meropenem consumption compared with January – December 2017. This target is currently being achieved due to guideline restriction.
- A 2% reduction in overall antimicrobial consumption compared with January - December 2017. This target is not currently being achieved as of March 2019, with an increase in consumption noted. This relates partially to an improvement in the pattern of prescribing, with more targeted antibiotics being used for patients. This increases the overall figure because more antibiotic combinations are required.
- Incorporation of antimicrobial stewardship into electronic prescribing and medicines administration, for implementation in 2019.

A significant risk to the achievement of the above indicators is the shortage of specialist infection doctors. This has necessitated a creative approach to provision of infection expertise, involving more pharmacy, nursing and scientist input, locum staff, and support from medical microbiologists across Yorkshire and the Humber.

Priority Five: Reduce the incidence of pressure ulcers.

Ensuring patients do not come to harm whilst in the Trust’s care is a key priority. 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.

In June 2018 NHS Improvement published the Pressure Ulcers: Revised Definition and Measurement summary and recommendations for trusts in England; these support a consistent approach to defining, measuring and reporting pressure ulcers. The intention is to provide each trust with an accurate profile of pressure damage so it can improve.

In May 2018, the Trust joined 22 other trusts in the NHSI Stop The Pressure Ulcer Collaborative. This was a great opportunity for the Trust to learn some new skills, to network with colleagues from around England who are working to reduce pressure ulcers, and a space for us to test improvement ideas in the Trust.

The Trust has a priority to reduce the incidence of pressure ulcers both within the hospital and also in the community, and the measures set to demonstrate achievement are as follows:

- At the end of 2018/19, the Trust achieved an overall decrease in Category 2-4 pressure ulcers of 19.7% compared to 2017/18.
- In 2019/20 we aim to reduce the incidence of Category 2-4 pressure ulcers in the Trust by 10% from 2018/19 baseline data.
Over the last 12 months the Trust has continued to strive towards reducing the number of hospital and community acquired pressure ulcers.

In the community the Trust introduced camera phones to record images of pressure ulcers. This has aided correct categorisation of wounds, early review and treatment guidance from the Tissue Viability Team and subsequent monitoring of any healing or deterioration of the wound. MY Therapy and community podiatry have completed training, and can now order pressure relieving equipment to prevent any delay in patient receiving pressure relieving devices. In June 2018 a ‘dressings on the shelf’ initiative commenced, ensuring the patient receives the right dressing at the first visit and there are no delays in treatment.

A senior nurse reviewer has been implemented to confirm and categorise pressure ulcers, alongside a daily handover and aide memoire which includes a review of pressure ulcer compliance. Many community patients reside in care homes. The Trust community nursing teams are supporting care homes with education and training regarding pressure ulcer prevention and management.

In the acute hospital the Trust has implemented training regarding skin assessments and preventative care into all the emergency departments and maternity wards.

A new pathway has been developed to complement the Purpose T Pressure Ulcer Risk Assessment Tool. This now directs staff to the actions they should take dependent on the level of risk of developing a pressure ulcer. The Trust continues to review and assess the SSKIN (Surface, Skin Integrity, Keep Moving, Incontinence, Nutrition) Assessment document to ensure it is user friendly and fit for purpose.

In May 2018 several wards in the Trust signed up to the 70-day PJ Paralysis Challenge. The campaign was aimed at improving patient activity and reducing the risk of complications associated with immobility, including the development of pressure ulcers.

In September 2018 the Tissue Viability Team and members of the Quality and Safety Team led a staff and public awareness campaign for International Stop the Pressure Day. The campaign was aimed at increasing healthcare professional and public awareness about the damaging impact of pressure ulcers.

Staff were asked to wear a red dot in key pressure points to start the conversation around preventing pressure ulcers.

In November 2018 the Pressure Ulcer Prevention and Management Care Bundle was launched. The pressure ulcer care bundle is a group of best practice interventions, tested locally and nationally, that when utilised help to reduce the development of pressure ulcers.
A Rapid Programme of Improvement Work was undertaken in December 2018. As a result of the improvement work the Tissue Viability Nurses are currently reviewing all hospital inpatients across the acute Trust within one or two working days.

Priority Six: Review all ward nursing models of care to investigate alternative roles to delegate identified tasks to other roles.

The National Quality Board (NQB) issued guidance to all trusts in July 2016 entitled ‘Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing’ to apply to nursing and midwifery staff and the broader multi professional workforce, in a range of care settings, to help NHS make local decisions that will support optimisation of productivity, efficiency whilst maintaining the focus on improving quality delivering high quality care for patients within the available staffing resource.

This gave an approach to deciding staffing levels and skills based on patient need, acuity and risks, which is monitored ward to board.

The development of new models of care through the Sustainability and Transformation Plans requires the Trust to think differently about staffing decisions, building teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to patient need across different settings, and allowing for alternative roles to be introduced to the traditional model of the nursing workforce.

The guidance gave three key measures that need to be considered when looking at alternative models of care to implement new roles. These are:

- introducing the care hours per patient day (CHPPD) metric as a first step in developing a single and consistent way of recording and reporting staff deployments and understanding the number of hours of care required by each patient
- identifying a triangulated approach - ‘right staff, right skills, right place and time’ - to staffing decisions
- offering guidance on using other measures of quality, alongside CHPPD to understand how staff capacity may affect the quality of care.

The Trust has therefore taken the following approach when introducing new roles into the non-medical workforce.

- An annual strategic staffing review is undertaken using evidence based tools (Safer Nursing Care Tool - SNCT) and professional judgment. Comparison with peers in local surrounding hospital trusts is also used to benchmark our decisions.
- The Trust Board is provided with a staffing review report following the review within six months, making recommendations of staffing, role and service changes.

By undertaking this approach the Trust has introduced a number of new roles in to the workforce. The nursing associate is a new role which is aimed at bridging the gap between the non-registered workforce and the registered nurse. The role is still registered and regulated but is designed to support the implementation of the planned care identified by the registered nurse.

To date the Trust has employed 89 apprentices on to the Trainee Nursing Associate Programme over three cohorts, the first due to qualify in June 2020. In
addition, the Trust is piloting a new role of advanced pharmacy technician where this worker is part of the nursing team, administering medication for part of the 24-hour period and providing advice on medication to patients. This releases the registered nurses’ time to undertake other care needs of patients that cannot be undertaken by a non-registrant in the workplace. The pilot is already showing very positive results and it is anticipated further development in recruitment of this role will occur in the next 12 months.

Implementing a new role in to the workforce can be challenging. However, the Trust has followed national recommendations and guidance to ensure a robust governance process is in place to monitor the impact on quality and safety of patient care, and is reassured that this measured approach will prevent any of these issues arising.

**Priority Seven: To provide our patients with the best possible experience demonstrated by better than the national average Friends and Family Test Score.**

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 inpatients and day case, emergency services, outpatient and community services have remained above the national average. Maternity services (at birth) have shown the most variation in scores with two months’ results dropping below the national average. Maternity staff have reflected on these results and triangulated these with other sources of feedback to look at ways to make improvements.

The graphs below show the proportion of patients who say they would ‘recommend’ the relevant service as a place to receive care if family or friends needed similar care or treatment.

The following key relates to all graphs. National average for FFT data is late in publication; therefore March 2019 national average is not available at time of report.

![Graph showing FFT scores for inpatients and day cases](image_url)

### Inpatients and day cases – recommend scores
The Trust continues to monitor and encourage participation in the national FFT. Suggestions for improvement within the comments are used alongside other sources of patient experience feedback to support the implementation of changes. The majority of the feedback is positive, and very much welcomed, and is used to identify ideas for sharing and helps raise morale amongst staff.

**Priority Eight: Improve the understanding of information given to patients at discharge about 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 September 2018 and March 2019, to ascertain patient satisfaction with information they receive regarding their medicines in hospital. These surveys demonstrated that patients continue to report greater satisfaction levels in our surveys than to the Picker survey, with a 47% improvement over the last 12 months in patients reporting they were told about medication side-effects. 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, and patients routinely report their satisfaction with the outpatient services.

A training package was developed and delivered to pharmacy staff in June 2018 to allow medicines optimisation staff to be able to counsel patients at ward level more effectively around their direct oral anticoagulant medications.

A patient information leaflet has been devised for patients who have recently suffered a myocardial infarction to give them more information about their new medications; piloting of this leaflet in early 2019 was successful and this has now been rolled out to the Cardiology Ward at Pinderfields and is being used by the Cardiac Rehabilitation Nursing Team also.

A further two near-patient dispensing terminals were implemented in the Pinderfields Hospital site during 2018/19; these were in addition to the two trolleys introduced in 2017/18 at Pinderfields 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 2018, the Medicines Optimisation Team repeated 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 2018, where advice services to staff and patients were promoted; this encouraged patients and staff to ask questions about their medicines and links to the national ‘Ask your Pharmacist’ week.

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 and capabilities of the system.

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: Electronic discharge summaries will be sent to GPs within 24 hours.

The NHS Standard Contract stipulates that discharge summaries (inpatient, day case and A&E attendances) are shared with GPs/referrers within 24 hours of discharge and that this information is shared electronically. It also states that the format and headings within the letter should be to a standard as set out by the Academy of Medical Royal Colleges (AoMRC).

The majority of discharges from the Trust are completed on a software system, SystmOne, that ensures they can be sent electronically, directly to GP practices who
use the same system. GPs who use a different software system are sent the summaries via NHSMail. The Trust uses other clinical systems such as EuroKing and BadgerNet from which, currently, it is not possible to send summaries electronically to GPs. The current practice is that the summaries are printed and posted to GPs, which does not meet the contractual requirement.

In January the SystmOne performance for discharge summaries, completed within 24 hours, was 47.8%. The overall Trust position was 37.7%, which is inclusive of all discharges. This shows that where discharge summaries cannot be sent electronically, this brings overall performance down.

So that the Trust can understand why compliance with SystmOne discharges is low, even though systems and processes are in place to achieve the 24 hours standard, observations were carried out in clinical areas over a number of months during 2018. These observations identified a number of issues and opportunities across a range of themes including:

- clinical engagement – so that clinicians complete discharge summaries in a comprehensive and timely manner and are aware of the importance of sending this information to GPs
- addressing technical barriers to transmission of discharge summaries electronically which is ongoing and is in testing phase; in addition, the access to and use of smart cards and the upgrade of systems to support electronic discharge
- addressing gaps in training and education to reduce variation in practice
- discharge summaries and supporting processes should not be reliant on one person or a particular clinician to complete; there is an opportunity for other types of clinician and staff members to be trained to complete discharge summaries and be involved in the process.

A number of specific actions and initiatives have been identified and implemented to address the particular themes outlined above, and performance over the year has continued to improve.
**Priorities for improvement 2019/20**

The Trust has undertaken a full review of progress made against the nine Quality Improvement Priorities set for 2018/19, 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 2018/19 Quality Improvement Priorities be continued into 2019/20 to deliver further improvements.

The Trust has considered the views of the Trust’s Stakeholder Forum, Healthwatch, the local authority overview and scrutiny committees and commissioners.

Stakeholders confirmed that the priorities focused on last year remain highly relevant and therefore, the Quality Improvement Priorities for 2019/20 remain the same as in 2018/19 except for the following amendments:

- Metrics for all priorities except for Priority 1 have been updated.
- Priority 6, Review all Ward Nursing Models of Care, has been removed.

The following list of Quality Improvement Priorities for 2019/20 is therefore a product of this process.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority number</th>
<th>Outcome measure/indicator</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>1</td>
<td>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).</td>
<td>Total number of MRSA bloodstream infections-national objective being a Zero tolerance to preventable infections.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total number of CDIFF cases-national objective for 2019/20 no more than 73 cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total number of gram negative blood stream infections-National objective to reduce gram negative bloodstream infection cases by 25% by 2021.</td>
</tr>
</tbody>
</table>
|                 | 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                                                                 | **AKI:**  
- For all stage 2 and 3 patients who are for active treatment, establish a baseline position AND 75% to have an appropriately completed fluid balance chart by the end of Q1  
- 100% of the above group of patients to have appropriately completed fluid balance charts by the end of Q4  
- 90% of the patients above to have appropriately completed discharge letters  
**Sepsis:**  
90% of patients to be screened for sepsis in ED  
60% completion of the sepsis screening tool for appropriate inpatients                                                                 |
|                 | 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 from falls                                                                 | Number of falls resulting in harm per 1,000 bed days to equate to 1.37                                                                                                                               |
|                 | 4               | Reducing the consumption of antibiotics and optimising prescribing practice                                                                                                                                              | 1% reduction in meropenem consumption  
2% reduction in overall antimicrobial consumption  
Incorporation of antimicrobial stewardship into electronic prescribing and medicines administration, for implementation in 2019.                                                                 |
|                 | 5               | Reduce the incidence of pressure ulcers                                                                                                                                                                                 | Reduce the incident of Category 2-4 pressure ulcers in the Trust by 10% from 2018/19 baseline.                                                                                                        |
| Experience      | 6               | To provide our patients with the best possible experience demonstrated by better than the national average Friends and Family score.                                                                                       | Metrics to reflect those in the Integrated Performance Report.                                                                                                                                       |
|                 |                 |                                                                                                                                                                                                                         | ‘FFT scores are better than national average’                                                                                                                                                     |
|                 | 7               | Improve the understanding of information given to patients at discharge about the effects of their medication                                                                                                         | Increasing % of patients reporting staff explained purpose of medicines – performance progress measured by the month +5 FFT data.                                                                 |
| Effective       | 8               | Electronic discharge summaries will be sent to GPs within 24 hours                                                                                                                                                      | 90% electronic discharges sent <24 hours.                                                                                                                                                           |
## Statements of assurance from the Board

### Review of services

During 2018/19, the Trust provided 131 relevant health services. These are:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
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<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>A&amp;E Primary Care Support</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>Intermediate Care</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>Interventional Radiology</td>
</tr>
<tr>
<td>Audiology</td>
<td>Looked after Children</td>
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<tr>
<td>Breast Surgery</td>
<td>Macmillan</td>
</tr>
<tr>
<td>Burns Care</td>
<td>Maternity Pathway</td>
</tr>
<tr>
<td>Burns Care Clinical Psychology</td>
<td>Medical Oncology</td>
</tr>
<tr>
<td>Burns Care Occupational Therapy</td>
<td>Neonatal Outreach</td>
</tr>
<tr>
<td>Burns Contract Adjustment</td>
<td>Neonatology</td>
</tr>
<tr>
<td>Burns Critical Care</td>
<td>Neurology</td>
</tr>
<tr>
<td>Cancer MDT</td>
<td>Neurology Learning Disabilities Epilepsy</td>
</tr>
<tr>
<td>Cancer Nurse Specialist</td>
<td>Obstetrics</td>
</tr>
<tr>
<td>Cardiac Rehab Post Discharge</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Children’s Community Nursing</td>
<td>Oral Surgery</td>
</tr>
<tr>
<td>Child Community Medical</td>
<td>Orthodontics</td>
</tr>
<tr>
<td>Child Death Review</td>
<td>Orthoptics</td>
</tr>
<tr>
<td>Child Health Admin</td>
<td>Orthotics</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>Pacemaker checks</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>Paediatric Burns Care</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>Paediatric Cardiology</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>Paediatric Diabetes Nurse Specialist</td>
</tr>
<tr>
<td>Service</td>
<td>Department</td>
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<tr>
<td>---------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Community - Care Home Vanguard</td>
<td>Paediatric Diabetic Medicine</td>
</tr>
<tr>
<td>Community - Connecting Care Hubs</td>
<td>Paediatric Endocrinology</td>
</tr>
<tr>
<td>Community - Home First</td>
<td>Paediatric Epilepsy</td>
</tr>
<tr>
<td>Community Cardiology</td>
<td>Paediatric Gastroenterology</td>
</tr>
<tr>
<td>Community Dental</td>
<td>Paediatric High Dependency Unit</td>
</tr>
<tr>
<td>Community Diabetes</td>
<td>Paediatric Nephrology</td>
</tr>
<tr>
<td>Community Dietetics</td>
<td>Paediatric Neuro-Disability</td>
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<tr>
<td>Community Geriatrics</td>
<td>Paediatric Neurology</td>
</tr>
<tr>
<td>Community NIV</td>
<td>Paediatric OT</td>
</tr>
<tr>
<td>Community Rehab</td>
<td>Paediatric Respiratory Medicine</td>
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<tr>
<td>Community Specialist Nurses</td>
<td>Paediatric Rheumatology</td>
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<tr>
<td>Critical Care Medicine</td>
<td>Paediatric Therapies</td>
</tr>
<tr>
<td>Critical Care Outreach</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>DAFNE</td>
<td>Pain Management</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Palliative Care Team</td>
</tr>
<tr>
<td>DESP</td>
<td>Palliative Day care</td>
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<tr>
<td>Diabetes Foot Protection Team</td>
<td>Palliative Medicine</td>
</tr>
<tr>
<td>Diabetic Medicine</td>
<td>PERT</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>Dietetics</td>
<td>Plastic Surgery</td>
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<tr>
<td>Direct Access Cardiology</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Direct Access Dietetics</td>
<td>Radiology</td>
</tr>
<tr>
<td>Direct Access EEG</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>Direct Access Pathology</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td>Direct Access Physiotherapy</td>
<td>Respiratory Physiology</td>
</tr>
<tr>
<td>Direct Access Radiology</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>EEG</td>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>Emergency Assessment Team</td>
<td>Spinal Injuries</td>
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<td>---------------------------</td>
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<tr>
<td>Endocrinology</td>
<td>Spinal Injuries Clinical Psychology</td>
</tr>
<tr>
<td>Ear Nose and Throat</td>
<td>Spinal Injuries Occupational Therapy</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Single Point of Contact</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Stroke Medicine</td>
</tr>
<tr>
<td>Gen Med - Ambulatory Care</td>
<td>Tissue Viability</td>
</tr>
<tr>
<td>General Community Nursing</td>
<td>Transient Ischaemic Attack</td>
</tr>
<tr>
<td>General Medicine</td>
<td>Trauma &amp; Orthopaedics</td>
</tr>
<tr>
<td>General Pathology</td>
<td>Trauma &amp; Orthopaedics Fracture Clinic</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Upper Gastrointestinal Surgery</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>Urology</td>
</tr>
<tr>
<td>Gynaecological Oncology</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Wakefield intermediate care unit</td>
</tr>
<tr>
<td>Gynaecology Early Pregnancy Assessment Unit</td>
<td>Weight Management Service</td>
</tr>
<tr>
<td>Hand Therapy</td>
<td>Youth Offenders Team</td>
</tr>
<tr>
<td>Hepatology</td>
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</tbody>
</table>

The Quality Account is based on a review of data available on the quality of care in all 131 of these services. The Mid Yorkshire Hospitals has reviewed all the data available on the quality of care in 131 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by the Mid Yorkshire Hospitals NHS Trust for 2018/19. The whole of the income the Trust received in 2018/19 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](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. The Trust strategy describes the strategic objective to “provide excellent research, development and innovation opportunities”.

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. The Trust actively engages with academic and healthcare organisations to explore and support research partnerships to improve 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.

Between 1 April 2018 and 31 March 2019, over 270 studies were active within the Trust. Of those, 46 studies were new and opened during 2018-19.

The number of patients receiving relevant health services provided or subcontracted by Mid Yorkshire Hospitals NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 2663. 98% (2620 participants) of this activity is related to research adopted onto the National Institute for Health Research (NIHR) portfolio. NIHRs ‘adoption’ is a nationally recognised sign of quality, meaning studies “attempt to derive generalisable (ie 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 the 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 2018/19, and that the Trust successfully recruited 2471 participants into non-commercial NIHR studies against the target of 1485.

The Trust has research activity across a wide range of clinical specialties. In 2018/19 the 39 new NIHR portfolio adopted studies were in a wide range of areas. These run alongside studies opened in previous years and new non-portfolio studies.

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

In April 2018, the Trust held a research event attended by over 110 people, to share the impact of our research with colleagues and external partners and to facilitate new research partnerships.

Some highlights have included the following.

- The Trust has a growing portfolio of vascular research. 40 patients took part in a study which has informed the use of compression first over any other treatment and led to the creation of the new local patient pathway which will be adopted by the wider venous community.

- In a study looking at the management of hard to heal diabetic foot ulcers, 21 patients took part in a study which has helped test a treatment which has contributed to significantly reducing the healing time of diabetic foot ulcers. This was the first time both Pinderfields and Pontefract podiatry clinics were involved in research.

- In 2018 we were the first hospital in the UK to recruit a patient to a research trial which is looking at the novel therapy alternative to Botox which can reduce urinary incontinence in patients with two distinct neurological conditions such as spinal cord injuries and multiple sclerosis.

In the Trust’s desire to continuously improve, a review of patient research experience has been undertaken. In December 2018/January 2019, 94 research patients completed a survey about their experiences. Findings are being analysed and will feed into service improvement. Comments made by patients completing these surveys have included the following.

“My personal journey has been well supported by the research team. Whenever I have needed assistance, they have been there to offer help and support.”

“All the treatment was done in a professional way, by people who are committed and really dedicated.”

“I am a big believer in research to help in the future.”

**Participation in clinical audit**

Clinical audit helps the Trust to identify ways in which it can improve the care it provides for patients. During 2018/19 48 national clinical audits and six national confidential enquiries covered relevant health services that the Mid Yorkshire Hospitals NHS Trust provides. During 2018/19 the Mid Yorkshire Hospitals NHS Trust participated in 45, (96%) of the national clinical audits and 5, (83%) of the national confidential enquiries, it was eligible to participate in. Of the remaining two projects, both are under negotiation for delivery in 2019-20 and plans are in place for these to be undertaken locally using the national data set, giving the best achievable compliance with the audit programme. The national clinical audits and national confidential enquiries that Mid Yorkshire Hospitals NHS Trust was eligible to participate in during 2018-19 are shown in a table included here as Appendix III.

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 2018/19 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.

**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:

- project plans for all level 1 audits started from the Annual Audit Priority Programme (AAPP)
- project summaries with action plans for all completed audits
- activity tracking tables for each speciality to monitor progress of audit projects identified on the AAPP
- action tracking tables where actions have been identified for all completed projects.

The reports of 52 national clinical audits were reviewed by the Trust in April 2018 to March 2019, and the Mid Yorkshire Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>National audit</th>
<th>Local actions/recommendation from national audit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain in Children</strong> 563 (College of Emergency Medicine)</td>
<td>Pain in children is one of the Royal College of Emergency Medicine (RCEM) clinical audit topics for 2017/2018. The purpose of the audit was to identify current performance in emergency departments against RCEM clinical standards. The five clinical standards audited against were: STANDARD 1: Pain score is assessed within 15 minutes of arrival STANDARD 2: Patients in severe pain (pain score 7 to 10) should receive appropriate analgesia in accordance with local guidelines (unless documented reason not to) STANDARD 3: Patients in moderate pain (pain score 4-6) should receive appropriate analgesia in accordance with local guidelines (unless there is a documented reason not to) STANDARD 4: 90% of patients with severe or moderate pain should have documented evidence of re-evaluation and action within 60 minutes of receiving the first dose of analgesic. STANDARD 5: If analgesia is not prescribed and the patient has moderate or severe pain the reason should be documented in the notes. The Trust's results showed a higher than national median percentage in all five standards. In order to maintain current practice and to further improve performance locally the following recommendations were identified: 1. All patients presenting with moderate or severe pain should have their pain reassessed 15 minutes after analgesia and 1 hour after analgesia. 2. Ensure appropriate nursing staff completed required training for</td>
</tr>
</tbody>
</table>
competency in prescribing patient group directive to ensure that pain levels are recognised early and appropriate pain relief can be administered at the earliest opportunity.

3. Ensure that all staff document the pain score at triage after initial assessment of a patient.

To implement recommendations, the following actions were developed and agreed:

- Develop and trial ‘pain passport’ document, to be used on each child in conjunction with parents to ensure appropriate monitoring and recording of pain scores are completed in a timely manner to ensure pain experienced by a child is kept to a minimum and managed appropriately and effectively.

- Continue to provide training of nurses to enable PGD prescribing.

The pain passport below is currently being trialled with a view to implementing permanently if successful once piloted and amendments made as appropriate. This will improve the experiences of children using services in emergency departments at Mid Yorkshire Hospitals.

### National Audit of Dementia (364) Royal College of Physicians

The National Dementia Strategy launched in 2009 identified improving the quality of care for people with dementia in general hospitals as one of its key objectives.

Investment in care for people with dementia should result in improved quality of life, improved quality of death and reduced costs to society.

The audit focused on care in general hospitals for those with dementia to examine the effectiveness of services as well as explore patient and carer experience in general hospitals.

Key messages derived from the national report found that:

- delirium recording requires improvement
• personal information to support better care must be accessible
• services must meet the nutritional needs of people with dementia
• championing dementia means supporting staff
• involve the person with dementia in decision making.

Based on those, a comprehensive action and quality improvement plan was developed and agreed and has now been completed, led and supported by the Trust Dementia Lead and Dementia Lead Nurse.

Delirium:
• identification and management on wards
• promote completion of cognitive score (AMTS) by junior doctors via ward based education sessions
• senior management (Deputy Chief Executive/Director of Nursing and Quality) support of delirium and dementia screening by ward nurses
• review of Trust’s Dementia Care Pathway to ensure clear links to delirium pathway from dementia pathway.

Personal information use:
• audit of ‘Forget-me-not’ document throughout the year by Dementia Support Team with findings shared at the Dementia Steering Group
• widen sharing of the findings to include Trust Dementia Champions meetings, ward managers and at ward meetings with staff
• Trust Dementia Lead to discuss with local clinical commissioning group (CCG) the proposal of having a nationally backed monitoring programme aimed at embedding the collection, sharing and use of person centred information.

Nutrition:
• Dementia Lead Nurse to contact Catering Lead Manager to obtain support for future tendering for catering contracts to request provision of finger foods for main meals and access to a range of snacks 24 hours a day
• ongoing promotion of open visiting and John’s Campaign by Dementia Lead and Dementia Lead Nurse to ensure Medical and Nursing Directors continue to promote attendance of key carers to complement support care provided by staff
• invite representatives from Catering Department to attend Dementia Steering Group meeting to address any barriers to introducing finger foods
• Dementia Lead Nurse to monitor carer feedback and complaints to assess access of carers to patients to support nutrition at mealtimes.
Championing dementia:

- Dementia Lead Nurse and Dementia Lead to gain agreement from Trust Lead Nurse for the aim of assessing ward staffing rotas across the Trust to ensure a Trust Dementia Champion is available to support staff 24 hours a day, 7 days a week.

Decision making:

- Dementia Lead to contact Trust Safeguarding Lead to support plans to enhance education of all staff in capacity, consent and Mental Capacity Act to improve documentation.

Patient care:

- Dementia Lead Nurse and Dementia Lead to gain agreement from Trust Lead Nurse for the Trust to work towards enhanced activity programmes to provide opportunities for social interaction for people with dementia - especially for patients experiencing longer lengths of stay – including extra resources and training for volunteer befrienders, healthcare assistants and expansion of the Dementia Support Team to enable this.

### NPCA

NPCA is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer. It is designed to collect information about the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes. The findings from the audit contribute to changes in clinical practice ensuring that patients receive the best care possible and experience an improved quality of life following a diagnosis of cancer.

#### Summary of national findings

- In England and Wales, the proportion of men diagnosed with metastatic disease at presentation has stabilised compared with previous years (but with some variation between providers).
- 55% of the men were 70 years old or over.
- 8% of men with low-risk, localised disease underwent radical treatment and are potentially ‘over-treated’ which compares favourably with 12% in 2014/15.
- Fewer men with high-risk localised/locally advanced disease were potentially ‘under-treated’ in 2015/16 – 73% of these men received radical treatment, which is an improvement compared with 61% of men in 2014/15.
- 4% were readmitted to hospital as an emergency within 90 days following radical prostatectomy.
- The number of men with low-risk, localised disease receiving radical therapies continues to reduce over time and more men are now being managed safely with active surveillance.
Within two years of undergoing radical treatment, one in ten men experience at least one severe genitourinary complication after undergoing radical prostatectomy, or a severe gastrointestinal complication following external beam radiotherapy.

The findings demonstrate the importance of appropriate counselling of patients regarding potential treatment-related toxicity and the provision of support services beyond the immediate post-treatment period.

Improvements are still required in other key data items including ASA score, performance status and key bespoke NPCA specialist surgery and radiotherapy.

MYHT performed above national average in five out of the eight criterion. Data completeness was better than national in the following:

- ASA completed
- Performance status
- PSA completed
- Multipara metric MRI performed
- At least one planned treatment recorded.

Improvements are required in completion of the following:

- Gleason score
- TNM staging
- At least one treatment modality recorded.

An action plan was put in place which has now been completed to further improve areas falling below national results and to enhance the progress of the patient pathway:

- MDT co-ordinators to record TNM staging at MDT meetings.
- Set up joint clinics to include surgeon, oncologist and CNS to ensure more effective and timely joined-up approach to seeing patients in clinic.

Parkinson’s disease (PD) is a common, chronic, progressive neurological condition, estimated to affect 100–180 people per 100,000 of the population (between 6 and 11 people per 6000 of the general population in the UK), and has an annual incidence of 4–20 per 100,000. There is a rising prevalence with age and a higher prevalence and incidence of PD in males.

Although PD is predominantly a movement disorder, other impairments frequently develop including psychiatric problems such as depression and dementia. Autonomic disturbances and pain (which is rarely a presenting feature of PD) may later ensue, and the condition progresses to cause significant disability and handicap with impaired quality of life for the affected person. Family and carers may also be affected indirectly.

The aim of the audit was to ascertain if the assessment and management of
patients with an established diagnosis of Parkinson’s complies with national guidelines in the new Parkinson’s service provided by Care of the Elderly in Mid Yorkshire Hospitals NHS Trust. Also to identify areas where the service may not be providing approved care to enable improvement in service and practice delivery.

MYHT Service at one year of development was largely compliant to national guidelines and appreciated by patients – 16 out of 17 patients surveyed felt that the service was ‘improving’ or ‘very good’.

Improvements required in the following:

a) inquiries about daytime sleepiness and driving
b) ICD monitoring
c) lying and standing BP in last year
d) assessment of fracture risk.

In addition to the clinical audit data, patient reported experience measures were included, which may or may not have been the same patients as included in the audit data. MYHT patients reported that:

- they were not notified to inform DVLA of their diagnosis
- poor support was offered for carers
- lack of information around lasting power of attorneys (LPAs).

Based on the findings, a comprehensive action and quality improvement plan, which has now been completed, was put in place whereby team education was provided within Elderly Medicine in respect of:

- daytime sleepiness and driving
- lying and standing blood pressure
- assessment of fracture risk
- DVLA information at diagnosis and review every time
- identify resources to provide support for carers
- provision of information about LPAs
- dopamine agonist consent leaflet is currently being developed within the Trust for ICD monitoring

National Oesophago-Gastric Cancer Audit (372)
NHS Digital

The National Oesophago-Gastric Cancer Audit (NOGCA) was established to investigate the quality of care received by patients with Oesophago-gastric (OG) cancer. Its long-term goals are to provide a benchmark against services to enable them to compare their performance and to identify areas where aspects of care can be improved.

Results are presented at a national level, strategic clinical network (SCN) level and individual NHS trust/health board level, and are primarily published to support the quality improvement activities in hospitals providing OG cancer care as well as the commissioners of cancer services.

MYHT performed better when compared nationally in the following measures:

- high grade dysplasia plan discussed at MDT
- treatment plan for active treatment in place
- first line treatment – endoscopic therapy.
Improvements are required in the recording of the following:
- referral source
- CT staging.

Overall findings show that clinicians are generally providing a high quality of care for patients with Oesophageal-Gastric cancer and high grade dysplasia. There has been an increased uptake of definitive chemo-radiotherapy among patients with oesophageal squamous cell carcinoma, and a greater use of combined therapies (surgery, radiotherapy and chemotherapy), demonstrating services are responding to a greater understanding of best practice.

<table>
<thead>
<tr>
<th>7 Day Service (773)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National debate continues around differences in care and outcomes based on which day, and what time, emergency patients attend and are admitted to acute hospital care. This prompted the development of national standards of care that were mandated to be adopted by all trusts by 2017. In order to support the introduction of the standards a national audit was instigated to raise awareness and allow for self-assessment of current practice, to enable healthcare organisations to aim to achieve the standards.</td>
</tr>
<tr>
<td>The audit focused on current availability and provision of services, providing trusts with the tools to self-assess against the clinical standards, identify gaps in current service provision, and understand what would be required locally to deliver safe, integrated care, seven days a week. It also enabled trusts to:</td>
</tr>
<tr>
<td>- monitor progress towards achieving the national clinical standards</td>
</tr>
<tr>
<td>- benchmark against others nationally, regionally and in comparator group</td>
</tr>
<tr>
<td>- produce trust reports prior to the national reports indicating areas for development</td>
</tr>
<tr>
<td>- consider how to use the views of patients and the public to inform services.</td>
</tr>
<tr>
<td>The clinical audit comprised two auditable standards:</td>
</tr>
<tr>
<td>- First consultant review within 14 hours of admission (90%) MYHT achieved 93% (within 15 hours 95.5%)</td>
</tr>
<tr>
<td>- Ongoing consultant review, this covered once and twice daily (90%) MYHT achieved once daily review = 97% MYHT achieved twice daily review = 99%.</td>
</tr>
<tr>
<td>Mid-Yorkshire NHS Trust evidenced excellent compliance with each standard for seven-day services. The ‘good news’ was shared throughout the organisation and was displayed across the Trust on all Trust PC screen savers to acknowledge the efforts of all involved in a fantastic achievement.</td>
</tr>
</tbody>
</table>
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 the 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 tracked and monitored until they are completed. A key focus throughout the year has been supporting development and improving the quality of action plans produced from clinical audits to ensure changes in practice are made to improve the services offered to patients at the Trust.

**Actions developed from local clinical audits**
The reports of 87 local clinical audits were reviewed by the provider in April 2018 to March 2019 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**

**Acute kidney injury discharge information (872)**
The Five Year Forward View (FYFV) has set out the vision for promoting wellbeing and preventing ill health, which among other things focuses on the care of patients with acute kidney injury. Acute kidney injury (AKI) is defined as a sudden reduction in kidney function and can usually occur without symptoms. Over half a million people in England sustain AKI every year, with this accounting for 5-15% of hospital admissions. As an organisational priority an audit was carried out to identify elements included on discharge summaries of patients with AKI in order to work towards improving follow up and recovery for individuals who have sustained AKI, reducing the risks of readmission, re-establishing medication for other long-term conditions.

Documentation was poor for the following elements:
- documentation of AKI stage
- medication review/changes to medication
- monitoring bloods/instructions for GPs.

Education around the importance of documenting these elements has been promoted around the Trust using screensavers. Changes on SystmOne have included mandated fields for completion of discharge letters and blood monitoring section is highlighted to prompt completion.

**Sepsis (548)**
Sepsis is a common condition where the body’s immune system goes into overdrive in response to an infection. Sepsis can potentially be life threatening in that it sets off reactions in the body that can lead to widespread inflammation, swelling and blood clotting which can lead to decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced. It is an acute condition that can affect all age groups and is a significant cause of mortality and morbidity in the NHS with around 35,000 deaths attributed to sepsis annually. Ensuring that the delivery of basic elements of sepsis care is undertaken is estimated to save up to £150 million annually and save 11,000 lives.

Problems with the detection and rapid treatment of sepsis have been identified in two recent reports by the Parliamentary and Health Service Ombudsman. This is
thought to contribute to a large number of preventable deaths from sepsis. Sepsis had therefore become a key priority for NHS England and healthcare organisations. In order to continuously review and improve the care for patients with sepsis, MYHT have implemented a continuous audit process which focuses on patients arriving in the hospital via the Emergency Department (ED) who have sepsis and inpatients who develop sepsis. As well as a range of actions for sepsis, rapid administration of antibiotics is the single most crucial action that can prevent deaths from sepsis and can be easily measured and reported on. The correct use of antibiotics and timely review are also essential to ensure effective management and improve survival.

Improvement work has continued throughout the year resulting in a gradual increase in improved performance for screening patients for sepsis and timely administration of antibiotics.

- During September the team initiated a sepsis awareness week as part of the National Sepsis Week, which included a re-launch of the sepsis screening tool, education and training around completion of the screening tool and importance of its use. The team also initiated a competition for the best pledges around sepsis awareness; the winners were presented with various prizes and teams produced some excellent work around awareness and the importance of recognising and treating sepsis early.

- Sepsis ward rounds have also been implemented to aid education and awareness of treating and recognising sepsis.

### Food allergy (908)

Food allergy has been defined as an adverse health effect arising from a specific immune response that occurs reproducibly on exposure to a given food.

- Food allergy is one of the most common types of allergy.
- It is a major health problem in Western countries. This is because of the potential severity of the allergic reactions (which can be life threatening if not treated quickly).
- There has been a dramatic increase in their prevalence.
- The National Institute for Clinical Excellence guideline on food allergy in under 19s states that the prevalence of food allergy in children under three years in Europe and North America ranges from 6% to 8%.

The NICE Quality Standard 118 is made up of six statements; the audit covered four statements which are relevant to the Mid Yorkshire Hospitals NHS Trust:

- Quality statement 1: Allergy focused clinical history
- Quality statement 2: Diagnosing IgE mediated food allergy
- Quality statement 3: Diagnosing non-IgE mediated food allergy
- Quality statement 6: Nutritional support for the food allergy.

100% compliance was evidenced in all four quality statements audited. Whilst results were excellent, the team felt that improvements could still be made in the following areas:

- devise proforma to include allergy focused clinical history, store with paediatric guidelines on the intranet for ease of use and access
• trained nurse to perform a skin prick test which would be more cost effective to the organisation – skin prick test 20p when compared to RAST test (specific IgE) which is nearly £30 for each test
• develop a secondary care allergy service according to standards set by BSACI to attract commissioners
• improve coding – allergy appointments should be coded as 255 Paediatric Clinical Immunology and Allergy – feedback to coding department
• carry out a prospective audit to enable identification of accurate cohort of patients seen in clinic.

This audit provides excellent assurance that the food allergy service at the Trust is in line with NICE guidance and meets the quality standard statements.

Breast MRI usage and Oncotype (589)
Breast cancer is the second biggest cause of death after lung cancer and is the most common cancer in women in England and Wales. Some patients are diagnosed in the advanced stages, when the tumour has spread significantly within the breast or to other organs of the body. In addition, a considerable number of people who have been previously treated with curative intent subsequently develop either a local or regional recurrence or metastases.

NICE quality standards set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. An audit carried out focused on two quality statements which form part of Quality Standard 12.

• Quality statement 2: Preoperative MRI scan
• Quality statement 3: Gene expression profiling.

Findings showed that Oncotype DX testing has been shown to be effective in predicting the course of disease in people with ER-positive, HER2-negative and lymph node-negative early breast cancer who have been assessed as being at intermediate risk of distant recurrence. This audit has reinforced that where Oncotype DX testing is not offered, there should be a clear reason documented for this, to ensure that there is consistent clinical care for all patients with the aim to improve outcomes in breast cancer recurrence, mortality from breast cancer and incidence of adverse effects from chemotherapy for all patients. This audit has reinforced that breast MRIs should only be requested when it is clinically appropriate to reduce any unnecessary, unbefitting stress on patients and reduce the burden on healthcare resources. The audit identified the need for a new neoadjuvant chemotherapy protocol to be developed to clarify the role of MRI scanning in patients receiving neoadjuvant chemotherapy, to ensure the provision of consistent clinical care.

Local 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)
• Patient Safety and Effectiveness Committee (and relevant sub groups)
• Medical Director’s Office
• steering groups (eg Falls Work Stream).
**Commissioning for Quality and Innovation Framework (CQUIN)**

A proportion of the Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body it entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation Payment Framework. The financial value attached through the framework to delivery of the agreed improvement goals in 2018/19 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 2018/19.

There were 25 schemes related to 11 CQUIN goals for 2018/19. This includes eight national (CCG) goals and three NHS England specialised commissioning goals. A summary of the Trust’s performance against the CQUIN indicators for 2018/19 is provided in the table below, as well as the actual and forecasted achievement.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at www.england.nhs.uk/nhs-standard-contract/cquin-19-20.
<table>
<thead>
<tr>
<th>CQUIN Indicator</th>
<th>Q1 Status</th>
<th>Q2 Status</th>
<th>Q3 Status</th>
<th>FOT Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commissioner: National (CCG)</strong></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Acute</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of health and wellbeing of NHS Staff</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>✧</td>
</tr>
<tr>
<td>Healthy food for NHS staff, visitors and patients</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>✧</td>
</tr>
<tr>
<td>Improving the update of flu vaccinations for frontline clinical staff</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>✧</td>
</tr>
<tr>
<td>Timely identification and treatment for patients with sepsis in ED and acute IP</td>
<td>🟢</td>
<td>🟢</td>
<td>🟢</td>
<td>🟢</td>
</tr>
<tr>
<td>Assessment of clinical antibiotic review</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Reduction in antibiotic consumption per 1,000 admission</td>
<td>🟢</td>
<td>🟢</td>
<td>🟢</td>
<td>🟢</td>
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<tr>
<td>Improving services for people with mental health needs who present to A&amp;E</td>
<td>🟢</td>
<td>✠</td>
<td>🟢</td>
<td>🟢</td>
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<tr>
<td><strong>Advice &amp; Guidance</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tobacco screening</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Tobacco brief advice</td>
<td>✡</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Tobacco referral and medication</td>
<td>🟢</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Alcohol screening</td>
<td>✡</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Alcohol brief advice or referral</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
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<tr>
<td>Tobacco screening</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Tobacco brief advice</td>
<td>✡</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Tobacco referral and medication</td>
<td>🟢</td>
<td>🟢</td>
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<td>✠</td>
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<tr>
<td>Alcohol screening</td>
<td>✡</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
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<tr>
<td>Alcohol brief advice or referral</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
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<tr>
<td>Improving the assessment of wounds</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Personalised care and support planning</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td><strong>Commissioner: NHS England - Specialised Services</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Hospital Pharmacy Transformation and Medicines Optimisation</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Optimising Palliative Chemotherapy Decision Making</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Nationally Standardised Dose Banding for SACT</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Data Quality - Secondary Care Dental</td>
<td>🟢</td>
<td>✠</td>
<td>✠</td>
<td>✠</td>
</tr>
<tr>
<td>Public Health - Health Inequalities</td>
<td>🟢</td>
<td>✠</td>
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<table>
<thead>
<tr>
<th>Actual</th>
<th>Expected</th>
</tr>
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<tbody>
<tr>
<td>🟢</td>
<td>🟢</td>
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<td>🟢</td>
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<td>🟢</td>
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</table>
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”.

In July 2018 the CQC carried out two unannounced inspections of hospital services across our three acute sites. These inspections covered five core services (urgent and emergency services, medical care including older people’s care, maternity, critical care and outpatients) and were followed by an announced three-day inspection of the well-led key question at Trust level. This was the Trust’s first inspection under the revised CQC inspection methodology introduced in spring 2017.

The final inspection reports were published on 7 December 2018. The Trust received an overall provider rating of ‘Requires Improvement’.

### Ratings for the whole trust

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

Whilst this means that the Trust’s overall rating was unchanged from the previous inspection, the latest ratings clearly demonstrate improvements in the quality and safety of our services achieved on our improvement journey to date, as assessed by our regulator. The Trust’s overall rating against the ‘Effective’ key question improved to ‘Good’, as did ratings against the ‘Well-led’ key question at site level for Pinderfields and Dewsbury, and the ‘Responsive’ rating for Pontefract Hospital.

There was also notable improvement in a number of core service areas, including medical care at Pinderfields and Dewsbury which achieved an overall rating of ‘Good’ in 2018, and critical care at Pinderfields which achieved a rating of ‘Outstanding’ against the ‘Caring’ key question and was rated as ‘Good’ overall. As shown in the chart below, 70% of our CQC ratings are now a rating of ‘Good’ or above, compared to less than 50% in 2015.

The CQC has not taken enforcement action against the Mid Yorkshire Hospitals NHS Trust during 2018/19. The CQC inspection report identified a total of 62 improvement actions for the Trust. Of these, 26 actions are ‘must do’ actions (actions subject to requirement notices which the Trust must take to comply with its legal requirements) and 36 ‘should do’ actions, which the Trust should take to address a minor breach or improve services.
A detailed action plan has been developed to address the areas for improvement identified which, in line with post-inspection requirements, was submitted to the CQC on 25 January 2019. Progress against the plan will be monitored regularly through the Trust’s internal governance arrangements, overseen by the Quality Committee and Trust Board.

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 not participated in any special reviews or investigations by the CQC during 2018/19.

**Update on the review of services for looked after children and safeguarding (CLAS) in Kirklees undertaken in 2017/18**

The Children in Care Team for The Mid Yorkshire Trust do not visit children who are looked after by Kirklees in the Kirklees area even if they attend Dewsbury & District Hospital. The Kirklees’s Looked after Children’s team have responsibility for their own looked after children residing in the Kirklees area.

**Information Governance Toolkit attainment levels**

The Trust has an Information Governance Steering Group (CIGSG) which meets every eight weeks chaired by the Trust’s Caldicott Guardian. The group’s membership also includes the Trust’s Senior Information Risk Officer and Data Protection Officer. 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 2018 (incorporating the General Data Protection Regulations EU GDPR 2016/679 and the Caldicott Principles).

The NHS Information Governance Toolkit for Acute Trusts, via its 45 requirements, provides an annual, mandatory assessment of the Trust’s 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 31 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 ‘Satisfactory’ (Green).

In addition, the Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian’s 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security, and that personal information is handled correctly. The toolkit is completed by our specialist ‘requirement owners’ and is audited by Internal Audit prior to 31 March final submission.

The Mid Yorkshire Hospitals NHS Trust Data Security and Protection Assessment was submitted in March 2019 with 100% completion.
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.

Each organisation that has regular contact and processing of Personal Identifiable Data must also have a Data Protection Officer in place as mandated by the EU GDPR 2016/679.

Clinical coding
The Mid Yorkshire Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2018/19.

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 has a Data Quality Policy and Strategy which it will continue to review, maintain and monitor.

The Mid Yorkshire Hospitals NHS Trust will continue to ensure that the following actions remain in place to assure its quality of data.

- All clinical and administrative staff (where appropriate) are given IT system and contextual training on how to input timely and accurate 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 2018 to January 2019 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:
Learning from deaths

During the reporting period April 2018 and March 2019, 1,998 of Mid Yorkshire Hospitals NHS Trust patients died as inpatients. This comprised the following number of deaths which occurred in each quarter of that reporting period:

<table>
<thead>
<tr>
<th>2018/19</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>467</td>
</tr>
<tr>
<td>Q2</td>
<td>450</td>
</tr>
<tr>
<td>Q3</td>
<td>501</td>
</tr>
<tr>
<td>Q4</td>
<td>580</td>
</tr>
</tbody>
</table>

The crude mortality rate was 2.40% and the relative risk of mortality (12 month rolling, latest available period (January 18 - December 18) has been reduced from 98.87 to 98.30 when comparing the same period (January 2017 – December 2017).

By 15 March 2019, 161 case record reviews and five investigations have been carried out in relation to 161 of the deaths in the table above.

The Trust process is to use the Structured Judgement Review methodology. 21 cases progressed to a second stage review, with 5 resulting in a Serious Incident investigation.

Therefore, in 5 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or investigation was carried out was:

<table>
<thead>
<tr>
<th>2018/19</th>
<th>Deaths reviewed in quarter</th>
<th>% of total deaths in quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>11</td>
<td>2.3%</td>
</tr>
<tr>
<td>Q2</td>
<td>42</td>
<td>9.3%</td>
</tr>
<tr>
<td>Q3</td>
<td>66</td>
<td>12.9%</td>
</tr>
<tr>
<td>Q4</td>
<td>57</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

Five deaths representing 0.25% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
3 representing 0.64% for the first quarter

2 representing 0.44% for the second quarter

zero cases, representing 0% for the third and fourth quarter.

These numbers have been estimated using the Structured Judgement Case Note Review methodology.

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:

- poor fluid balance monitoring
- poor completion of medical and nursing notes
- poor communication between clinicians
- poorly documented escalation plans
- missed opportunities for do not attempt cardiopulmonary resuscitation (DNACPRs).

A number of actions have already been implemented/introduced to address these learning points:

- visual aids to prompt timely escalation and SBAR template available at the point of care delivery (laminated info sheets attached to every dinamap)
- collaboration between divisions and Palliative Care Team in relation to having difficult conversations and appropriate DNACPR completion
- NEWS scores added to and discussed at safety huddles
- fluid balance awareness and training month in November

- review and update of fluid balance policy.

In addition, the Sepsis Group has actioned a number of initiatives including the provision of appropriate 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.

It is difficult to quantify the individual effects of these actions. However, we have seen:

- an improvement in the percentage of patients with identified sepsis having their antibiotics administered within one hour
- improvement in the monitoring of fluid balance and the management of acute kidney injury
- improvements in the engagement of the Palliative Care Team with patients at the end of life
- improved compliance with nursing observations and the surveillance and management of non-compliance
- improved engagement of the divisional clinical teams.

11 case record reviews or investigations were completed after 1 April 2018 which related to deaths before the start of the reporting period.

Of these one representing 0.05% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Case Note Review methodology.

Seven representing 0.3% of the patient deaths during 2017/18 are judged to be more likely than not to have 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 education and training**

Improvement events run regularly in the Trust, ranging from week-long RPIWs through to small local team improvements. As part of these events, training and education in MYQIS is delivered in various ways.

Classroom-based training programmes are aimed at all levels of healthcare staff to expand networks, share ideas and experiences with colleagues, solve issues and lead on their own improvement project. Staff are then able to apply new tools in their own workplace.

**MYQIS training so far within the Trust has resulted in:**

- 45 certified leaders
- 25 MYQIS foundation
- 25 MYQIS leaders
- 375 RPIW day one training.

**MYQIS Leader course**

This is a six half-day taught day course over a six-month period and the participants present their improvements back to the rest of the group. MYQIS Leader is designed for service and department changes and is aimed at leaders in the Trust to understand the QIS toolkit and run smaller scale improvement projects. This group of staff can also provide support to certified leaders during rapid improvement events.

**MYQIS foundation course**

This is a two-day course over a three-month period and the participants present their improvements back to the rest of the group. It's suitable for any staff wanting to make improvements by using the MYQIS tools day to day to continuously improve their own workplace.

**Rapid process improvement workshops**

During 2018/19, there have already been some real success stories, as a result of 29
RPIWs. In the RPIWs, staff have implemented their ideas to make improvements to their service, reducing waste and improving outcomes for patients and colleagues. Examples of these include the following.

**Serious Incident (SI) Process**
The SI RPIW team have ‘reframed’ and streamlined the front end of the SI process to put patient safety first.

From observation and gathering information by studying the process, they have made it easier for staff to do the right thing, by structuring the early learning response from ward to board level, structuring the expected response to an SI and incorporating the 72 hour report, including that all communications are now captured within Datix.

They have eliminated 54 wastes and 51 defects to free up on average 1978 mins per month of staff time.

**Pathology**
Blood samples taken from the Emergency Department were often rejected, impacting on the four hours Emergency Care Standard. This was due to samples being incorrectly labelled or haemolysed which in turn required repeating.

Following the completion of the RPIW event, the time for the entire process, calculated from placing the sample in the Pneumatic air tube system in ED to entering the analytical equipment in Pathology, reduced from 980 seconds (approx. 16 minutes) to just 292 seconds (approx. 5 minutes), an improvement of 70.2%.

Furthermore, the number of samples incorrectly labelled reduced from 72 per month to 18, an improvement of 75% which is continuing to reduce the number of ED breaches due to blood samples.

**Community Continence Service**
Due to inappropriate referrals to the Community Continence Service, patients were waiting 69 days on average for continence assessments. This often resulted in patients buying their own continence products or being admitted to hospital.

As a result of this RPIW patients now receive their treatment within 3.2 days.

**Datix**
This RPIW focused on investigating low harm/no harm incidents due to the continuing and escalating challenges of a backlog of 947 incidents as at December 2017. This signified a lack of learning from incidents in a timely manner, often taking on average 35 working days to investigate.

This RPIW resulted in a Trust-wide improvement to the Datix system with new deadlines in line with national guidelines, resulting in a total time of 23 working days for investigation and the backlog totally eliminated.

**Duty of candour**
During 2018, the Trust reviewed the duty of candour/being open policy; amendments included a change to the duty of candour template letter to ask if patients, families or carers had any questions regarding the investigation or if they would like to be involved.

Duty of candour is also included within Datix, root cause analysis and human factors training sessions. Advice and information has also been shared with staff through attendance at divisional meetings and on an individual basis as required.

The Trust monitors duty of candour adherence of the verbal and written duty of candour notifications on a daily basis.
In 2018 an internal audit was undertaken in response to ‘Learning from Incidents/Duty of Candour/Root Cause Analysis’. The overall opinion of the review was ‘High Assurance’.

Information is on the Trust’s internet page for patients, carers, staff and relatives and leaflets are available.

There has been no duty of candour breaches in 2018/19.

**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 two Never Events in the Trust during 2018/19 which is comparable with 2017/18 when there were two reported Never Events.

Using the national Never Event criteria, the two Never Events reported in 2018/19 were:

- wrong site surgery - an invasive procedure performed on the wrong patient or at the wrong site
- misplaced naso- or oro-gastric tubes - misplacement of a naso- or oro-gastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration.

**Number of Serious Incidents (SIs)**

There have been 83 Serious Incidents reported in 2018/19; three incidents were de-logged following initial reviews, therefore there were 80 Serious Incidents reported. This is a decrease from 2017/18 where there were 104 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 where lapses in care have been identified 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 21 of reported Serious Incidents and falls were reported in 20 episodes. The number of Serious Incidents per 1,000 bed days was 0.18 (based on 83 reported incidents).

There were:

- 13 serious incidents reported in quarter 1
- 24 serious incidents reported in quarter 2
- 28 serious incidents reported in quarter 3
- 18 serious incidents reported in quarter 4.

The sharing of Serious Incidents and incident analysis and lessons learned to Trust Board is through the Patient Safety and Clinical Effectiveness Committee. The monthly and quarterly reports provide oversight on identifying and managing risks to safe care, investigating and taking action on sub-standard performance, sharing learning and ensuring delivery of best practice. Any key concerns are raised directly to Trust Board via the Reportable Issues Log.

Learning from Serious Incidents, incidents, safeguarding, Health & Safety, RIDDOR and Mortality Reviews are shared and 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. In 2018 an internal audit was undertaken in response to ‘Learning from incidents/duty of candour/root cause analysis’. The overall opinion of the review was ‘High Assurance’.

Learning from complaints
The Trust recognises that sometimes things can go wrong and people wish to complain, and it is the Trust’s duty to undertake a full investigation of the complaint in line with the Trust’s constitutional responsibility. The complaints process is an important mechanism for patients to provide feedback regarding the quality of our services. This feedback is highly valuable and 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 that can be appropriately resolved quickly through an informal route, are being managed informally.

During the period 1 April 2018 to 31 March 2019, 1076 formal complaints were received. The Trust is pleased to report that this represents an overall 15% improvement compared with the same period in 2017/18.

The graph below shows the number of complaints received from April 2017 to March 2019. The figures clearly show that there is 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 the following.

Pain Management Task and Finish Group (to address clinical treatment)
The Pain Management Task and Finish Group aims to co-design improvements in the management of patient 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.

Compassion in Care Project
The Compassion in Care (to address staff attitude/behaviour) project group has been developed to lead on a number of
improvement initiatives focused on how to enable a compassionate workforce.

One of those initiatives is a Compassion in Care Card which has been developed to award those members of staff who have gone ‘above and beyond’ their normal duties with regards to caring for patients.

A ‘culture of care barometer’ designed by NHS England has been used across the Trust to gauge whether the culture of care in different parts of an organisation is conducive to delivering compassionate, patient-centred care.

To ensure organisational learning from complaints, any recommendations made following the investigation of a complaint are recorded and monitored through the Patient Experience Sub-Committee meeting and the Patient Experience Working Group Divisional Reports.

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 2018 to 31 March 2019 the Trust has been issued with a total of nine Patient Safety Alerts (PSA) from the Central Alerting System.

Five of these alerts have been completed:

- one completed but beyond the stipulated deadline.

There are four remaining PSAs:

Three still within the completion dates:

- 8 May 2019
- 5 June 2019

These alerts are still to be completed and the relevant leads will work towards completion within the timescales.

One alert is outstanding – completion date 25 January 2019. This alert is very near to completion.

Quality Improvement Strategy
The Trust’s new Quality Strategy sets out the Trust’s ambitions for improving quality for the next four years.

This strategy identifies the quality priorities for the Trust. These quality priorities reflect national priorities and are underpinned by measurable and reported improvement goals. The quality priorities are overarched by three areas:

- reduce avoidable harm
- improve patient experience
- improve patient outcomes and reduce mortality.

Ward to board assurance is achieved through the Quality Strategy and Clinical Assurance Framework. This enables the Trust Board to monitor the quality of - and risks to the delivery of - our services, ensure delivery of the Quality Strategy and outline the systems and processes that we use to monitor and measure quality. The divisional clinical governance groups and corporate teams provide controls by the management of the policies, procedures and work programmes they are responsible for.
The data they collate and information they produce, for feedback to the clinical services, acts as a further control enabling services to reflect on their performance, highlight and manage potential risks and secure improvement. The Trust is shifting its assurance model to an enabling improvement model as part of the journey of growing a culture of continuous quality improvement.

**Nursing Quality Governance Framework**

The Nursing Quality Governance Framework was developed as a means of improving standards whilst providing assurance through clinical and quality indicators collated from Trust-wide statistics, ward level metrics and ward accreditation inspections.

This is with the aim of providing evidence of effective performance at ward level and ensuring control systems are in place, with potential areas for improvement set out.

To ensure that performance and updates are communicated from ward to board, the outcomes from the quality and clinical indicators 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 indicators collated is embedded into nursing practice, providing useful ways for ward managers to develop and continually improve while monitoring 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 Clinical Commissioning Groups (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 clinical areas and divisions, to ensure that any learning from the feedback can be embedded quickly and effectively.

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, the clinical division report any 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.

**Implementation of priority clinical standards for seven day services**

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh. These standards define what
seven day services should achieve, no matter when or where patients are admitted

With the support of the Academy of Medical Royal Colleges, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes and identified as being ‘must do’ by 2020. This will ensure patients admitted to hospital in an emergency:

- don’t wait longer than 14 hours to initial consultant review – standard 2
- get access to diagnostic tests with a 24-hour turnaround time — for urgent requests, this drops to 12 hours and for critical patients, one hour - standard 5
- get access to specialist, consultant-directed interventions – standard 6
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds – standard 8.

For the last three years trusts have been asked to complete a self-assessment tool in the spring and autumn of each year, which included a case note review of over 200 patients admitted over a consecutive seven-day period to assess compliance with standards 2 and 8. The results of the spring survey from 2018 are shown below:

- Standard 2 (14-hour review)
  - Compliance standard = 90%
  - MYHT performance = 93%
  (within 15 hours 95.5%)
- Standard 5 – compliant
- Standard 6 – compliant
- Standard 8
  - Compliance standard = 90%
  - MYHT performance once daily review = 97%
  - MYHT performance twice daily review = 99%

As part of the pilot Board Self-Assessment Framework for Seven Day Services, the Trust has reported that it remains compliant against these standards.

**Junior doctor rotas**
The Medical Director’s Office reports gaps in its junior doctor rotas to the Trust Resources and Performance Committee on a quarterly basis. Rota fill is determined by allocation from Health Education England of doctors within national training programmes, and the individual recruitment activities of the Trust.

The rota gap position at the last rotation of doctors in training programmes is shown below.

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<tr>
<td>Total Number on rotas</td>
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<td>Total Gaps</td>
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<td>Total Number on rotas</td>
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<tr>
<td>Total Gaps</td>
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<td>Fill percentage</td>
<td>88</td>
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In order to fill gaps in the rotas the Trust has carried out a range of actions including:

- recruitment to Trust-appointed posts
- consideration of an appointment to alternative clinical roles
- appointment of temporary medical locums through the Trust neutral vendor and managed bank arrangements.

**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
2018/19; 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 four 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 April 2018, the Pontefract Emergency Department successfully converted to an Urgent Treatment Centre (UTC). Since reopening as an UTC, the department has consistently achieved >95% performance in the Emergency Care Standard.

In November 2018, the Mid Yorkshire Winter Room was re-launched (open 12 hours a day, seven days a week), following a very successful period during the 2017/18 winter months. Led by a director, the winter room has once again brought together a number of key individuals to aid with the flow of patients in and out of the Trust’s two emergency departments, the Urgent Treatment Centre as well as through the wider hospital by ensuring patients are discharged as soon as they are medically fit.

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) and super-stranded patients (over 21 days in hospital). There has been a 26% decrease in the number of super-stranded patients Trust wide. Further efforts continue to focus on reducing the number of patients who have delayed transfers of care (DTOC) requiring social input for discharge, and other complex discharge-related matters.

Following further improvement work and the implementation of a dedicated ‘flow nurse’ in Pinderfields and Dewsbury EDs, the Trust has and continues to see significant improvement in its ambulance turnaround performance; up to February 2019, performance has been consistently above 90%, with the Trust regularly outperforming other regional trusts on this indicator.

The Trust continues to progress its internal plans to support patient flow. This year, this has included among other initiatives:

- conversion of Pontefract Emergency Department to an Urgent Treatment Centre
- the continuation 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
- ‘Fit2Sit’ initiative at Pinderfields ED to improve flow throughout the ED
- ENT Ambulatory Clinics, accepting direct referrals from ED
- virtual fracture clinics to improve waits for fracture clinic appointments
and reduce the number of re-attendances to ED
- extended roll out of access to ICE referral pathways into specialty clinics to allow ED staff faster access to urgent outpatient appointments
- established a direct admission pathway to the Frailty Admissions Unit at the Dewsbury site with plans to extend this to the Frailty Assessment Unit on the Pinderfields site
- introduced a ‘tele-medicine surgical abscess initiative’ at Dewsbury to prevent unnecessary transfers between Dewsbury and Pinderfields Hospitals
- Mental Health Frequent Attenders CQUIN Initiative – this initiative has introduced a multi-disciplinary approach in patients’ care pathways which has successfully reduced the number of attendances for a cohort of patients
- investment in seven-day therapy to support weekend discharges.

Cancer services
The Trust’s two-week performance has been an area of success in the first eight months of 2018/19. However, due to capacity issues arising within Breast Surgery, the number of patients seen within two weeks with suspected breast cancer has reduced and subsequently reduced the Trust’s overall position.

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The Trust’s 31-day performance in cancer services has been another success story during 2018/19, with the Trust exceeding the national target in nine of the 11 months reported to
date, with an average of 98% of patients seen within 31 days compared to the national target of at least 96%.

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The Trust has, however, struggled to meet the 62-day standard throughout the year which was also reflected throughout England.

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During quarters 1, 2 and 3 of 2018/19, the Trust has consistently outperformed the English average in the two-week-wait standard, 31-day standard and 62-day Referral to Treatment Standard.

The Cancer Services Team have worked hard to recover performance and deliver sustainable services and are currently working on improving the capacity issues in Breast Surgery. In addition, focused work has taken place to reduce the volume of the longest waiting patients. This is in the context of growing demand for cancer services.

**Referral to treatment time**

The Referral to Treatment (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; a significant imbalance between capacity and demand contributes to this. 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 2018/19, the Trust 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 the increased implementation of electronic advice and guidance
- in-depth service review of Ophthalmology, Gastroenterology, Respiratory and Urology as clinical services via collaborative clinical summits that identify key actions for improvement
- 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
• targeted actions to reduce the active waiting list to the same levels as March 2018.

Although performance against the incomplete 92% standard has improved over the last 12 months, progress since the start of the financial year has slowed. The Trust has not been able to meet the national standard which has also been reflected across England.

The Trust compares favourably (as of latest national data available – February 2019) against 10 England average specialties – outperforming Urology and Cardiology by near 4%. The Trust’s largest improvements in RTT performance since April are seen in General Surgery (7.7%), Ophthalmology (8.8%), Oral Surgery (5.7%), Respiratory (6.7%) and Urology (4.5%).

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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.

**Focus on patient experience**

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 current patient experience priorities are:

- discharge (including internal transfers and medicines awareness)
- communication (access to information, knowing who is responsible for my care and what’s happening next)
- respect and dignity (involved in decisions, compassion emotional needs and attitude)
- pain management.

The Trust’s Patient Family and Carer Experience action plan, led 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, service and ward level.

Questions relating to the Trust patient experience priorities have been added to the Inpatient Friends and Family Test (FFT) cards so that the impact of any changes can be monitored on a monthly basis. Work is ongoing making improvements in these key areas. These questions were updated to reflect the new priorities in October 2018. The following chart shows the results for October 2018 to December 2018.
Patient experience feedback is also gained from the Trust’s participation in the national survey programme, which allows the Trust to compare itself against other trusts nationally. The Trust uses the results to identify areas of good practice and ideas for improvement.

**National Maternity Survey 2018**
Areas where the Trust is performing well include midwives providing relevant information about feeding, offering consistent advice and asking how mothers are feeling emotionally. Areas identified for improvement include providing information about mother’s physical recovery after birth, having a choice of venue for antenatal care and offering mothers the opportunity to discuss their birth experience.

**National Adult Inpatient Survey 2017/18**
Areas where the Trust is performing well included ensuring specialists give all the necessary information prior to a planned admission, cleanliness, ensuring patients get enough drinks, and not changing planned admission dates. Areas identified for improvement included improvements in discharge planning and information sharing, pain management, compassion in care, and ensuring patients know what’s happening next.

**Initiatives to improve patient experience**
Key projects for action have been based around the patient experience priorities. 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 patients. The Patient Experience Team have been working with staff and patients on Gate 34 to look at supporting emotional needs and improving communication.

A visitor’s information board was designed and is updated on a monthly basis with latest figures around patient safety and feedback. There has been a cultural shift in relation to including patients in ‘what’s happening next?’ The Trust is also using Always Event® methodology to work in partnership with other wards including Gate 32a and Gate 38.
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 co-ordinating care to support those patients in the palliative stage of life. Work undertaken with a focus on fast-track discharge has been nominated for a Patient Experience Network National Award. The Patient Experience Team was shortlisted for the Enhancing Patient Dignity category of the Nursing Times Awards for the end of life care resource drawers.

Maternity services have worked in partnership with recent users of the service to prioritise actions for improvement based on ‘what matters most’ to mothers. A self-assessment against the ‘Fifteen Steps for Maternity’ toolkit was also undertaken using an observational approach to understanding service users’ experience. Improvements have included further development of welcome information, changes made to the format of the postnatal records and introduction of a dedicated Birth Matters clinic to support women with de-brief, discussion and support around care planning outside of pathways of care.

The volunteer ward befriender scheme has continued to expand with more students joining the scheme supporting vulnerable patients who may require regular reassurance and assistance. During winter pressures, dining companions have been assisting the wards to ensure that patients receive and are supported with food at mealtimes.

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. Around Christmas many essential and luxury items were donated to hospital inpatients. Volunteers assembled over 500 stockings, a large proportion kindly handmade, for older people in hospital over the festive period.

The family waiting and viewing area within Pinderfields hospital mortuary has been refurbished to provide a more comfortable and calm environment. This was officially opened on the 4 February 2019.

Pinderfields hospital’s relatives overnight stay rooms have been refurbished to provide a more comfortable and private area to utilise whilst visiting their loved ones. Plans are underway to develop a similar room at Dewsbury hospital.

A children’s menu has been designed and implemented as well as a dementia friendly menu to allow for greater, more accessible choice at mealtimes.

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 healthcare organisation they work for. The survey was sent to a sample of 1,250 staff working at the Trust and ran from the beginning of October 2018 until 30 November 2018. Over 500 members of staff in the Trust responded which equates to 42% of staff and is 1% better than the average response rate for combined acute and community trusts.
The detailed content of the questionnaire has been summarised and presented in the form of 10 key themes such as morale, quality of care and health and wellbeing, etc. Full results can be found at www.nhsstaffsurveys.com.

The five questions where the Trust most improved on the 2017 scores were:

- 10% improvement from 31% to 41% of respondents saying they are satisfied with their level of pay
- 9% improvement from 47% to 56% of respondents who would recommend the Trust as a place to work
- 9% improvement from 49% to 58% of respondents who would be happy with the standard of care provided by the Trust if a friend or relative needed treatment
- 8% improvement from 84% to 92% of respondents saying they had an appraisal in the last 12 months
- 8% improvement from 50% to 58% of respondents saying their manager supported them to receive the training, learning or development identified at their appraisal.

The Trust’s best five ranking scores compared to peers were:

- % of respondents report working additional unpaid hours
- % of respondents said senior managers act on staff feedback
- % of respondents saying they had an appraisal in the last 12 months
- % of respondents saying their manager supported them to receive training, learning or development identified at their appraisal
- % of respondents saying they receive regular updates on patient experience feedback in their directorate.

The five questions for which the Trust compares least favourably with other combined acute and community trusts were:

- % of respondents saying they or a colleague reported physical violence at work the last time they experienced it
- % of respondents who have any physical or mental health conditions, disabilities or illnesses say the Trust has made adequate adjustments to enable them to carry out their work
- % of respondents would be happy with the standard of care provided by the Trust if a friend or relative needed treatment
- % of respondents say they have experienced musculoskeletal problems in the last 12 months as a result of work activities
- % of respondents saying during the last 12 months they have felt unwell as a result of work-related stress.

The Trust is required to report against the following indicators:

- 16% of staff said they experienced discrimination in the last 12 months (12% in 2017/18)
- 81% of staff said they believed the organisation offers equal opportunities for career progression (83% in 2017/18)
- 27% of staff said they had experienced bullying or harassment by patients, relatives or members of the public (26% in 2017/18)
- 38% of staff said they had reported their most recent experience of bullying or harassment (41% in 2017/18).

The results of the survey are based on 102 questions. Of those 102 questions the Trust improved on 37, deteriorated on 37, stayed the same on 15 and there are 13 new questions. Feedback from staff is more positive than last year and the Trust
has shown some significant improvements on some key areas, especially regarding the percentage of respondents who would recommend the Trust as a place to work and would be happy with the standard of care provided if a friend or relative needed treatment. There are a number of key areas where the Trust is below average and these will be areas of focus. Improvement plans will be developed with staff in the coming year to address the key issues.

**Freedom to Speak Up**
The Trust Board is committed to ensuring that there are effective speaking up arrangements in place within the organisation which will help to protect patients and improve staff experience. The Trust believes that a healthy speaking up culture is one of the very important characteristics of the Trust being well-led. The Trust also believes that making it easy for staff to speak up about their concerns, and protecting them from detriment when they do, is very consistent with the Trust’s values and behaviours.

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. Staff can contact the Guardian by phone or email, or can choose to share concerns anonymously, posting details using internal/external mail services. Discussion with the reporter focuses on how concerns can be referred to senior managers for investigation and further action. Where an issue includes a patient safety concern, the Guardian will always escalate that concern, even in circumstances where a reporter expresses reluctance for that to happen. Feedback on actions taken by managers is shared with all those reporting concerns, and feedback from the reporters is then gathered to establish their level of satisfaction with the support provided by the Guardian.

For those colleagues who do not wish to contact the Guardian directly, they have other options. The Trust has a team of volunteer Freedom to Speak Up Champions, clinical and non-clinical staff, working across all Trust sites. Staff can also contact the Chief Executive directly via a web-based reporting system: [www.myconcerns.org](http://www.myconcerns.org). Details of all these options are included in Freedom to Speak Up publicity materials and on the ‘Speaking Up’ page on the Trust intranet, and are shared at a range of publicity and staff engagement events across the year. In circumstances where the Guardian is not available (annual leave, training, etc), out of office messages give details of how staff can speak up and who they can speak up to.

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 and staff experience 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 the financial year 2018/19, the Guardian was contacted on 227 occasions.
by staff wishing to speak up, across a wide range of issues including:

- concerns over the quality of care delivered on a ward
- bullying behaviour by colleagues
- recruitment practice
- a staff member acting outside the scope of their role, compromising the quality of patient care
- sharing of information leading to a breach of patient confidentiality.

A key focus of Francis' enquiries was the experience of staff who speak up, and the reasons they may feel reluctant to do so. Francis' findings suggested that it is often an anxiety that speaking up will lead to professional or personal repercussions; that a staff member may suffer a detriment, which acts as a barrier to speaking up. Over and above the legal protection afforded to staff members, enshrined in a wider policy framework, fundamental to the work of the MYHT Freedom to Speak Up Guardian has been the development of a service which seeks to remove that barrier.

This includes:

- **Offering a confidential service:** There are some situations where it isn't possible for the Guardian to assure complete confidentiality:
  - where the staff member has already shared an intention to speak to a member of the Freedom to Speak Up Team with their colleagues
  - where the staff member shares a concern which has a safeguarding, or criminal element
  - should an issue be raised which results in a Public Interest Disclosure Act claim, and a tribunal judge subpoenas information held by a Guardian.

Outside of those situations, the Guardian commits to maintain the confidentiality of staff members. All feedback received by the Guardian for this reporting period indicates that those staff members who have made contact, have been confident that appropriate confidentiality has been maintained.

- **A discussion around detriment with reporters:** As part of the initial contact with all colleagues who speak up, the Freedom to Speak Up Guardian makes sensitive and appropriate reference to the aspect of the role which focuses on identifying situations where a detriment might result, and the support that would be available should that happen.

- **A close partnership with human resources colleagues:** In situations where reporters indicate that they feel they may have been treated differently as a result of speaking up, the Guardian will alert colleagues in the HR team, and seek advice on the most appropriate support and management of the situation (with due consideration of the need to maintain confidentiality).

- **A close partnership with union colleagues:** In situations where reporters indicate that they feel they may have been treated differently as a result of speaking up, the Guardian will advise contact with an appropriate union colleague, to ensure they secure adequate representation and support to raise the issue more formally, should they choose to do so.

- **Seeking support from the National Freedom to Speak Up Guardian:** The office of the National Guardian
offers Freedom to Speak Up Guardians advice and support to ensure an effective response, where reporters have suggested they have suffered a detriment as a result of speaking up. The MYHT Guardian has consulted the national office for advice in this reporting period.

- **Training for the Freedom to Speak Up Guardian and Champions:** The MYHT Guardian and Champions have all completed appropriate and recognised training, in line with recommendations of the National Guardian’s Office. This training includes reference to the Public Interest Disclosure Act, to ensure an awareness of the protection available to those who believe they have suffered a detriment as a result of speaking up.

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 previous reporting period. A comprehensive ‘stand-alone’ Freedom to Speak Up report is delivered in person to the Trust Board every six months; again, in line with the recommendation of the National Guardian.

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.
Statements from our stakeholders

Quality Accounts 2018/19

Statement from Mid Yorkshire Hospitals NHS Trust Stakeholder Forum

The Quality Accounts are a thorough indication of the direction of travel for the Mid Yorkshire Hospitals NHS Trust. The areas for improvement and those targeted for the specific needs of the service that is to be delivered are clearly outlined in the report.

The accounts are a demonstration of the challenges faced by the Trust given the limited resources in terms of money and staffing levels, and the Trust relies heavily on the goodwill and cooperation of the dedicated staff that work within the Trust. It highlights the current and future demands that will be placed on the Trust during the coming five years. There is always room for improvement but the Trust seems to be 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.
The following statement is presented on behalf of Wakefield and North Kirklees Clinical Commissioning Groups. We welcome the opportunity to comment on the 2018/19 Quality Account. Throughout the year we have had access to a range of information about the quality and safety of services provided by the Trust. We are assured that this information is thoroughly assessed by the Trust Board and its subcommittees, 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 their quality priorities which aim to reduce harm, improve experience and ensure delivery of effective care. The Trust has been transparent in describing the reasons they have not been able to meet a number of the quality priorities, and as commissioners these are areas we will continue to support and influence, where possible. We are pleased to see that initiatives implemented to support a reduction in the number and severity of pressure ulcers in the community has been successful, and learning from this work is informing improvement within hospital based services.

Although disappointing that the Trust’s overall CQC rating did not improve following the inspection in summer 2018, it is testament to the work the Trust has undertaken that the improvements in individual services have been recognised, and that the CQC continue to rate the ‘Caring’ domain as ‘Good’. We will continue to receive assurance on progress with the CQC action plan, and will utilise our patient safety walkabouts to ‘test’ these improvements in the areas we visit each month.

Our quality assurance and governance processes have been reviewed over the past year with the establishment of a clinical executive group which discusses finance, contracting, transformation and quality every month. Since October 2018, we have attended the Trust’s Quality Committee which gives further assurance for commissioners about the safety, effectiveness and experience of the Trust’s acute and community services. This has given us greater confidence that the Trust has a full understanding of the quality of care it provides to patients, and the MYQIS structure is being used consistently across the Trust as a comprehensive and consistent approach to quality improvement. We have welcomed the Trust’s invitation to be involved in a number of the rapid process improvement workshops, and hope our input and influence with primary care colleagues has helped to achieve the desired outcomes.

Over the year we have built on our system-wide working to implement specific workstreams which support demand and capacity management, improve patient flow, reduce length of stay and ensure timely discharge from hospital. This has meant that our health and care systems have been able to respond to the shared
financial challenge and more effectively manage the increasing demand on the services the Trust provides.

We fully support the Trust’s decision to continue to focus on the existing quality priorities, including the timeliness of sending discharge summaries to GPs. We continue to receive negative feedback from GPs about the late receipt of discharge letters, particularly where medication has been changed while the patient was in hospital. Although the pressure ulcer measure is now combined for the whole Trust, we would recommend that the data remains separated between acute and community services to ensure progress can be tracked.

As in previous years, the report is largely focused on the quality of services provided in hospitals. The Trust is undertaking work to improve the quality of care in community services, and is an active partner as part of the emerging Integrated Care Partnership. We would have liked to have seen more information about this work in the Quality Account.
Statement from Wakefield MDC Adults Services, Public Health and the NHS Overview and Scrutiny Committee - Mid Yorkshire Hospitals NHS Trust Quality Account 2018/19

Through the Quality Accounts process the Adults Services, Public Health and the NHS Overview and Scrutiny Committee (OSC) 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 2017/18 Quality Account, including a dedicated session with the Trust on the 11 April 2019. 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.

Whilst the Committee accepts that the continuum of improvement should be maintained, specifically by retaining the 2018/19 priority improvement targets, the Committee questioned whether the Trust should consider other, equally important areas for improvement. In response the Trust agreed that improvement must be sustained in those areas where this was required, but it was accepted that the process should be kept under review.

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. However, the Committee was concerned with the large number of acronyms used in the report.

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 four-hour standard, together with the number of patients waiting longer than the 18-week standard. This position has continued into 2018/19 despite efforts by the Trust to improve performance.

The Committee is concerned in relation to medication delays which could increase hospital length of stay with examples being given of patients having to stay overnight because their medication was not available at the point of discharge. Members welcomed the increased involvement of Pharmacy which should improve the process.

The Committee welcomes the sustained improvement in sepsis awareness leading to better practice and reduced mortality. It was disappointing to note that the Trust had not seen the expected improvement in acute kidney injury. However, members noted the further actions that have been identified to deliver this improvement.

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 therefore pleasing to see the improvements in relation to pressure ulcers in the community but equally disappointing to see an increase in the acute Trust.

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 noted that a significant risk to reducing the consumption of antibiotics was a shortage of specialist infection doctors. The Committee acknowledged that there was a national shortage but welcomed the number of local initiatives to address the problem, including innovative ways of using existing staff.

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 was pleased to note that the falls prevention target had been met.

The Committee was disappointed that insufficient progress had been made in relation to electronic discharge letters but acknowledged the specific actions and processes that have been put in place to achieve the 24 hours standard.

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 2018/19.
Healthwatch Wakefield comment on the Quality Account of 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 2018/2019. 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 & Finish Group has 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 2018/19, 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 and surrounding area.

It is heartening to see that the Trust's collaboration with the University of Bradford in setting up a School of Nursing at Dewsbury and District Hospital. This will undoubtedly provide a boost not only for local healthcare services but also for the reputation of the hospital. We do, however, note that the CQC rating remains at ‘Requires Improvement’, although it is good to see improvements in many of the indicators the CQC inspect. Whilst we recognise there is still work to be done, Healthwatch Wakefield remains happy to see steps being taken in the right direction.

Review of 2017/18 Quality Priorities

Although the challenging target of zero was narrowly missed, it is nevertheless encouraging to see a good result against the target to reduce cases of healthcare associated MRSA cases (one reported case compared to four in 2017/18), especially considering this was an area for concern last year. It is, however, slightly disappointing to note that the number of Clostridium Difficile infections has increased, significantly missing its target.
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 continue to have a positive impact, and particularly commend the Trust on their achievement in again reducing the number of people who have a fall which results in harm per 1,000 bed days to 1.34 (compared with the 2017/18 figure of 1.59).

Healthwatch Wakefield were interested to see how performance in terms of reducing the consumption of antibiotics and optimising prescribing practice developed over 2018/19 and were hoping to see ongoing improvements in this area. This has again proved to be an apparently challenging area for the Trust with overall consumption increasing by 7%. It is noted, however, that Carbapenem usage has reduced by half, and this is a welcome result.

Reducing the incidence of pressure ulcers is always a challenging area, particularly as many of the factors that affect this are beyond the Trust's direct control. It is heartening to see that improvements have been made in reducing the incidences of category 2-4 pressure ulcers in community settings (15.23% as opposed to 18.33% in 2017/18), especially as this was an area of concern last year.

We are pleased to again see improvements in the Friends and Family Test feedback, both staff and patient related, and hope that this can be maintained. We remain particularly disappointed that no improvements in the delivery of electronic discharge summaries to GPs within 24 hours have been made, and urge the Trust to rectify this situation with utmost urgency in order to provide high quality continuing care for their patients when transferred back to primary or community care settings.

Healthwatch Wakefield is concerned to note that there has been a further ‘Never Event’ during the course of 2018/19, and whilst this is a replication of last year (when there was again a single Never Event), 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 2018/19

Healthwatch Wakefield welcomes the fact that, given performance against all 2017/18 priorities has not been completely successful, the vast majority of priorities are being rolled over into next year. We also agree that realigning the metrics used to measure the incidence of pressure ulcers is necessary, and will be worthwhile in making performance measurements against this priority clearer. We are hopeful that this change will help continue to drive improvements in this area.

Overall summary

The draft document that was presented to Healthwatch Wakefield for review is well designed and comprehensive. We again like the clear summary of performance against 2018/19 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 again 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 reports need 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 take at least the same approach.

We would also be keen to see a new target regarding patients being readmitted within 28 days of leaving hospital. There may not yet be a national target but we feel it would be best practice to introduce a local one, or identify steps to reduce the number of patients being readmitted.

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 and surrounds, and we look forward to continuing to support and work with the Trust to help ensure continuous improvements are sustained.
INDEPENDENT AUDITORS’ LIMITED ASSURANCE REPORT TO THE DIRECTORS OF THE MID YORKSHIRE HOSPITALS NHS TRUST ON THE QUALITY ACCOUNT

We have been engaged by Mid Yorkshire Hospitals NHS Trust to perform an independent assurance engagement in respect of Mid Yorkshire Hospitals NHS Trust’s Quality Account for the year ended 31 March 2019 (“the Quality Account”) and certain performance indicators contained therein.

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, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:
• Percentage of patients 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 Directors and auditors
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care (DHSC) 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 DHSC guidance.

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

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the DHSC on 29 January 2015 (“the Guidance”) and applicable to 2018-19; 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 consider whether it is consistent with the requirements of the Regulations and 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 2018 to April 2019;
- papers relating to quality reported to the Board over the period April 2018 to April 2019;
- feedback from NHS Wakefield and NHS North Kirklees Clinical Commissioning Groups;
- feedback from Healthwatch Wakefield;
- feedback from Wakefield MDC Adults Services, Public Health and the NHS Overview and Scrutiny Committee;
- the Trust’s latest complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- Care Quality Commission inspection report, dated December 2018;
- the Head of Internal Audit’s annual opinion over the trust’s control environment for the year ended 31 March 2019;
- the annual governance statement for 2018/19; and
- any other information included in our review.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

This report, including the conclusion, has been prepared solely for the Board of Directors of Mid Yorkshire Hospitals NHS Trust.
We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, 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, except 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;
- 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 and Social Care. 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.

**Qualified 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 2019:
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 supporting Guidance.

Cameron Waddell
Partner, for and on behalf of Mazars LLP
Chartered Accountants and Statutory Auditor
Salvus House
Aykley Heads
Durham
DH1 5TS

23 May 2019
Appendix I: 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 2018/19.

Summary Hospital Level Mortality Indicators

The Trust considers this data is as described for the following reasons:

- The Trust Learning from Deaths 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 and so the quality of services, 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.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Preventing People from dying prematurely; and 2: Enhancing quality of life for people with long-term conditions</td>
<td>12 a) Summary hospital-level mortality indicator (SHMI)</td>
<td>98.45</td>
<td>99.07</td>
<td>-</td>
<td>69.17</td>
<td>126.81</td>
</tr>
<tr>
<td></td>
<td>SHMI Value</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>98.45</td>
<td>99.07</td>
<td>-</td>
<td>69.17</td>
<td>126.81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SHMI Banding</td>
<td>12 b) Percentage of patient deaths with palliative care coded at either diagnosis or specialty level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 b) Percentage of patient deaths with palliative care coded at either diagnosis or specialty level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>As expected</td>
<td>As expected</td>
<td>-</td>
<td>Lower than expected</td>
<td>Higher than expected</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25.4%</td>
<td>31.3%</td>
<td>33.6%</td>
<td>59.5%</td>
<td>14.3%</td>
<td></td>
</tr>
</tbody>
</table>

Patient Reported Outcome Measures (PROMS)

The patient reported outcome score for groin hernia surgery

The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reason. Provisional data for April 2017 to September 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 national collection of this data ceased at this time.

The patient reported outcome measures scores (PROMS) for varicose vein surgery

The national collection of this data ceased during the reporting period and the Trust’s results are not available.
The patient reported outcome measures scores (PROMS) for hip replacement surgery

The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reason. Provisional data for April 2017 to March 2018 remains below national average performance but has shown improvement when compared to previous years.

The Mid Yorkshire Hospitals NHS Trust has taken the following action to improve this score, and so the quality of its services, by continuing 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

The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reason. Provisional data for April 2017 to March 2018 shows the Trust’s PROMs scores for knee replacement surgery have improved and are now above or at national average for all indicators.

The Mid Yorkshire Hospitals NHS Trust has taken the following action to improve this score, and so the quality of its services, by continuing to review the patient pathway to improve this score and so the quality of its services.

<table>
<thead>
<tr>
<th>Related NHS Outcomes Framework Domain</th>
<th>Prescribed Information</th>
<th>EQ VAS</th>
<th>EQ-SD Index</th>
<th>Aberdeen Score</th>
<th>EQ VAS</th>
<th>EQ-SD Index</th>
<th>Oxford Hip Score</th>
<th>Oxford Knee Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 (i)</td>
<td>Adjusted Average Health Gain: groin hernia surgery</td>
<td>-1.2</td>
<td>0.08</td>
<td>-13.09</td>
<td>10.28</td>
<td>0.39</td>
<td>16.41</td>
<td>4.95</td>
</tr>
<tr>
<td>18 (ii)</td>
<td>Adjusted Average Health Gain: varicose vein surgery</td>
<td>-2.49</td>
<td>0.07</td>
<td>n/a</td>
<td>9.92</td>
<td>0.41</td>
<td>17.57</td>
<td>8.4</td>
</tr>
<tr>
<td>18 (iii)</td>
<td>Adjusted Average Health Gain: hip replacement surgery</td>
<td>-1.16</td>
<td>0.09</td>
<td>-8.45</td>
<td>13.88</td>
<td>0.46</td>
<td>22.21</td>
<td>8.15</td>
</tr>
<tr>
<td>18 (iv)</td>
<td>Adjusted Average Health Gain: knee replacement surgery</td>
<td>3.61</td>
<td>0.14</td>
<td>-0.93</td>
<td>18.9</td>
<td>0.55</td>
<td>25.09</td>
<td>14.68</td>
</tr>
</tbody>
</table>

*Italicics: Contains April 2017 to September 2017 only - Nationally ceased collection of GH and VV data.*
Percentage of Patients aged 0-15 and 16 or over readmitted within 28 days

The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reason. 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 8.42% of patients were readmitted during the 28 days period post-discharge which represents an improvement in performance from data reported last year.

The Mid Yorkshire Hospitals NHS Trust has taken the following action to improve this percentage, and so the quality of its services, by achieving an understanding of this performance. 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 is better than national average.

Responsiveness to the personal needs of patients

The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reasons. 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 Trust’s score for responsiveness to personal needs of patients remains below the national average.
The Mid Yorkshire Hospitals NHS Trust has taken the following action to improve this percentage, and so the quality of its services, by implementing the Patient Family, & Carer Experience action plan, developed by the Patient Experience Sub Committee, which aims to achieve improvements against the Trust’s priorities for improvement. The focus is on improving patient involvement in and experience of the discharge process; improving communication and access to information; ensuring patients, families and carers are treated with respect and dignity and to improve the management of those patients suffering from pain. 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.

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends

<table>
<thead>
<tr>
<th>Related NHS Outcomes Framework Domain</th>
<th>Prescribed Information</th>
<th>MYHT 2017</th>
<th>MYHT 2018</th>
<th>National Average</th>
<th>Other Trusts – Best</th>
<th>Other Trusts – Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>4: Ensuring that people have a positive experience of care</td>
<td>Staff Friends &amp; Family - Staff who would recommend the Trust as a provider of care to their family or friends.</td>
<td>49.2%</td>
<td>57.7%</td>
<td>69.9%</td>
<td>90.3%</td>
<td>49.2%</td>
</tr>
</tbody>
</table>

National Average and Other Trusts Best and Worst for Combined Acute and Community Trusts

The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reasons. The data shown is based on NHS Staff Survey 2018 data which shows the Trust has improved significantly on last year’s score but still remains in the lowest quartile. Key challenges for the Trust have related to staffing levels and service pressures, and this is reflected in the feedback from staff.

The Mid Yorkshire Hospitals NHS Trust intends to take the following actions to improve this score, and so the quality of its services, by continuing to embed the MYQIS approach to quality improvement and continuing to listen and act on all sources of staff and patient’s feedback.

Patients who would recommend the Trust to their family or friends

<table>
<thead>
<tr>
<th>Related NHS Outcomes Framework Domain</th>
<th>Prescribed Information</th>
<th>MYHT Feb’18</th>
<th>MYHT Feb’19</th>
<th>National Average</th>
<th>Other Trusts – Best</th>
<th>Other Trusts – Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>4: Ensuring that people have a positive experience of care</td>
<td>A&amp;E Friends &amp; Family Test – Patients who would recommend the Trust as a provider of similar treatment or care to their family or friends.</td>
<td>94.3%</td>
<td>94.3%</td>
<td>85.3%</td>
<td>99.3%</td>
<td>57%</td>
</tr>
</tbody>
</table>

There is a not a statutory requirement to include this indicator in the quality accounts reporting but NHS provider organisations should consider doing so.
The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reason. 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 Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reason. 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.

<table>
<thead>
<tr>
<th>Related NHS Outcomes Framework Domain</th>
<th>Prescribed Information</th>
<th>MYHT Q3 17/18</th>
<th>MYHT Q3 18/19</th>
<th>National Average</th>
<th>Other Trusts – Best</th>
<th>Other Trusts – Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>5: Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.</td>
<td>95.01%</td>
<td>89.21%</td>
<td>95.65%</td>
<td>100%</td>
<td>54.9%</td>
</tr>
</tbody>
</table>

**Rate of C Difficile Infections (CDI)**

The Mid Yorkshire Hospitals NHS Trust considers that this data is as described for the following reason. The national objective for CDI for 2018/19 is no more than 26 Trust-attributed cases.

At the end of February 2019 the Trust had reported 43 Trust-attributed CDI cases. This is an increase of 18 cases from the previous reporting year. 36 of the cases were deemed not preventable, two preventable cases and five cases remain in the review process at the end of February 2019.
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, a CDI summit was held 9 May 2018 where a CDI improvement plan was implemented and educational sessions have taken place with clinical staff where learning has been shared and improvement pledges made. Public Health England colleagues were invited into the Trust on 13 November 2018 to review the CDI position and made the following recommendations:

- continue to promote multi-disciplinary review of all CDI cases including doctors
- review testing and diagnostic procedures, particularly in the emergency departments
- look at options for implementing antimicrobial three-day review: stop-start-continue antibiotics
- provide prompts for medical reflection on prescribing behaviour or post infection review, including information to clinicians for immediate patient review
- positive reinforcement for good practice
- develop a robust plan for using HPV post CDI infection
- introducing toxin gene PCR testing to distinguish between toxigenic- and non-toxigenic CDI strains to free up space for others needing side rooms.

<table>
<thead>
<tr>
<th><strong>Related NHS Outcomes Framework Domain</strong></th>
<th><strong>Prescribed Information</strong></th>
<th><strong>MYHT 2016/17</strong></th>
<th><strong>MYHT 2017/18</strong></th>
<th><strong>National Average</strong></th>
<th><strong>Other Trusts – Best</strong></th>
<th><strong>Other Trusts – Worst</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5: Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>The rate per 100,000 bed days of cases of C difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.</td>
<td>13.2</td>
<td>10.76</td>
<td>13.65</td>
<td>0.0</td>
<td>91.0</td>
</tr>
</tbody>
</table>

**Patient safety incidents**

The Trust considers that this data is as described for the following reasons. The data reflects incidents reported to the National Reporting and Learning System (NRLS) over a given period. The Trust has a dedicated Quality and Safety Team that is responsible for the identification and investigation of Serious Incidents (SIs) 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.

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.
Overall, 2017/18 has seen a slight decrease in the number of incidents reported compared to 2016/17 and a reduction of incidents that resulted in severe harm or death.

<table>
<thead>
<tr>
<th>Related NHS Outcomes Framework Domain</th>
<th>Prescribed Information</th>
<th>MYHT 2016/17</th>
<th>MYHT 2017/18</th>
<th>National Average</th>
<th>Other Trusts – Best</th>
<th>Other Trusts – Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>5: Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>Patient safety incidents and those that resulted in severe harm or death</td>
<td>16,230</td>
<td>16,084</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Number of incidents reports (all harm)</td>
<td>48.68</td>
<td>46.33</td>
<td>42.17</td>
<td>23.85</td>
<td>117.9</td>
</tr>
<tr>
<td></td>
<td>Rate per 1,000 occupied bed days (all harm)</td>
<td>54</td>
<td>48</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Number that resulted in severe harm or death</td>
<td>0.33%</td>
<td>0.3%</td>
<td>0.35%</td>
<td>0.0%</td>
<td>1.76%</td>
</tr>
<tr>
<td></td>
<td>Percentage that resulted in severe harm or death</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

National average and Other Trusts Best and Worst for Acute (Non Specialist) Trusts
Appendix II: Statement of Directors’ responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (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 III: National clinical audits and national confidential enquiries that Mid Yorkshire Hospitals NHS Trust was eligible to participate in during 2018-19

<table>
<thead>
<tr>
<th>National Clinical Audit and Clinical Outcome Review Programme</th>
<th>Host Organisation</th>
<th>MYH</th>
<th>Number Included (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Yes</td>
<td>698</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>British Thoracic Society</td>
<td>Yes</td>
<td>10 – 100% agreed with NACAP monthly sample of 5 patients</td>
</tr>
<tr>
<td>Adult Cardiac Surgery</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>N/a</td>
<td></td>
</tr>
<tr>
<td>BAUS Urology Audits: Cystectomy</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>32 (100%)</td>
</tr>
<tr>
<td>BAUS Urology Audits: Nephrectomy</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>87 (100%)</td>
</tr>
<tr>
<td>BAUS Urology Audits: Percutaneous Nephrolithotomy</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>37 (100%)</td>
</tr>
<tr>
<td>BAUS Urology Audits: Radical Prostatectomy</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>72 (100%)</td>
</tr>
<tr>
<td>BAUS Urology Audits: Female Stress Urinary Incontinence</td>
<td>British Association of Urological Surgeons</td>
<td>Yes</td>
<td>37 (100%)</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>Royal College of Surgeons</td>
<td>Yes</td>
<td>337 (100%)</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Yes</td>
<td>40 Loops ICD/CRTD/P unvalidated</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>Yes</td>
<td>854 (100%)</td>
</tr>
<tr>
<td>Child Health Clinical Outcome Review Programme a) Young Peoples Mental Health b) Chronic Neurodisability c) Cancer in Children</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>Yes</td>
<td>a) 2/2 (100%) b) 1/1 (100%) c) no applicable patients</td>
</tr>
<tr>
<td>Health Area</td>
<td>Coordinator/Website</td>
<td>Complete?</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>and Young Adults</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>N/a</td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Disease (CHD)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Yes</td>
<td>434 (100%)</td>
</tr>
<tr>
<td>Coronary Angioplasty National Audit of Percutaneous Coronary Interventions (PCI)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Yes</td>
<td>187 – Pontefract and Pinderfields 120 – Dewsbury Hospital</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Elective Surgery National PROMs Programme</td>
<td>NHS Digital</td>
<td>Yes</td>
<td>a) 274/305 (89.8%) 60/123 (48.8%) b) 475/520 (91.3%) 112/229 (48.9%)</td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit</td>
<td>British Association of Endocrine and Thyroid Surgeons</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>Inpatient falls 30 (100%) Hip fracture database 578 (100%)</td>
</tr>
<tr>
<td>Fractured Neck of Femur</td>
<td>Royal College of Emergency Medicine</td>
<td>Yes</td>
<td>50 (100%)</td>
</tr>
<tr>
<td>Head and Neck Cancer Audit</td>
<td>Saving Faces - The Facial Surgery Research Foundation</td>
<td>N/a</td>
<td></td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Programme</td>
<td>Inflammatory Bowel Disease (IBD) Registry</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Learning Disability Mortality Review (LeDeR)</td>
<td>University of Bristol</td>
<td>Yes</td>
<td>5/5 (100%)</td>
</tr>
<tr>
<td>Major Trauma Audit</td>
<td>Trauma Audit and Research Network (TARN)</td>
<td>Yes</td>
<td>500 (unconfirmed as not verified)</td>
</tr>
<tr>
<td>Maternal, New born and Infant Clinical Outcome Review Programme</td>
<td>MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)</td>
<td>Yes</td>
<td>7 neonates 19 maternal</td>
</tr>
<tr>
<td>Medical &amp; Surgical Clinical Outcome Review Programme</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>Yes</td>
<td>a) 7/7 (100%) b) 0 – cases identified for sample c) 5/5 (100%)</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review</td>
<td>National Confidential Inquiry into Suicide and Homicide (NCISH)</td>
<td>N/a</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>National Audit of Anxiety and Depression</td>
<td>Royal College of Psychiatrists</td>
<td>Yes 30/30 (100%)</td>
<td></td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients (NABCOP)</td>
<td>Clinical Effectiveness Unit, The Royal College Surgeons of England</td>
<td>Yes 638 (100%)</td>
<td></td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>Royal College of Psychiatrists</td>
<td>Yes 50 (100% case notes) 53 (eligible staff questionnaires) 62 (eligible career questionnaires)</td>
<td></td>
</tr>
<tr>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>NHS Benchmarking Network</td>
<td>Yes 47/50 (94%)</td>
<td></td>
</tr>
<tr>
<td>National Audit of Psychosis</td>
<td></td>
<td>N/a</td>
<td></td>
</tr>
<tr>
<td>National Audit of Rheumatoid and Early Inflammatory Arthritis</td>
<td>British College of Psychiatrists</td>
<td>Yes Dewsbury 56 Pinderfields 54 Pontefract 66 Total 176 (100%)</td>
<td></td>
</tr>
<tr>
<td>National Audit of Seizures and Epilepsies in Children and Young People</td>
<td>Royal College of Paediatric and Child Health</td>
<td>Yes 27 (100%)</td>
<td></td>
</tr>
<tr>
<td>National Bariatric Surgery Registry (NBSR)</td>
<td>British Obesity and Metabolic Surgery Society (BOMSS)</td>
<td>Yes 43 (100%)</td>
<td></td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>Yes Number of calls 670 Cardiac arrests 93 Number of patients 93</td>
<td></td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Royal College of Physicians</td>
<td>Yes Dewsbury 242 Pinderfields 1970 Total 2212 (100%)</td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit of Specialist Rehabilitation</td>
<td>London North West Healthcare NHS Trust</td>
<td>N/a</td>
<td></td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme; Massive Haemorrhage</td>
<td>NHS Blood and Transplant</td>
<td>Yes 5 (100%) 43 (100%)</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Manager/Owner</td>
<td>Validated</td>
<td>Notes</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Haematology Adult Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| National Diabetes Adults;  
a) National Diabetes Inpatient Audit (NaDIA)  
b) National Pregnancy in Diabetes (NPD)  
c) National Foot Care Audit (NFA) | Health and Social Care Information Centre (HSCIC)                            | Yes       | a) Pinderfields 106 Dewsbury 28  
b) 17  
c) 16 |
| National Emergency Laparotomy Audit (NELA)                                 | The Royal College of Anaesthetists                                           | Yes       | 116/121 (96%)                                                       |
| National End of Life Care Audit                                             |                                                                               | Yes       | 80 (100%)                                                          |
| National Heart Failure Audit                                                | National Institute for Cardiovascular Outcomes                               | Yes       | 909 (100%)                                                        |
| National Joint Registry (NJR)                                               | Healthcare Quality Improvement Partnership                                   | Yes       | 1282/1303 (98%) Unvalidated                                      |
| National Lung Cancer Audit (NLCA)                                           | Royal College of Physicians                                                  | Yes       | 523 (100%)                                                        |
| National Maternity and Perinatal Audit                                      | Royal College of Obstetricians and Gynaecologists                           | Yes       | 6276                                                               |
| Neonatal Intensive and Special Care (NNAP)                                  | Royal College of Paediatrics and Child Health (babies may have more than one episode) | Yes | 476 (100%) episodes  
434 (100%) babies |
| National Neurosurgical Audit Programme                                      | Society of British Neurological Surgeons                                     | N/a       |                                                                     |
| National Ophthalmology Audit (2017 patients)                               | Royal College of Ophthalmologists                                            | Yes       | 1668 patients  
2086 cataract ops (100%)                                           |
| National Vascular Registry                                                 | Royal College of Surgeons of England                                         | N/a       |                                                                     |
| National Oesophago-Gastric Cancer Audit (NOGCA)                             | Royal College of Surgeons                                                    | Yes       | 108 tumours  
3 HGD (100%)                                                      |
<p>| Paediatric Intensive Care (PICANet)                                        | University of Leeds                                                          | N/a       |                                                                     |
| Pain in Children                                                            | Royal College of Emergency Medicine                                         | Yes       | 100 (100%)                                                        |
| Prescribing Observatory for Mental Health (POMH-UK)                        | Royal College of Psychiatrists                                                | N/a       |                                                                     |
| Procedural Sedation in Adults (Care in Emergency Department)               | Royal College of Emergency Medicine                                         | Yes       | 44 (100%)                                                         |</p>
<table>
<thead>
<tr>
<th>National Prostate Cancer Audit</th>
<th>Royal College of Surgeons</th>
<th>Yes</th>
<th>276 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>681 (100%)</td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT): UK</td>
<td>Serious Hazards of Transfusion National Haemovigilance Scheme Transfusion Associated Circulatory Overload (TACO)</td>
<td>Yes</td>
<td>21 (100%)</td>
</tr>
<tr>
<td>UK Parkinson’s Audit</td>
<td>Parkinson’s UK</td>
<td>No</td>
<td>20 (100%)</td>
</tr>
<tr>
<td><strong>Other National Audits non QA 2017-18</strong></td>
<td><strong>Provider</strong></td>
<td><strong>%/number of Cases</strong></td>
<td></td>
</tr>
<tr>
<td>Penile Prosthesis</td>
<td>British Association of Urologists (BAUS)</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Each Baby Counts</td>
<td>Royal College of Obstetricians and Gynaecologist</td>
<td>12 (100%)</td>
<td></td>
</tr>
<tr>
<td>iBRA-2: Immediate Breast Reconstruction and Adjuvant Therapy Audit</td>
<td>Association of Breast Surgery (ABS), British Association of Plastic and Reconstructive Surgery (BAPRAS), Royal College of Radiologists (RCR) and Oncologists</td>
<td>10 (100%)</td>
<td></td>
</tr>
<tr>
<td>National Audit of Small Bowel Obstruction (NASBO)</td>
<td>Bowel Disease Research Foundation (NASBO) The Association of Coloproctological of Great Britain and Ireland (ACPGBI)</td>
<td>23/24 (100%)</td>
<td></td>
</tr>
<tr>
<td>BAD Non-Melanoma Skin Cancer Excisions Audit</td>
<td>British Association of Dermatologists</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>7 Day Service (773)</td>
<td>NHS England</td>
<td>246 (100%)</td>
<td></td>
</tr>
<tr>
<td>Breast and Cosmetic implant Registry (Keogh review Recommendation)</td>
<td>National Registry Association of Breast Surgery</td>
<td>85 (entered onto register unvalidated)</td>
<td></td>
</tr>
</tbody>
</table>
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 have been 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 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 or 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 Board:** 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 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 care.

**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 and Scrutiny Committee (OSC)**: 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 and 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 system 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 to NHS-funded care where the consequences are significant or where the potential for learning is high.

**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.