



MY ANNUAL REPORT

The Mid Yorkshire Hospitals NHS Trust

2015/2016



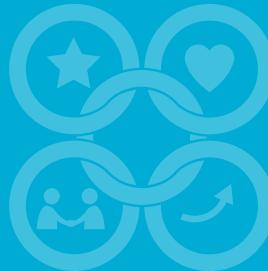


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ANNUAL REPORT 2015/16

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CHAIRMAN'S STATEMENT

Jules Preston MBE
Chairman

Thank you for taking the time to read our annual report and accounts for 2015/16.

This document gives us, as a Trust, the opportunity to: showcase the work we have been doing across the financial year; provide information on our financial position; inform you of some of our challenges and the issues we face; and outline some of the plans we are developing to improve services over the next few years.

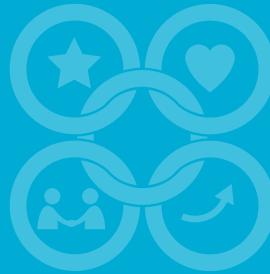


Our Trust is no different to any other. We continued to experience consistently high levels of demand throughout the year which we had to set against a very challenging financial position. Occasionally we did not meet the standards expected by patients, families or indeed by ourselves. My apologies to those patients but we did deliver good care in the vast majority of cases.

More and more people are living longer and learning to manage their complex conditions. Improvements in medical treatments and technologies continue apace. This is the background to what we set out to achieve in 2015/16. This report details how we responded to these issues and the levels of performance we delivered.

We continue to work closely with all our partner organisations to strive to improve services for our communities. Strong and effective working relationships are vital and I would like to thank all our partners for their support, guidance and counsel through the year.

There is no doubt the NHS nationally and our Trust locally, will continue to face varied and significant challenges. We need to be ready for these – with robust and flexible plans in place and a workforce ready to deliver excellent care. Our staff work together every day to provide the best possible care. I would like to thank them – as well as all our fantastic volunteers – for their continued dedication and commitment to help our patients improve their health.



CHIEF EXECUTIVE'S STATEMENT

Martin Barkley
Chief Executive

Last year proved to be a challenging year for the Trust. There was a planned inspection by the Care Quality Commission (CQC) in June and this was followed by two unplanned inspections later in the year.

The report identified staffing as a key issue, something the Trust has been addressing throughout the year, to recruit staff and increase retention, latterly with pretty good success.

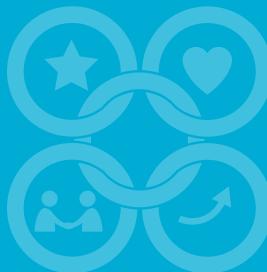
Another key challenge was the Trust's financial position: the year ended with a deficit of £20.5 million which was considerably worse than planned, a significant cause being high expenditure on agency staff. The Trust continued to experience increases in demand for our services across all three hospitals as well as our community services which was at times difficult to match with our capacity and regrettably resulted in increased waiting times for some services.

Despite these challenges the Trust continued to work hard to improve services and some of our highlights of the year include: our new state of the art Eye Centre which both patients and staff helped to design. At Dewsbury we have invested almost £1m in new equipment, ranging from resuscitaires on the Delivery Suite to ultrasound transducers in Accident and Emergency, to ensure we have the very best equipment available to support the provision of high quality care.

In August we welcomed the opening of new family rooms on Ward 43 at Pinderfields by one of the co-founders of John's Campaign (better services for people who have dementia) and we now have a total of seven rooms for family members to stay with their loved ones.

In September the Macmillan Cancer Information and Support Service was launched. Based at Pinderfields Hospital it offers support, advice and information for anyone affected by cancer, not just the patients. In the same month we introduced a new Rapid Elderly Assessment Care Team (REACT).





CHIEF EXECUTIVE'S STATEMENT CONTINUED

This team of doctors, nurses, community therapists and social workers aims to help elderly patients with a timely discharge from hospital and co-ordinate their ongoing care, where appropriate, with community services and other professional agencies such as social services and Age UK.

We were also delighted when our associate non-executive Director Dr Nisreen Booya was added to the list of those colleagues who have gained recognition from the Queen for their hard work and passion by receiving an MBE.

I became the Accountable Officer of the Trust in April 2016 to be the Chief Executive whilst my predecessor Stephen Eames is on secondment to a Trust in Cumbria and I want to take this opportunity to pay tribute to his contribution to the achievements of the Trust.

Looking forward to the year that began in April 2016, a very important programme of work will be to complete the reorganisation of services, mainly involving Dewsbury and Pinderfields Hospitals. We will be working with local GP Federations and Clinical Commissioning Groups to support the establishment of Multi-Specialty Community Provider arrangements.

" I have been hugely impressed by the staff I have met. Working in a busy NHS Trust can be difficult and challenging but also incredibly rewarding. The staff work really hard to provide the best service they can and are very keen to work to improve the quality of services provided. **"**

Our key priorities for the current year are to better match our capacity to increasing levels of demand to meet the standards set out in the NHS Constitution and improve patient experience. We are working to make the Trust a better place to work by reducing pressure on staff and improving engagement and communication with our staff. We will also continue to work to ensure the cost of providing services is aligned to the income the Trust receives.

I have been hugely impressed by the staff I have met. Working in a busy NHS Trust can be difficult and challenging but is also incredibly rewarding. The staff work really hard to provide the best service they can and are very keen to work to improve the quality of services provided.

I would like to take this opportunity to thank all the employees of the Trust for their hard work and commitment and I am really looking forward to working with them and supporting them in their work. I also want to take this opportunity to thank our local Clinical Commissioning Groups, Local Authority partners, GPs and volunteers for their help and support.

CHAPTER ONE

ABOUT THE TRUST

More than half a million people living in the Wakefield and North Kirklees districts of West Yorkshire use the services in the Trust's three hospitals – Pinderfields in Wakefield, Dewsbury and District and Pontefract. The Trust also provides services in the community for Wakefield residents.

The Mid Yorkshire Hospitals NHS Trust was established in April 2002, bringing together the three hospitals under one Trust. In 2010, we also started providing community therapy services and intermediate care services. These services provide short term specialist care to people who have been discharged from hospital but need extra support, care and rehabilitation before they go home. In April 2011, we expanded to provide community health services for the Wakefield district to include Adult Community Nursing and Children's and Family Health Services.

All our services are provided from the three hospitals and in a range of community settings such as health centres, clinics, GP surgeries, family centres and in people's own homes.

Our Vision

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

Our Values

In 2015/16 we continued to build on our values and ensure they are at the heart of everything we do. As a Trust we are committed to embedding them in all the services we provide and the activities we undertake – both clinical and non-clinical.

The values are:

 **RESPECT** - showing value and respect for everyone and treating others as we would wish to be treated.

 **HIGH STANDARDS** - taking responsibility for providing the best services and patient experience.

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

 **CARING** - ensuring quality of care is at the heart of everything we do.

In 2015/16 the Trust:

- Had 1,023 beds available
- Treated 96,814 patients who were admitted to hospital
- Saw 67,063 patients as day cases
- Dealt with 232,968 attendances at its three Emergency Departments
- Delivered 6,293 babies
- Handled 485,952 outpatient appointments



CHAPTER TWO HIGHLIGHTS

Let's take a look back over 2015/16 and celebrate some of the great work, achievements and improvements of the Trust.





CARING

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

WORLD PREMATURITY DAY

Our Neonatal Departments donned the colour purple last year to raise awareness of babies who are born prematurely, for World Prematurity Day on 17 November.

According to figures from Bliss, 15 million babies are born too soon each year across the globe and around one million of these babies will not survive.

Julia Thomas, Neonatal Nurse at Pinderfields said: "Care at our Neonatal Units is the very best way to ensure that the smallest and sickest babies get the best possible care and the best chance of surviving healthily. Having a premature or sick baby can turn your world upside down but all neonatal staff know that parents are under stress and are there to help and support them, as well as their baby."

To mark the day, the Neonatal Unit at Pinderfields festooned its unit with purple decorations and signs, wore purple t-shirts and ate lots of cake! The Supporters of Families and Babies (SOFAB) charity, who provides family centred care, advice and support to neonatal units, held a cake sale in the atrium at Pinderfields and the Neonatal Unit at Dewsbury organised a coffee morning.



MORE TIME TO VISIT

At the beginning of March we introduced open visiting at all three hospitals, so people can now visit their loved ones when they wish and where appropriate, be actively involved in their care.

It is important to recognise the invaluable contribution friends and family can make when it comes to patient care and having loved ones around more often can help a patient's stay much more comfortable.

These are some of the comments we received on Facebook about open visiting: *Tamsyn Relins: "What a brilliant idea."*

KS, Brotherton: "It's great news as this will mean that people who otherwise couldn't get there in the visiting times, can visit."

STOP PRESSURE ULCER DAY

The Tissue Viability team were out and about in Trinity Walk, Wakefield, last November promoting STOP Pressure Ulcer Day. They organised the awareness raising event to share information about pressure area management by reaching out to the public to inform them about pressure ulcers and how they can be prevented.

Claire Hoggard, Tissue Viability Nurse Specialist, said: "The day was a huge success and was well attended by shoppers passing by. Pressure ulcers can cause patients long term pain and distress and at the stand we demonstrated some of the work we are doing to prevent them from happening to make life better for our patients."



RESPECT

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

LGBT HISTORY MONTH

February was LGBT (Lesbian, Gay, Bisexual and Transgender) History Month, which was a great opportunity for us to better understand the needs and challenges of LGBT patients. There were displays at our three hospital sites and an interactive masterclass in the Lecture Theatre at Pinderfields.

The masterclass was led by the charity Stonewall and examined the issues faced by LGBT patients when accessing healthcare, as well as how the NHS can best treat transgender patients in single sex wards. It also included contributions from David Melia, Deputy Chief Executive/ Acting Chief Nurse, who has acted as a confidant to vulnerable LGBT colleagues.

Delegates at the masterclass learnt that the NHS is a fairly healthy place for LGBT patients and employees but with figures showing that around a quarter of NHS LGBT staff have been bullied at work because of their sexual orientation, delegates were encouraged to do more to root out discrimination and make the NHS a place where people "can be themselves".

Mohammed Rawat, Diversity and Inclusion Project Manager, said: "Studies show that staff who feel they can truly be themselves at work, perform better. In the case of the NHS a happier workforce would also mean better care for patients in Mid Yorkshire."



HIGH STANDARDS

Taking responsibility for providing the best services and patient experience.

GROUND BREAKING DEVICE

A new state of the art, implantable cardioverter-defibrillator has recently been fitted to a patient at Pinderfields. The device will now be recommended to patients at risk of a sudden cardiac arrest.

Previously, a normal defibrillator would be implanted in the upper chest of a patient with a wire going directly into the heart, leaving a large scar and there is a risk of infection.

The S-ICD System is a new device that sits just under the skin, constantly monitoring the heart, ready to deliver treatment if sudden cardiac arrest strikes. The device provides protection without placing a wire on the patient's heart and sits quietly within the patient. Should the patient's heart beat dangerously fast, it gives an electric shock to get it back into rhythm.

Richard Johnson, 39, from Pontefract, was the first patient to be fitted with the new device at Pinderfields. **He said:** "The operation went great. There was no pain. Staff were fantastic and the hospital was clean."

Vikrant Nayar, Cardiology Consultant, said: "This new technology is potentially better suited to many of our patients, especially those at high risk of infections, or when a standard defibrillator implantation is not possible. In providing this service, as at Leeds General Infirmary or other tertiary cardiac centres, we now offer implantation and follow-up for the full range of defibrillators."

FORWARD THINKING

Lots of hard work and organisation has paid off for the Plastic Surgery Dressing Clinic Team at Pinderfields who have become the first outpatient clinic and department within the surgical directorate to achieve 'dementia friendly environment' status.

The team arranged for large clocks to be fitted in the clinic waiting room and treatment rooms, to orientate patients regarding day, date and time. The toilet facilities are now easier to find, with large picture signage on the doors and red painted door frames. In addition, all team members have completed their Dementia Awareness training.

The team are very proud to have achieved their status and would like to thank all who helped them to reach their goal!

BARONESS BACKS BOOTHROYD!

Baroness Betty Boothroyd was welcomed to the Boothroyd Centre named after her which she opened 20 years ago at Dewsbury.

The former first lady speaker of the House of Commons was welcomed by Terry Moran, Non-Executive Director; Kathryn Fishwick, Consultant Gynaecologist; and Tony Browning, Consultant Urologist.

Until now the Boothroyd Centre has primarily been used as a day care facility but as part of the Trust's hospital reconfiguration plans, it will be home to an increased endoscopy department, pain management and a new one-stop-shop urology clinic.

The clinic will be much more convenient for patients; enabling them to have their initial consultation, any investigation, diagnostic tests and biopsies in one appointment. It is estimated that this will result in 60 percent of patients being either discharged or put on a list for surgery after their first visit.

During her visit Baroness Boothroyd also visited the stroke ward and had the opportunity to meet some of the patients.



BEST IN CLASS!

Congratulations to members of the Pharmacy team who received a 'Best Poster' accolade at a recent national conference of the UK Clinical Pharmacy Association (UKCPA).

One of the team's projects was around improving the reach of their clinical pharmacy services and, after discovering there was little in the way of published literature about this, the team produced a conference poster, entitled 'Identifying the minimum and optimum levels of clinical pharmacy services'.

Siobhan Conaghan, Clinical Lead Pharmacist and Hameda Lane, Associate Director of Pharmacy for Patient Care, were the authors of the poster and Hameda presented it last November at the UKCPA Autumn Symposium 2015. Well done to them!



IMPROVING

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

FRIENDS AND FAMILY TEST

The Friends and Family Test (FFT) asks a simple question to find out whether, based on their experience, patients would recommend the care they received to their friends and family as well as comment on what was good about their care and what could be improved. From these comments we're really able to act and make changes.

From 14 to 18 March was the Friends and Family Test Spotlight Week. During the week our Patient Experience team shared details, across all three sites, of the improvements teams and services have made following feedback from patients. It was also an opportunity to increase awareness of the test amongst patients and visitors.

In the last three years the Trust has received over 250,000 responses from patients via the FFT and has implemented many changes on the back of these.

One has been the introduction of a permanent Macmillan Information Pod and support service at Pinderfields following a patient comment that it would be "good to have better information in hospital regarding treatment and future treatment for cancer."

We also issued information to the local media which featured in the Wakefield Express and shared our stories of feedback and improvements through our social media channels.

NEW CHANGES TO MATERNITY SERVICES

All three of our hospitals will this year have a midwife led unit now referred to as a 'birth centre', increasing the choice for women giving birth.

Pinderfields maternity unit will be expanded to include more delivery and recovery rooms, a high dependency unit, triage, ante natal and post-natal beds and more theatre capacity.

Our midwives will assess women throughout their pregnancy to help them decide whether a midwife led unit or the labour ward are the best place for them.

The units will be called:

- Bronte Birth Centre - at Dewsbury and District Hospital
- Pinderfields Birth Centre
- Friarwood Birth Centre - at Pontefract hospital.



IMPROVING LIVES THROUGH RESEARCH

Clinical research is extremely important in the discovery of new treatments and the improvement of existing ones.

The Urology Clinical Research Team consists of Bev Taylor and Victoria Dean, Research Sisters; Steve Littler, Research Charge Nurse and Jim Anderson, Clinical Trials Assistant. The team is actively supported by the Trust's urology consultants, input from clinical and medical oncology at Leeds, clinical nurse specialists, senior doctors, Pharmacy, Radiology and the Urology Investigations Unit.

The Trust recently took part in a very important national research trial funded by the National Institute for Health Research. The trial looked at smooth muscle relaxant drugs (drug therapy) in the assistance of ureteric stone passage. Patients were randomly allocated either a placebo, a calcium channel blocker (Nifedipine) or an alpha-blocker (Tamsulosin).

The study found no evidence that the drugs reduced pain, hastened time to stone passage or improved health. The results were published in *The Lancet* which has subsequently led to a change of clinical practice. Our Trust was the second highest recruiter nationally of patients for this trial.

Currently the Urology Clinical Research Team has the following active trials:

- **Prostate cancer trials** – genetic, hormone therapy, efficacy and safety, and detection of radiological spinal cord compression.
- **Urinary stones trial** – first treatment options for patients.
- Assessment of **polymorphisms trial** for predicting the effects of radiotherapy.
- **Radiotherapy and androgen deprivation trial** in combination after local surgery.
- **Urinary bladder trial** - urinary tract tissue is sent to the Department of Molecular Carcinogenesis in York.
- **Upper tract urothelial cancer trial** – peri-operative chemotherapy versus surveillance.
- **Bladder cancer trial** – patients receive chemoresection or standard surgical intervention.
- **Stress incontinence post prostatectomy trial** - patients receive either male sling or an artificial urinary sphincter.

The team is committed to research which is evident in their excellent track record and performance. They are the highest recruiter of patients for the PATCH trial (hormone patches vs standard care for prostate cancer patients) and the RADICALS trial (looking at radiotherapy and hormone therapy after surgery for prostate cancer).



CORONARY CARE PATIENTS GETTING A BETTER SERVICE

Patients with serious heart problems are getting a better service since the Coronary Care Unit was centralised at Pinderfields last summer.

The centralisation – one of the first to take place as part of hospital reconfiguration – is undergoing evaluation.

Initial findings on the changes showed:

- A reduction in length of stay by 2 days, despite a significant proportion of the bed base continuing to be utilised by other types of patients due to the elevated demand being experienced by the Trust.
- The number of transfers post centralisation continues to be consistent with modelling, at less than two transfers per day.

Consultant Cardiologist, Paul Brooksby, said:
“We said these changes would improve the standard of care for the most seriously ill cardiology patients across Mid Yorkshire and that’s what’s happening.

“These changes mean we now meet the British Cardiovascular Society recommendations that patients presenting with acute cardiac conditions should be managed by a specialist, multi-disciplinary cardiac team and have access to key cardiac investigations and interventions, at all times.”





CHAPTER THREE PERFORMANCE

The Trust's Quality Account sets out achievements over the last year and this is available at NHS Choices or on our website at: www.midyorks.nhs.uk

The Trust has an agreed Performance Framework which sets out the robust processes and systems in place to ensure the sustainable delivery of mandatory and locally agreed performance targets as well as strategic and annual objectives.

RAG STATUS GREEN	ACHIEVED	the required standard has been met for this indicator
RAG STATUS AMBER	NOT ACHIEVED	the required standard has not been met by a narrow margin and performance is within an agreed tolerance
RAG STATUS RED	NOT ACHIEVED	the required standard has not been met and performance is not within an agreed tolerance

The Trust uses a Red, Amber and Green (RAG) rating illustrated above to monitor performance against a set of national and locally agreed standards and identify where actions are needed to manage under-performance.

For the purpose of reporting, indicators are grouped in to the five domains of quality (caring, safe, effective, responsive and well led) identified by the Care Quality Commission (CQC) and mirrored in the Trust Development Authority (TDA) Accountability Framework.

Performance in each of the domains in 2015/16 is summarised below. This is based on the year end position reported to the Trust Board in the March 2016 Performance Report, or the latest information available. A full breakdown of performance against each indicator can be found in the following section.

2015/16 Performance

In line with the majority of other NHS Trusts, 2015/16 proved a difficult year for Mid Yorkshire Hospitals in regard to a number of performance indicators.

The chart on the following page demonstrates the Trust performance in the different CQC domains in 2015/16, in addition to activity and finance which are key to sustainability. The chart shows that the Responsive (access targets) and Finance had the highest number of indicators that were not achieving the standard set out in the TDA Accountability Framework.

“ I cannot praise too highly the professional care my husband has received both from the consultant and the nursing staff. Our heartfelt gratitude for providing such a wonderful service. **”**

Dermatology Department at Pinderfields

CHAPTER THREE PERFORMANCE CONTINUED

Performance Summary March 2016

- Green = achieved
- Amber = not achieved, inside agreed tolerance levels
- Red = not achieved, outside agreed tolerance levels



The following section gives a brief summary of the performance in the Caring, Safe, Effective, Responsive and Well Led domains; the Activity section relates to contract activity and is integrally linked to the Trust's finances, performance against which is referred to elsewhere in this report.

Caring

- At year end (March 2016) the Trust was not achieving the target for the proportion of staff who would recommend the Trust as a place to work or receive care. During the year there was one breach of the zero tolerance single sex accommodation indicator; no harm was encountered as a result of this breach and a decision was made at the time of the breach that it was the safest course of care.

Safe

- Of 21 indicators reported in the Safe domain of quality in 2015/16, the required standard was not achieved against six indicators based on annual performance. These included the infection standards related to MRSA and C-Diff. It must be noted though that the MRSA figure* for the Trust (two) was the second best performance in the last five years. ** In regard to C-Diff, although there were 36 cases of C-Diff, completed analysis has shown that only eleven were preventable.
- The majority of Safe indicators were achieved and although the target of 95% of patients receiving Harm Free care was not achieved, the Trust demonstrated further progress in this area such that 94.09% of patients had harm free care. This was an improvement from 2014/15 of 1.5%.
- The full list of indicators can be seen on pages 17 to 21.

Effective

- The Trust achieved the required standard against seven of the nine indicators included within the effective domain both at year end and cumulatively across the year.
- Year on year performance also showed improvement in the key mortality indicators when compared to validated data.

* Trust attributable infection cases.

** Following further validation, decreased to one case based on the findings of an arbitration panel that the case in March 2016 was not Trust attributable. Consequently, performance in 2015/16 was equal to the Trust's best performing year in the previous 5 years.

Responsive

- Like the majority of the NHS, The Mid Yorkshire Hospitals NHS Trust has struggled to achieve continued improvement and delivery of the Responsive indicators that relate to access times and patient waiting lists.
- The NHS as a whole is seeing increased pressure on emergency services which in turn affects the flow of patients through the hospital. The Trust experience in the year has been no different to the national picture, as a result the Trust has struggled in 2015/16 to maintain the performance achieved in recent years for indicators related to urgent care.
- The four hour standard and 12 hour trolley waits have worsened during 2015/16 when compared to previous years. The Trust is working closely with commissioners and the Local Authority to agree transformational change that will reduce the demand on emergency services but also improve the speed at which patients are seen, treated and discharged from the hospital.
- The Trust was ranked 96 out of 144 in 2015/16 when benchmarked in regard to performance against the four hour emergency care standard.
- Planned care; the Trust has also seen continued growth in demand for planned services over and above the levels of activity that it has undertaken suggesting demand is outstripping capacity. This identifies itself in growing waiting lists and performance against the planned care targets such as 18 weeks, cancer targets and the six week diagnostic target.
- National performance on 18 weeks and cancer waiting times has worsened and the Trust position reflects this in 2015/16.
- To improve the current position, the Trust is working closely with commissioners and GP groups to introduce innovative ways to reduce waiting times and improve access for those patients most needing it.

Well-led

- Indicators for the well led domain include the Friends and Family Tests, the staff stability and turnover indicators as well as staff sickness and appraisal rates amongst others.
- In performance terms the Trust has not seen a great deal of change in these areas during 2015/16.

“ The Trust remains committed to working with its staff and patients along with commissioners and the Local Authorities to improve performance further in 2016/17.

CHAPTER THREE

PERFORMANCE CONTINUED

Progress

Over the last four years, up to and including 2014/15, the Trust has demonstrated year on year improvement. Due to the challenges the NHS overall has faced in 2015/16 the Trust has struggled to maintain this upward trend. As the NHS faces increasing financial difficulty and growing demand for its services, the Trust, along with other healthcare providers, has seen waiting lists and waiting times grow at a time of increased costs.

As a result, some of the performance indicators, in particular those related to waiting times have seen a worsening in position. On a positive note, indicators related to safer and effective care have shown improvement, such as the harm free care indicator or the lead indicator for mortality rates.

The table opposite shows the key indicators from out of the TDA accountability framework that the Trust's uses as a benchmark to compare for year on year trends.

The table shows during 2015/16, 14 indicators improved or maintained achievement of the standard compared to 2014/15, whereas 12 indicators worsened. To put this into context, 2015/16 performance improved, or the standard was maintained, in 20 of the indicators when compared to the average of the previous four years.

The Trust remains committed to working with its staff, trade unions, patients, Stakeholder Forum members, local authorities and commissioners to improve performance further in 2016/17; to overcome some of the difficulties that the local health economy are facing to improve the care that patients receive at The Mid Yorkshire Hospitals NHS Trust.

Year on Year Performance Comparison

	STANDARD	PERIOD	2011/12	2012/13	2013/14	2014/15	2015/16	ASSESSMENT AGAINST PROGRESS IN YEAR	ASSESSMENT AGAINST PROGRESS OVER PREVIOUS FOUR YEARS
Caring									
Single sex sleeping accommodation breaches	0	Apr – Mar	152	4	3	0	1	●	●
Safe									
Publishing of the formulary	Yes	Apr – Mar	Yes	Yes	Yes	Yes	Yes	●	●
Zero tolerance MRSA	0	Apr – Mar	12	8	7	1	1	●	●
Minimise rates of Clostridium difficile	≤27 (15/16)	Apr – Mar	101	39	43	33	36	●	●
Harm Free Care	≥95%	Apr – Mar	-	-	90.54%	92.94%	94.09%	●	●
Never Events	0	Apr – Mar	0	1	4	1	0	●	●
New serious incidents reported	-	Apr – Mar	18	13	45	59	67		
Effective									
Summary Hospital-level Mortality Indicator – SHMI (relative risk)	≤100	Q2	97.79	90.94	**	**	89.59	●	●
Hospital Standardised Mortality Ratio (HSMR) (rolling year)	≤100	Feb – Jan	103.81	98.72	**	**	98.97	●	●
Responsive									
A&E waiting times (admitted, transferred or discharged) within 4 hours	≥95%	Apr – Mar	93.7%	96.1%	96.8%	94.1%	85.0%	●	●
RTT waiting times within 18 Weeks – Incomplete Pathways	≥92%	Mar	92.0%	91.2%	90.8%	92.0%	83.9%	●	●
Zero tolerance RTT waits over 52 weeks – Incomplete at month end	0	Apr – Mar	-	115	16	33	29	●	●
Diagnostic test waiting times less than 6 weeks	≥99%	Apr – Mar	99.01%	99.29%	99.27%	99.46%	97.72%	●	●
Maximum 2 weeks wait for 1st outpatient appointment - all cancers	≥93%	Apr – Mar	99.8%	97.9%	96.3%	95.4%	96.9%	●	●
Maximum 2 weeks wait for 1st outpatient appointment - breast	≥93%	Apr – Mar	98.7%	97.4%	97.0%	97.8%	97.0%	●	●
Maximum 31 days wait from diagnosis to 1st treatment	≥96%	Apr – Mar	99.6%	99.4%	99.3%	99.0%	98.8%	●	●
Maximum 31 days wait for subsequent treatment - surgery	≥94%	Apr – Mar	99.1%	99.8%	98.1%	96.4%	98.2%	●	●
Maximum 31 days wait for subsequent treatment - drug regimen	≥98%	Apr – Mar	100.0%	100.0%	100.0%	100.0%	99.9%	●	●
Maximum 62 days wait from urgent GP referral to 1st treatment	≥85%	Apr – Mar	88.1%	86.2%	85.3%	86.6%	87.2%	●	●
Maximum 62 days wait from screening service referral to 1st treatment	≥90%	Apr – Mar	97.0%	94.4%	95.8%	92.5%	96.6%	●	●
Delayed transfers of care – acute and sub acute	≤3.5%	Apr – Mar	-	-	3.04%	3.78%	4.22%	●	●
Delayed transfers of care – community beds	≤7.5%	Apr – Mar	-	-	13.44%	10.60%	11.69%	●	●
Cancelled operations not offered a binding re-admission date ≤28 days	0	Apr – Mar	88	17	1	4	6	●	●
No urgent operation to be cancelled for a second time	0	Apr – Mar	0	0	0	0	0	●	●
Well-led									
Sickness absence rate	≤4%	Apr – Mar	5.38%	4.68%	4.49%	4.83%	4.95%*	●	●
Non medical appraisal rate (rolling 12 months)	≥85%	Apr – Mar	57%	69%	72%	75%	72%	●	●
Core mandatory and statutory training compliance (rolling 12 months)	≥95%	Apr – Mar	-	95%	95%	96%	88%	●	●

Never Events - based on date of incident, not date reported. *Sickness 2015/16 up to Feb 16 **Confidence issues with Dr Foster data

DESCRIPTION	TREND	DESCRIPTION	TREND
14 improved from 2014/15 position or maintained the standard	●	20 improved or maintained the standard compared to average 2011/15	●
12 worsened from 2014/15 position	●	6 worsened compared to average 2011/15	●

Trust Board Balanced Scorecard - EFFECTIVE

INDICATOR	PERIOD	TARGET	ACTUAL	YTD	PERFORMANCE RAG STATUS IN PREVIOUS SCORECARDS	TREND IN PERFORMANCE FROM PREVIOUS	Q1	Q2	Q3	Q4
Hospital Standardised Mortality Ratio (HSMR) Relative Risk - elective and emergency admissions	Jan-16	≤100	91.94	99.18	● ● ● ● ●	↑ ↑ ↓ ↑ ↓	101.70	97.09	93.82	● Forecast
Hospital Standardised Mortality Ratio (HSMR) Relative Risk - Weekend (emergency admissions)	Jan-16	≤100	103.03	106.36	● ○ ○ ○ ○	↓ ↑ ↑ ↓ ↓	109.93	101.67	100.53	○ Forecast
Hospital Standardised Mortality Ratio (HSMR) Relative Risk - Weekday (emergency admissions)	Jan-16	≤100	86.77	96.44	○ ● ● ● ●	↑ ↓ ↑ ↑ ↓	98.86	95.18	91.39	● Forecast
Deaths in low risk conditions	Jan-16	≤100	160.21	120.51	○ ○ ○ ○ ○	↑ ↑ ↓ ↑ ↓	132.78	100.85	102.24	○ Forecast
Summary Hospital Mortality Indicator (SHMI)	Q2	≤100	89.59		● ● ● ● ●	↑	93.55	89.59	● Forecast	● Forecast
Crude mortality rate - non elec. ordinary admissions only (%)	Jan-16	To Monitor	2.60%	2.40%	● ● ● ● ●	↑ → ↓ ↑ ↓	2.59%	2.22%	2.35%	
Emergency readmissions within 30 days following an elective or emergency spell at the Trust (%)	Oct-15	≤9.38%	8.54%	8.98%	● ● ● ● ●	↑ ↓ ↓ ↑ ↑	9.10%	9.01%	● Forecast	● Forecast
Emergency readmissions within 7 days following an elective or emergency spell at the Trust (%)	Oct-15	≤4.05%	3.78%	3.92%	○ ● ● ● ●	↑ ↓ ↑ ↑ ↓	4.01%	3.88%	● Forecast	● Forecast
Emergency readmissions within 14 days following an elective or emergency spell at the Trust (%)	Oct-15	≤6.31%	5.77%	6.14%	○ ○ ○ ○ ○	↑ ↓ ↑ ↑ ↑	6.21%	6.20%	● Forecast	● Forecast
Emergency readmissions within 28 days following an elective or emergency spell at the Trust (%)	Oct-15	≤9.05%	8.21%	8.70%	○ ○ ○ ○ ○	↑ ↓ ↓ ↑ ↑	8.82%	8.76%	● Forecast	● Forecast

Trust Board Balanced Scorecard - CARING

INDICATOR	PERIOD	TARGET	ACTUAL	YTD	PERFORMANCE RAG STATUS IN PREVIOUS SCORECARDS	TREND IN PERFORMANCE FROM PREVIOUS	Q1	Q2	Q3	Q4
Mixed sex sleeping accommodation breaches	Mar-16	0	0	1	● ● ● ● ●	→ ↓ ↑ → →	0	0	1	0
Complaints - rate per 1,000 bed days	Mar-16	To Monitor	5.26	4.27	● ● ● ● ●	↑ ↑ ↓ ↓ ↓	4.09	4.21	4.10	4.65
Staff FFT: % recommend care	Q4	≥70%	54.0%	N/A	● ● ● ● ●	↑ ↓ ↑ → ↓	58.0%	58.0%	N/A	54.0%
Staff FFT: % not recommend care	Q4	≤12%	22.0%	N/A	● ● ● ● ●	↑ ↑ ↓	18.0%	17.0%	N/A	22.0%
Inpatient and Daycase FFT scores: % positive	Mar-16	≥95.2%	97.2%	96.4%	● ○ ● ● ●	↓ ↑ ↑ ↑ ↓	95.9%	96.7%	96.0%	97.2%
Inpatient and Daycase FFT scores: % negative	Mar-16	≤1.6%	1.28%	1.18%	● ● ● ● ●	↓ ↓ ↑ ↑ ↓	1.36%	0.94%	1.29%	1.14%
A&E FFT scores: % positive	Mar-16	≥87.5%	91.6%	94.1%	● ● ● ● ●	↓ → ↑ ↓ ↓	94.2%	94.7%	94.1%	93.0%
A&E FFT scores: % negative	Mar-16	≤6.4%	3.71%	2.70%	● ● ● ● ●	↓ ↑ ↑ ↓ ↓	2.28%	2.40%	3.09%	3.24%

Trust Board Balanced Scorecard - SAFE

INDICATOR	PERIOD	TARGET	ACTUAL	YTD	PERFORMANCE RAG STATUS IN PREVIOUS SCORECARDS	TREND IN PERFORMANCE FROM PREVIOUS	Q1	Q2	Q3	Q4
MRSA bacteraemia infection (Trust attributable)	Mar-16	0	1	2	●●●●●	→→→→↓	1	0	0	1
Clostridium difficile incidence (Trust attributable)	Mar-16	≤3 (27)	3	36	●●●●●	↓↑↓↑↓	14	7	7	8
Clostridium difficile – incidence rate per 100,000 occupied bed days	Mar-16	≤8.3	10.3	11.1	●●●●●	↓↑↓↑↓	17.6	8.9	8.7	9.5
Clostridium difficile – variance from plan	Mar-16	To Monitor	0	9	●●●●●	↓↑↓↑↓	8	1	1	-1
VTE risk assessment compliance (%)	Mar-16	≥95%	95.7%	95.4%	●●●●●	↓↑↓↑↑	95.6%	95.2%	95.3%	95.4%
Publication of the Formulary	Mar-16	Y	Y	Y	●●●●●	→→→→→	Y	Y	Y	Y
Duty of Candour breaches	Mar-16	0	0	0	●●●●●	→→→→→	0	0	0	0
Never events: No. (count) in month	Mar-16	0	0	0	●●●●●	→→→→→	0	0	0	0
Never events: Incidence rate per 100,000 occupied bed days	Mar-16	0	0	0	●●●●●	→→→→→	0	0	0	0
Never events: Time since last event (months)	Mar-16	To Monitor	18 mths		●●●●●		9 mths	12 mths	15 mths	18 mths
Never events: No. of repeat events (in year)	Mar-16	0	0	0	●●●●●	→→→→→	0	0	0	0
No. of never events: identified in the month	Mar-16	0	0	0	●●●●●	→→→→→	0	0	0	0
Medication errors causing serious harm	Mar-16	0	0	0	●●●●●	→→→→→	0	0	0	0
NHS Safety Thermometer – harm free care (%)	Mar-16	≥95%	92.42%	94.09%	●●●●●	↑↑↑↓↑	94.23%	94.25%	94.59%	93.29%
NHS Safety Thermometer – new harm (%)	Mar-16	≤2.8%	3.32%	2.52%	●●●●●	↑↑↓↓↓	2.45%	2.54%	2.12%	2.95%
Serious incidents: No. of new in month	Mar-16	To Monitor	9	67	●●●●●	↑↓↑↓→	16	15	16	20
Serious incidents: Rate per 1,000 occupied bed days	Mar-16	To Monitor	0.31	0.21	●●●●●	↑↓↑↓↑	0.20	0.19	0.20	0.24
Pressure Ulcer Serious Incidents – new Cat. 3 or 4 Trust acquired (acute and community services) (Local) (based on date reported to STEIS)	Mar-16	<16	5	82	●●●●●	↑↓↓↑↓	47	15	7	13
Proportion of reported patient safety incidents that are harmful – Trust total (%)	Mar-16	≤29%	27.1%	29.8%	●●●●●	↑↓↑↓↑	34.9%	32.1%	25.8%	27.9%
Proportion of reported patient safety incidents that are harmful – acute services (%) (Local)	Mar-16	≤29%	22.7%	25.2%	●●●●●	↑↓↑↓↑	29.5%	27.2%	21.9%	23.7%
Proportion of reported patient safety incidents that are harmful – community services (%) (Local)	Mar-16	≤50%	56.1%	59.4%	●●●●●	↑↑↓↓↑	69.7%	62.0%	52.6%	55.7%
Potential under-reporting of patient safety incidents: Rate of incidents reported to NRLS per 1000 bed days	Mar-16	≥41.17	44.85	45.25	●●●●●	↓↓↓↑↓	39.60	42.40	51.28	47.50
Potential under-reporting of patient safety incidents resulting in death or severe harm: Rate of severe harm/death incidents reported to NRLS per 1000 bed days	Mar-16	To Monitor	0.10	0.12	●●●●●		0.08	0.15	0.11	0.14
Consistency of reporting to the National Reporting and Learning System (NRLS) – Data published 6 monthly	Apr 15 – Sep 15	6 mths	6 mths	6 mths (2015/16)	●●●●●	→→→→→	3 mths	3 mths	Forecast	Forecast
Outstanding CAS alerts (number)	Mar-16	0	0	0	●●●●●	→→→→→	0	0	0	0
Outstanding CAS alerts: time to closure (months)	Mar-16	To Monitor	0	0	●●●●●	→→→→→	0	0	0	0
Emergency C-section rate (%)	Mar-16	≤16%	15.2%	15.3%	●●●●●	↓↑↓↓↑	16.0%	13.7%	15.7%	16.0%

“ I would like to praise all your district and community nurses for the wonderful job they do – Debbie, Donna, Julie and Tina, not forgetting the weekend nurses. Keep up the good work! ”

District and community nurses at Featherstone Health Centre

Trust Board Balanced Scorecard - WELL-LED

INDICATOR	PERIOD	TARGET	ACTUAL	YTD	PERFORMANCE RAG STATUS IN PREVIOUS SCORECARDS	TREND IN PERFORMANCE FROM PREVIOUS SCORECARDS	Q1	Q2	Q3	Q4
Completion of valid NHS number in acute commissioning dataset submitted via SUS - % (YTD)	Apr 15 - Feb 16	≥99%	99.8%		● ● ● ● ●	→ → → → →	99.7%	99.8%	99.8%	● Forecast
Completion of valid NHS number in A&E commissioning dataset submitted via SUS - % (YTD)	Apr 15 - Feb 16	≥95%	99.3%		● ● ● ● ●	→ → → → ↑	99.2%	99.2%	99.2%	● Forecast
FFT Response Rate (%) - Inpatient and Daycase	Mar-16	≥27%	26.4%	27.6%	● ● ● ● ●	↓ ↓ ↓ ↑ ↓	26.5%	27.3%	29.7%	27.0%
FFT Response Rate (%) - A&E	Mar-16	≥20%	15.3%	23.4%	● ● ● ● ○	↓ ↓ ↑ ↓ ↓	27.6%	23.5%	23.9%	18.6%
FFT Response Rate (%) - Staff	Q4	≥25%	24.0%	N/A	● ● ● ● ●	↓ ↑ ↓ ↓ ↑	27.0%	21.0%	N/A	24.0%
Staff FFT: % of staff who would recommend (likely or very likely) the Trust to friends and family as a place to work	Q4	≥55%	43.0%	N/A	● ● ● ● ●	↑ ↓ ↑ ↑ ↓	45.0%	46.0%	N/A	43.0%
Staff FFT: % not recommend as a place to work	Q4	≤25%	33.0%	N/A	● ● ● ● ●	↑ → ↓	31.0%	31.0%	N/A	33.0%
Staff stability - rate (%)	Mar-16	≥89%	89.47%		● ● ○ ○ ○	↓ ↓ ↓ ↑ ↑	86.82%	89.50%	88.79%	89.47%
Overall safe staffing fill rate (%)	Mar-16	≥85%	92.3%	N/A	● ● ● ● ●	↓ ↓ ↑ ↑ ↓	92.1%	95.1%	93.9%	92.3%
Safe staffing fill rate - number of wards with <80% fill rate (split by day/night, RN/HCA)	Mar-16	To Monitor	23	N/A	● ● ● ● ●	↑ → ↓ ↓ ↓	16	17	15	23
Staff sickness - rate (%)	Feb-16	≤4%	5.36%	4.95%	○ ○ ○ ○ ●	↓ ↓ ↓ ↓ ↑	4.63%	4.78%	5.07%	● Forecast
Temporary staff spend on nurse and medical staffing (£m)	Mar-16	Awaiting Guidance	£2,658	£28,339	● ● ● ● ●	↑ ↓ ↓ ↓ ↓	£7,093	£7,713	£6,745	£7,585
Non medical staff appraisal rate (%) - 12 months rolling	Mar-16	≥85%	72.4%		● ● ● ● ●	↓ ↑ ↓ ↓ ↓	82.3%	80.3%	77.9%	72.4%
Medical (consultant) staff appraisal rate (%) - 12 months rolling (Local)	Mar-16	≥91%	96.3%		○ ○ ○ ○ ●	↑ ↑ ↓ ↑ ↑	91.2%	88.3%	93.7%	96.3%
Medical (non consultant) staff appraisal rate (%) - 12 months rolling (Local)	Mar-16	≥91%	92.4%		● ● ○ ○ ●	↑ ↑ ↑ ↓ ↑	82.2%	78.8%	92.9%	92.4%

Trust Board Balanced Scorecard - RESPONSIVE

INDICATOR	PERIOD	TARGET	ACTUAL	YTD	PERFORMANCE RAG STATUS IN PREVIOUS SCORECARDS	TREND IN PERFORMANCE FROM PREVIOUS SCORECARDS	Q1			
							Q1	Q2	Q3	Q4
A&E - % admitted, transferred or discharged within 4hrs of arrival at A&E (Trust level)	Mar-16	≥95%	79.7%	85.8%	●●●●●	↓↑↓↓↓	90.0%	89.2%	83.5%	80.4%
Trolley waits >12 hours in A&E	Mar-16	0	0	18	●●●●●	↓↑↓↑↑	0	0	7	11
Ambulance handovers must take place within 15 minutes with none waiting more than 30 minutes: No. >30 minutes	Mar-16	0	690	3409	●●●●●	↓↑↓↓↓	447	466	946	1550
Ambulance handovers must take within 15 minutes with none waiting more than 30 minutes: % >30 minutes	Mar-16	0%	17.48%	7.69%	●●●●●	↓↑↓↓↓	4.01%	4.30%	8.62%	13.64%
Ambulance handovers must take within 15 minutes with none waiting more than 60 minutes: No. >60 minutes	Mar-16	0	247	869	●●●●●	↑↑↓↓↓	65	100	222	482
Ambulance handovers must take within 15 minutes with none waiting more than 60 minutes: % >60 minutes	Mar-16	0%	6.26%	1.96%	●●●●●	↑↑↓↓↓	0.58%	0.92%	2.02%	4.24%
Delayed transfers of care - acute and sub acute beds (% of total occupied bed days delayed in the month)	Mar-16	≤3.5%	3.60%	4.22%	●●●●●	↑↑↓↑↓	4.08%	4.99%	4.00%	3.79%
Delayed transfers of care - community beds (% of total occupied bed days delayed in the month)	Mar-16	≤7.5%	16.61%	11.69%	●●●●●	↓↑↑↓↓	10.84%	8.18%	14.36%	14.10%
18 Weeks RTT - % incomplete pathways <18 weeks (inc community)	Mar-16	≥92%	83.9%	83.9%	●●●●●	↑↓↑↑↓	92.0%	88.0%	84.3%	83.9%
RTT waits >52 week incomplete at month end	Mar-16	0	0	8	●●●●●	→→→→	4	4	0	0
Diagnostic tests: % waiting <6 weeks for a diagnostic test	Mar-16	≥99%	95.69%	97.72%	●●●●●	↓↓↑↑↓	99.35%	99.16%	96.46%	96.41%
Cancer: 2 week wait from urgent GP referral to 1st OP (all suspected cancers)	Mar 16 (unvalidated)	≥93%	96.6%	96.9%	●●●●●	↓↑↓↑↓	98.1%	95.6%	96.8%	97.0%
Cancer: 2 week wait from urgent GP referral to 1st OP (breast symptoms)	Mar 16 (unvalidated)	≥93%	97.9%	97.0%	●●●●●	↓↑↑↑↓	98.3%	96.1%	95.9%	97.7%
Cancer: 31 days from diagnosis to 1st definitive treatment (all cancers)	Mar 16 (unvalidated)	≥96%	99.5%	98.8%	●●●●●	↓↓↑↑↓	98.9%	99.0%	98.9%	98.4%
Cancer: 31 days for subsequent treatment (surgery)	Mar 16 (unvalidated)	≥94%	95.8%	98.2%	●●●●●	↓↑↓↑↓	98.0%	99.1%	99.0%	96.3%
Cancer: 31 days for subsequent treatment (drug regimen)	Mar 16 (unvalidated)	≥98%	100.0%	99.9%	●●●●●	→↓↑→	100.0%	100.0%	99.6%	100.0%
Cancer: 62 days from urgent GP referral to 1st definitive treatment (all cancers) - TSSG level included in Appendix 3	Mar 16 (unvalidated)	≥85%	90.8%	87.2%	●●●●●	↑↓↓↓↑	89.6%	88.2%	86.5%	83.9%
Cancer: 62 days from referral from an NHS screening service to 1st definitive treatment (all cancers)	Mar 16 (unvalidated)	≥90%	100.0%	96.6%	●●●●●	↑↑↑↓↑	100.0%	95.7%	93.5%	97.4%
Cancer: 62 days for first definitive treatment following a consultant's decision to upgrade the priority of the pt (all cancers) - number	Mar 16 (unvalidated)	≤12 annual	0.0	8.5	●●●●●	↓→↓↑↑	3.0	1.5	1.0	3.0
Last minute cancellations of elective operations for non-clinical reasons (number) (Local)	Mar 16	To Monitor	34	372	●●●●●	↑↓↓↑→	88	71	108	105
Last minute cancellations of elective operations for non-clinical reasons (% of total elective activity) (Local)	Mar 16	<0.8%	0.58%	0.49%	●●●●●	↑↓↓↑↓	0.46%	0.38%	0.56%	0.57%
Patients not treated within 28 days of a last minute cancellation for non-clinical reasons (number)	Mar 16	0	0	6	●●●●●	↓↑↓↑→	2	0	2	2
% of patients not treated within 28 days of a last minute cancellation for non-clinical reasons	Mar 16	0%	0%	1.6%	●●●●●	↓↑↓↑→	2.3%	0%	1.9%	1.9%
No urgent operation should be cancelled for a second time	Mar 16	0	0	0	●●●●●	→→→→	0	0	0	0
Provider outpatient cancellation rate - % (<6wks from appt. date)	Feb 16	≤8%	10.7%	7.5%	●●●●●	↓↑↓↓↓	7.4%	6.7%	7.8%	Forecast

“ Wonderful service by the nurse who sorted my mum's knee out after a fall. She couldn't have been more kind and empathetic and talked her through everything that was happening. She really is a credit to the hospital **”**

A&E at Pontefract

CQC INSPECTION

In December 2015 the Care Quality Commission (CQC) released the latest results of their inspection of services operated by Mid Yorkshire Hospitals NHS Trust.

The CQC carried out their follow-up inspection of the Trust between 23-25 June 2015 and made planned and unannounced inspections in August and September.

The CQC rates NHS services by classifying them as

Outstanding, Good, Requires Improvement or Inadequate against five criteria including whether services are safe, effective, caring, responsive and well-led.

Overall the Trust was rated as Requires Improvement. Scores in maternity/gynaecology, children and young people's health, outpatients and diagnostic imaging had all improved since the last inspection.

CQC judgement on quality and care at The Mid Yorkshire Hospitals NHS Trust

OVERALL RATING FOR THE MID YORKSHIRE HOSPITALS NHS TRUST	REQUIRES IMPROVEMENT
Are services caring?	Good
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services responsive?	Requires Improvement
Are services well-led?	Requires Improvement

More information about what work the Trust is doing to improve its services is available in the Trust's Quality Account. This can be found on the Trust website.

The full CQC report is available at: www.cqc.org.uk/provider/RXF

TRAVEL AND TRANSPORT

Travel and Transport remain a high priority for the Trust. In 2015/16 there were further developments in both the Trust Shuttle Bus services and hospital bus services provided by Metro.

Metro operate two core hospital bus services: the 113 service which provides an hourly service across the three Mid Yorkshire sites and a 111 service from Wakefield bus station to Pinderfields Hospital. In 2015/16, the 111 service from Wakefield to Pinderfields was expanded to give a full seven day service.

Each month between 5,000 and 7,500 passengers use the 113 bus to travel between the sites.

Using the Department of Transport 'fuel use' figures the following table indicates the Trust's contribution to CO₂ reductions.

The Trust maintains an active patient forum to provide feedback on travel and transport support for our patient services. In 2015/16 the forum was expanded to include representation from Healthwatch, METRO, Yorkshire Ambulance Service and Wakefield Council.

Topics reviewed in year included travel card concessions, accessible taxi provision, survey feedback on car parking changes together with a number of other travel areas to support the changes in clinical services related to the reconfiguration of hospital services and the Trust's Travel and Transport Strategy.

FUEL	TYPE	MILES	CO ₂ (TONNES)
Diesel	Shuttle Bus	354998	77.03
			77.03
Diesel	Shuttle Bus Cargo	277200	60.15
Petrol	Passengers Medium Cars	865874	303.05
Diesel	Passengers Medium Cars	330486	97.82
			461.02
Total CO₂ Savings by Shuttle Bus Services			383.99

“ District nurses listen and go out of their way to help. Suggest things that can help me, and when possible do that for me. I understand they are workers but to me were friends.

District Nurses

”

FOOD SERVICES

An important area of sustainable development for the Trust is development in food standards in line with the government's 2014 report on Hospital Food Standards, which includes a requirement to work towards full compliance on the Government Buying Standards for Food.

The key theme of this is sustainability in the procurement and production of hospital food. To support this a first draft of a Food and Drink strategy has been developed for the Trust to take the program of work to 2018.



WASTE MANAGEMENT

For the Trust the safe management of healthcare waste and the adoption of good environmental practice, including re-cycling, remains our priority. To support this, a range of good practice initiatives to reduce landfill and CO2 emissions will continue.

Volumes of segregated hospital waste that were produced in 2015/16

	ORANGE	YELLOW	YELLOW	RED	BLUE	PURPLE	TIGER	
	Infectious	Sharps	Anatomical	Pharmacy	Cytotoxic	Hygiene		
	Waste Tonnes	Total Tonnes						
All Sites	255.2895	148.284	53.9671	12.839	44.557	16.0197	330.7005	861.6568

The Trust maintains an active Waste Management Group, in 2015/16 the group has continued its programme of utilising safe 'best practice' methods for alternative waste streams for hospital waste, this year the focus has been to improve re-cycling.

Each year the Trust splits waste into different types to make sure as much as possible is re-cycled. The table shows the volumes of segregated hospital waste which were produced in 2015/16. The table shows the Trust is working hard to increase the waste which can be disposed of safely and according to good practice.

SUSTAINABILITY REPORT

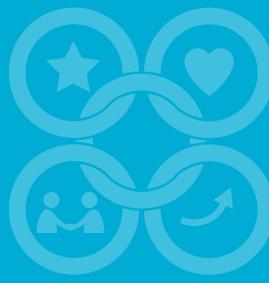
Energy Management

The Trust's Energy Group has in year taken forward a number of key energy improvement schemes a number of these are supported by the Trust's PFI partners to meet both national and regional targets and make a substantial contribution to reducing carbon emissions, schemes in 2015/16 included chiller optimisation, window replacement, improved insulation and lighting in a number of areas.

The following table details the Trust's utility consumption and carbon emissions for 2015/16. Trust emissions are also reported through participation in both the EU Emissions Trading Scheme and CRC Energy Efficiency Scheme.

To support staff to segregate waste properly a new ward pilot has been initiated to support effective segregation. Emphasis in the pilot was placed on good staff information, including guidance booklets and posters.

TYPE	TOTAL KWH	UTILITY COST	TOTAL CARBON (TONNES)	2015/16 REDUCTION IN CARBON (TONNES)
Gas	32,792,375	£1,027,003	6,880	266
Electricity	33,710,286	£3,718,013	19,381	-2,952
Water (m3)	200,728	£545,220	183	12
Fuel Oil	1,589,153	£62,378	509	-509
Total		£5,352,616	26,953	3,183



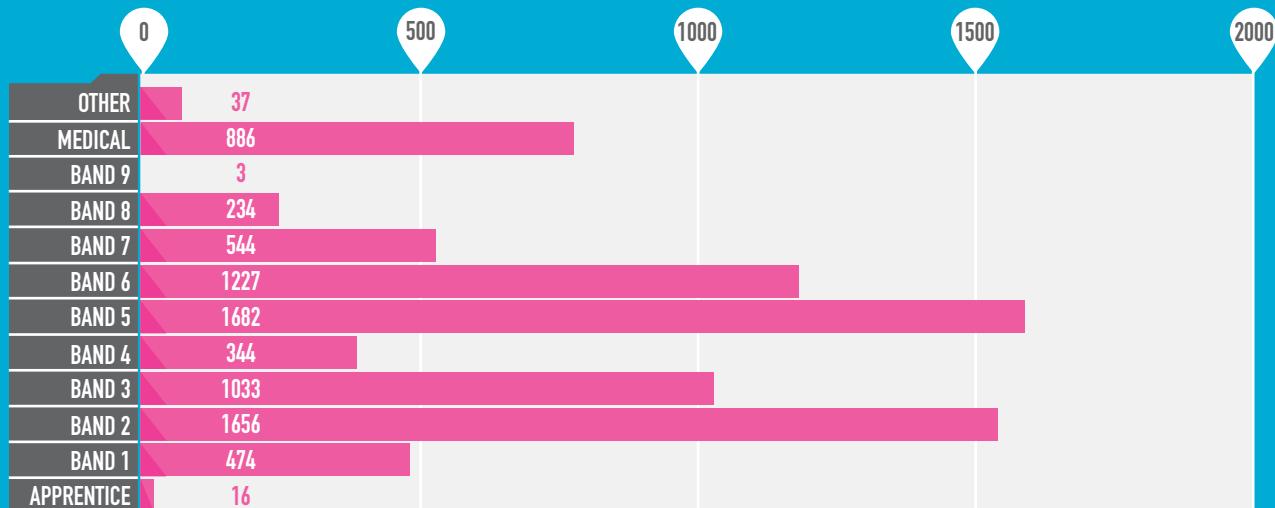
CHAPTER FOUR OUR STAFF

'Develop one another to achieve the best for us and our patients' is one of the Trust's five strategic priorities. Our staff are committed to our values of respectfully delivering high standards of care, alongside improvements in services and embracing new ways of working for better patient care.

As highlighted elsewhere in this report, the Trust continued to experience shortages in staffing in some parts of the organisation. Work took place throughout the year in an attempt to tackle this. In nursing, for example, the Trust undertook focused activity to try to recruit more nurses including a Return to the NHS campaign aimed at registered nurses who now work in other settings and a campaign to recruit nurses from other parts of the world.

Throughout the year, the Trust continued to review and update its policies around staffing matters including those addressing occupational stress, absence management and equal opportunities.

Staff in post by band – Numbers refer to headcount.



Band 8A and above at 31 March 2016

PAYSCALE DESCRIPTION		WHOLE TIME EQUIVALENT		HEAD COUNT
Band 8	Non Review Body Band 8 – Range A		45	42.93
	Non Review Body Band 8 – Range B		25	23.39
	Non Review Body Band 8 – Range C		17	17
	Non Review Body Band 8 – Range D		7	7
	Review Body Band 8 – Range A		91	85.49
	Review Body Band 8 – Range B		29	27.05
	Review Body Band 8 – Range C		16	14.90
	Review Body Band 8 – Range D		4	4
Band 8 Total		220.08		229
Band 9	Review Body Band 9		2	1.60
Band 9 Total		1.60		2
VSM	Chief Executive		1	1
	Director		5	5
	Personal Salary		10	7.74
	Trust Chair – Band 1		1	1
	Trust Non-Executive Member/Director		6	6
VSM Total		16.23		17
Grand Total		260		245.10

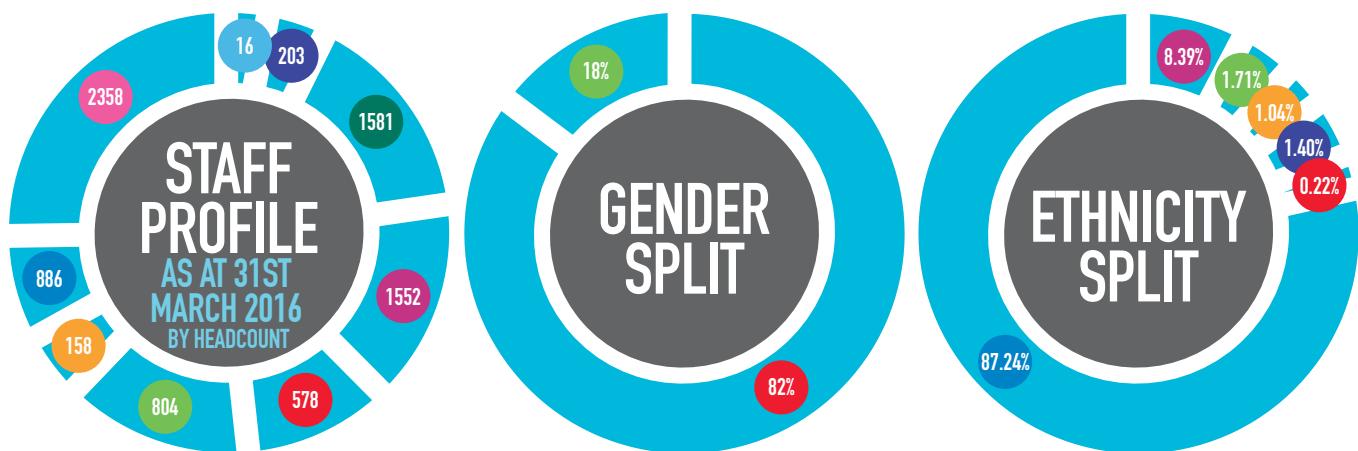
Staff Numbers Analysis

	2015-16	2015-16	2015-16	2014-15	2014-15	2014-15
	TOTAL	PERMANENTLY EMPLOYED	OTHER	TOTAL	PERMANENTLY EMPLOYED	OTHER
AVERAGE STAFF NUMBERS	WHOLE TIME EQUIVALENT					
Medical and dental	917	746	171	895	739	156
Administration and estates	1,458	1,153	305	1,353	1,125	228
Healthcare assistants and other support staff	642	642	0	620	620	0
Nursing, midwifery and health visiting staff	3,239	2,829	410	3,204	2,881	323
Nursing, midwifery and health visiting learners	14	14	0	23	23	0
Scientific, therapeutic and technical staff	917	860	57	855	835	20
Healthcare Science Staff	291	286	5	294	294	0
Other	4	4	0	4	4	0
Total	7,482	6,534	948	7,248	6,521	727
Of the above – staff engaged on capital projects	10	5	5	9	5	5

“ Dr Das and Mrs Nicholls and their team treated me with the utmost care, respect and dignity. I was seen by about ten members of staff and without exception they worked in a highly professional and caring way from the moment I arrived until the time I left the hospital. I cannot praise them highly enough and I would like to thank everyone involved. ”

Gastroenterology, Dewsbury

CHAPTER FOUR OUR STAFF CONTINUED



- Add Prof Scientific and Technic
- Additional Clinical Services
- Administrative and Clerical
- Allied Health Professionals

- Estates and Ancillary
- Healthcare Scientists
- Medical and Dental
- Nursing and Midwifery Registered
- Students

- Male
- Female

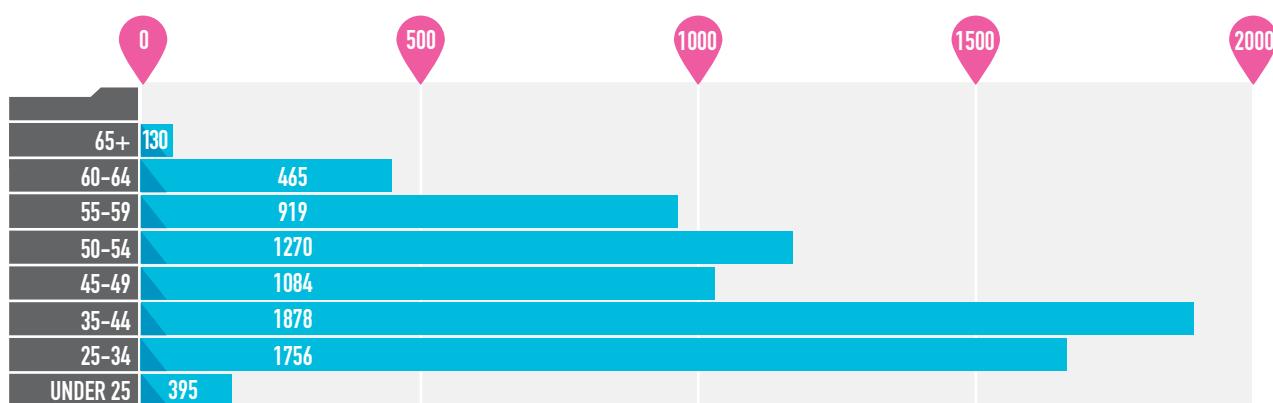
- Asian
- Black
- Mixed
- Other
- Unknown
- White

“I cannot thank the staff enough in the Boothroyd Centre for putting me at ease and explaining every little detail about my procedure. Everyone works really hard to make all the patients comfortable, so big thanks to everyone who was involved with my care – you are all worth your weight in gold.

Gynaecology at Dewsbury

”

Age Profile



Sickness Absence Rates

	2015-16 NUMBER	2014-15 NUMBER
Total Days Lost	73,245	72,539
Total Staff Years	6,725	6,766
Average working days Lost	10.89	11

Staff sickness absence data is based on full-time equivalent days for the calendar year January 2015 to December 2015 (2014-15: January 2014 to December 2014) as provided by the Health and Social Care Information Centre, Electronic Staff Record Data Warehouse.

ANNUAL STAFF SURVEY 2015

February 2016 saw the publication of the results of the National NHS staff survey. The survey was open between September and November 2015 and the Mid Yorkshire response rate was 41 per cent, higher than the average response rate for those Trusts which used the same survey company (The Picker Institute).

The national results compares the Trust to other similar Trusts. This year The Mid Yorkshire NHS Trust changed category and is now defined as a combined acute and community Trust. This means the final report from NHS England benchmarks the Trust against the 37 other combined Trusts rather than the 142 acute Trusts as in previous years.

Areas where the Trust compares most favourably with its peer group Trusts include: the percentage of staff working extra hours; staff appraisals carried out in the last 12 months; and the percentage of staff suffering physical violence from patients, visitors or colleagues. Areas where the Trust compares least favourably include: the percentage of staff recommending the Trust as a place to work or be treated; staff satisfaction with the quality of care they are able to provide; the quality of appraisals; and recognition of staff by their managers and the organisation.

There were a total of 60 questions asked in both the 2014 and 2015 surveys. In comparison with the 2014 results the 2015 findings show Mid Yorkshire has:

- improved on 20 of these 60 questions
- deteriorated on 32 questions
- remained the same on 8 questions.

These results show there has been an improvement in the effective use of patient feedback and staff motivation levels. Staff experience has deteriorated most in relation to working long hours and confidence that the Trust is providing equal opportunities for progression and promotion.

Whilst there are some pockets of good news within the results they were, on the whole, very disappointing. Work is on-going to tackle the issues raised by the results and the Trust needs to: listen to staff; make changes and do things differently; and tell staff what the Trust has done as a result of the feedback received from staff.

A thorough analysis of the Trust-wide results and the free text comments staff made, it is clear there are certain themes which are common to the majority of the responses.

The themes and action to address them are:

Staffing levels

- A sustained recruitment drive to address staffing levels with regular communication on progress is required.

Management and culture

- Enhanced support for middle managers with regards to development programmes and opportunities, including communication skills.
- The development of a Meeting the Challenge people plan to make sure we get inform staff about changes to hospital services and how they affect them.
- Increasing and improving health and wellbeing support.

Not being listened to / not feeling valued

- For the first time we have included priorities for staff development in the Quality Account 2016/2017 to make sure their views are reflected and it contains aims to improve things for staff as well as patients.
- Better engagement with staff to make sure their views are heard and acted upon.

Communications

- Undertake a thorough review of our staff communication channels to make sure they are effective.
- Find ways to celebrate more examples of the good work of our teams.

The national NHS staff survey results for 2015 can be found at www.nhsstaffsurveys.com

“I was absolutely delighted with the quality of care I received during my stay. The nursing staff, volunteers, and consultants couldn't have been more helpful. This was my first surgery and the staff did everything they could to make me feel at ease.

Ward 15 and Appendectomy at Dewsbury

EXPENDITURE ON CONSULTANCY

In 2015-16 the Trust's expenditure on consultancy was £2,036k (2014-15: £3,402k). The consultancy services were to support operational projects and cost improvement programmes.

	2015-16	2014-15
	£000s	£000s
Consultancy Services	2,036	3,402

SUPPORT AND DEVELOPMENT

In addition to the Leadership Community Forum that continues to attract approximately 100 senior managers and clinical leaders every month, the Trust established an Operational Managers Forum. This was to support middle managers in the organisation, in recognition of the difficult job of leading patient services.

A further 15 Ward Managers and Community Team Leaders joined the existing 65 in the Trust "Circle of Excellence", a year-long leadership development programme. 85 staff and first line managers attained Institute of Leadership and Management Awards in supervision and coaching.

A similar number participated in "Leading an Empowered Organisation", a leadership programme accredited by Leeds University.

Two development programmes were run for approximately 30 consultants; an established programme which helps new consultants adapt to their roles and another programme to help senior consultants with their responsibilities around patient service leadership.

We continued to take essential learning very seriously making sure the staff attain mandatory training compliance and receive a yearly appraisal. Investments were made in support staff training and development, together with clinical skills input.

Apprenticeships continue to be offered throughout the Trust, as well as a comprehensive programme of courses, workshops and qualifications provided on Trust premises.

The Trust also provided 200 work experience placements for schools and colleges within the North Kirklees and Wakefield areas.



CHILDCARE SUPPORT

Our Childcare and Carers Support Service supports all staff by providing information and advice about childcare and carers issues to help them balance work and family commitments.

The service has extended their support for staff with school aged children by increasing their opening hours and providing additional childcare to cover school closure periods. This extra support has enabled our staff to continue to work at the Trust by combining their responsibilities as an employee and a parent.

The childcare voucher scheme and onsite nursery salary sacrifice scheme has enabled staff to make significant savings on their childcare costs.



EQUALITY, DIVERSITY AND INCLUSION

The Trust respects the diversity and difference that exists within our workforce and the communities we serve. We continue to ensure that in delivering services we give regard to the needs of diverse groups within our workforce and the wider population.

We are committed to promoting inclusive practices in our day to day interactions with all our patients, carers, visitors and staff regardless of their race, ethnic origin, gender, age, gender identity, mental or physical disability, religion and belief, sexual orientation, maternity or social class.

We continue to develop connections with diverse communities; we are a member of the Wakefield Community Engagement Partnership, we attend the Kirklees Deaf and Hard of Hearing Group and we are regularly invited to contribute to the Wakefield Deaf Society.

The Trust's Access Group is focused on improving access for patients with disability and is supporting implementation of the health and social care Accessible Information Standard.

For the first time the Trust used the NHS Equality Delivery System, in partnership with the local Clinical Commissioning Groups, as the basis for community engagement events in Wakefield and North Kirklees. The outcomes from these events have been used to help us improve how we communicate with the different communities we serve.

We recently assessed our recruitment and selection processes and benchmarked them against the new NHS Workforce Race Equality Scheme. We are making changes as a result of this work, to ensure we provide equality of opportunity for all job applicants, staff and volunteers.

“ I can't thank you enough for what you did for me. Without your help, kindness and care I would not have got through it. You are a wonderful team and are very special. ”

Nurses, carers, therapists and staff at Queen Elizabeth House, Wakefield

HEALTH AND WELL-BEING

The year from April 2015/2016 was a very challenging year for the Trust's Occupational Health and Well Being Service which experienced an increase in activity and a reduction in skill mix to manage the increased level of complex cases being referred.

The reasons for the rise are many and varied but there are common themes including: an ageing workforce and an increase in serious health issues that are age-related such as arthritis, cancers, neurological disorders; increasing pressures in the workplace; and increasing patient throughput. Staff visiting us for assistance for mental health reasons has increased as has the complexity of the cases seen.

The year saw increases in all areas of health referrals. In the period January 2015 to January 2016 the service managed 2625 manager referrals for staff with health issues associated with sickness absence.

The highest rated absence remains for mental health and musculo-skeletal ill health. These account for 1356 of the total cases (51%) absent for those two reasons. The total throughput of cases, appointments, self-referrals and telephonic support etc. for the service in the last financial year reached 63,534 episodes of care which equals eight episodes per annum per capita of workforce.

The Trust continues its efforts on the reactive processes to manage ill health but is moving to an increasing level of proactive work to try to offset future health absence.

The true focus for the coming years and built into the new five year plan is to concentrate on building the skill mix differential in the Occupational Health team to ensure it is equipped to manage the increase in MSK and mental health issues in the workforce.

The plan includes:

- Changing the counselling provider to gain a more comprehensive level of support and save money.
- Utilise the savings to gain clinical psychology support for both education/training and face to face sessions for staff at a time when community services are unable to support staff in need.
- Change the skill mix in the occupational health service to include mental health as well as health and wellbeing specialists.
- Employ a Senior Consultant in Occupational Medicine to ensure timely and competent senior level support for the Trust.
- Upgrade the IT infrastructure of the service to allow for remote access to the system by managers and staff (to relevant non-confidential information) to save time and energy on paper driven processes.
- Develop a robust health and wellbeing strategy and infrastructure for the Trust working as a cohesive team with colleagues e.g. Engagement and Wellbeing, Childcare Support and Staff Benefits, Organisational Development and Human Resources.

OFF-PAYROLL ENGAGEMENTS

TABLE 1

**For all off-payroll engagements as of 31 March 2016,
for more than £220 per day and that last longer than six months:**

	NUMBER
Number of existing engagements as of 31 March 2016	2
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

TABLE 2

**For all new off-payroll engagements between 1 April 2015 and 31 March 2016,
for more than £220 per day and that last longer than six months:**

	NUMBER
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	11
Number of new engagements which include contractual clauses giving Mid Yorkshire Hospitals NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	3
Number for whom assurance has been requested	3
Of which:	
assurance has been received	1
assurance has not been received	2
engagements terminated as a result of assurance not being received	0

For the posts where assurance was not sought, this was managed under standard NHS agreement and referred to GPS who are required to maintain good standing as part of GMC registration

TABLE 3

**For any off-payroll engagements of board members and/or,
senior officials with significant financial responsibility,
between 1 April 2014 and 31 March 2015**

	NUMBER
Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility, during the financial year (1)	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.(2)	20



CHAPTER FIVE BOARD REPORT

The Director's Report

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

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

The Trust also has one associate non-executive director who does not have voting rights. Non-executive directors are not employees of the Trust and are appointed to provide independent support and challenge to the Trust Board. All Board directors are required to comply with the Trust Standards of Business Conduct, including declaration of any actual or potential conflict of interest.

Our Board of Directors as at 31 March 2016

NON-EXECUTIVE DIRECTORS AND BOARD MEMBERS

Jules Preston MBE – Chairman

Julie Charge – Non Executive Director

David Hicks – Non Executive Director

Terry Moran CB – Non Executive Director

Simon Stone – Non Executive Director

Charlotte Sweeney – Non Executive Director

EXECUTIVE DIRECTORS

Stephen Eames – Chief Executive

Caroline Griffiths – Director of Planning and Partnerships

Jane Hazelgrave – Director of Finance, appointed 18 January 2016

Sally Napper – Chief Nurse, role currently being carried out by

David Melia – Acting Chief Nurse

Karen Stone – Medical Director

ASSOCIATE NON-EXECUTIVE DIRECTOR (NON-VOTING)

Nisreen Booya MBE (sabbatical 1 December 2015 to 31 March 2016)

CHAPTER FIVE BOARD REPORT CONTINUED

The Trust Board had one non-voting Director of Engagement. This role was covered on an interim basis by Julie Bolus, whilst the substantive post-holder David Melia was covering the Chief Nurse role. In addition there were three Directors of Operations, Michael Forster, Bev Reid and Kevin Oxley, who attended the Trust Board.

Directors who have left the Trust during 2015/16

Terry Carter – Non Executive Director, left 31 July 2015
Shafi Chopdat – Associate Non-Executive Director, left 31 May 2015
Trevor Lake – Non Executive Director, left 30 September 2015
Louise Scott – Non Executive Director, left 31 May 2015
Robert Chadwick – Director of Finance and Corporate Resources, left 30 November 2015
Gary Boothby – Acting Director of Finance, for the period 9 December 2015 to 17 January 2016

“ This unit is a real credit to the Trust and this should be rightly acknowledged. All staff work tirelessly and efficiently, clearly putting patient needs first, whilst ensuring there is consistently the right balance between treatment, advice and humour. ”

Orthopaedic suite at Pontefract

DECLARATIONS OF INTERESTS FOR DIRECTORS IN POST 2015/16

Declarations of interests for Directors in Post 2015/16

DIRECTORS IN POST AS AT 31 MARCH 2016:

Jules Preston	Chair	Nil	Nil	Nil	Nil
Simon Stone	Non-Executive Director	Nil	Owner Digitising Healthcare Ltd	Nil	Nil
David Hicks	Non-Executive Board	Nil	Nil	Specialist Advisor CQC	Nil
Charlotte Sweeney	Non-Executive Director	Nil	Nil	Board Member of Trading Company, Carers UK	Nil
Terry Moran	Non-Executive Director	Nil	Nil	Chair, Together for Short Lives Charity Trustee – Social Care Institute for Excellence	Nil
Julie Charge	Non-Executive Director	Director of Finance, Salford University	Nil	Nil	Nil
Nisreen Booya	Associate Non-Executive Director	Nil	Nil	Specialist Advisor CQC; Honorary President of Support to Recovery; MPTS Medical Panellist	Husband – Consultant Surgeon at CHFT; Daughter is a Yorkshire and Humberside Deanery FY Trainee; Daughter employed by MYHT; Associate Clinical Consultant to Grant Thornton
Stephen Eames	Chief Executive	Nil	Nil	Interim Chief Executive (part time) at North Cumbria University Hospitals NHS Trust	Nil
Jane Hazelgrave	Director of Finance	Nil	Nil	Nil	Nil
Sally Napper	Chief Nurse	Nil	Nil	Nil	Husband – Partner, Wellington House Surgery, Batley/Birstall and member of CURO Federation; Sister – Associate Hempsons Solicitors, Personal Injury
Karen Stone	Medical Director	Nil	Nil	Nil	Nil
Caroline Griffiths	Director of Planning and Partnerships	Nil	Nil	Nil	Husband – NED of Tees, Esk and Wear Valleys NHS Foundation Trust
David Melia	Interim Chief Nurse and Deputy Chief Executive	Nil	Nil	Nil	Nil
Julie Bolus	Interim Director of Engagement	Nil	Director at Bolus Consulting Ltd	Council Member National Association of Primary Care; Senior Associate Good Governance Institute	Nil
Kevin Oxley	Director of Operations	Nil	Nil	Nil	Nil
Mike Forster	Director of Operations	Nil	Nil	Nil	Nil
Bev Reid	Director of Operations	Nil	Nil	Nil	Nil

DIRECTORS WHO HAVE LEFT DURING 2015/16:

Robert Chadwick	Director of Finance and Corporate Services	Nil	Nil	Nil	Nil
Louise Scott	Non-Executive Director	Nil	Nil	Nil	Nil
Shafi Chopdat	Non-Executive Board Advisor	Nil	Nil	Nil	Nil
Terry Carter	Non-Executive Director	Nil	Nil	Nil	Nil
Trevor Lake	Non-Executive Director	Nil	Nil	Independent Joint Audit Committee Chair – office of Police and Crime Commissioner and Police Force West Yorkshire	Nil

ARRANGEMENTS FOR THE PERFORMANCE REVIEW OF BOARD MEMBERS

All Board members have an annual appraisal and the Chair has his appraisal with the Chair of the NHS Trust Development Authority.

The Chair conducts a quarterly performance review meeting with all non-executive directors culminating in an annual appraisal. The annual objectives of the Chief Executive reflect the priorities of the organisation set by the Trust Board and are agreed with the Chair. The Chair reviews the Chief Executive's performance against these objectives and provides a formal report to the Remuneration and Terms of Service Committee.

Each Executive Director agrees objectives with the Chief Executive which reflect their contribution to delivery of the Trust's priorities. The Chief Executive conducts quarterly performance reviews for each Director and an annual appraisal which is reported to the Remuneration and Terms of Service Committee.



“ I was seen by an excellent doctor within an hour who immediately knew what the problem was. In and out within 90 minutes, which is brilliant for any A&E, especially one that was full! ”

A&E at Pontefract

KEY		
✓	✗	
Present	Apologies	Not required

Attendance at Trust Board 2015/16

NAME	2/4/15	15/5/15	4/6/15	2/7/15	6/8/15	1/10/15	5/11/15	3/12/15	4/2/16	3/3/16	
J Preston	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	9/10
C Sweeney	✓	✗	✓	✓	✓	✓	✓	✗	✗	✓	7/10
D Hicks	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	8/10
S Stone			✓	✓	✓	✓	✓	✓	✓	✓	8/8
T Moran									✓	✗	1/2
J Charge									✓	✓	2/2
N Booya			✓	✓	✓	✓	✓	✗			5/6
S Eames	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
S Napper	✓	✓	✓	✓	✓						5/5
C Griffiths	✓	✓	✓	✓	✓	✗	✓	✓			7/8
K Stone	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/10
D Melia	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	9/10
J Hazelgrave									✓	✓	2/2
B Reid					✓		✗	✗	✗	✗	1/5
K Oxley							✓	✓	✓	✓	4/4
M Forster							✓	✓	✗	✗	2/4
J Bolus									✓	✓	2/2
T Lake	✓	✗	✓	✗	✓						3/5
T Carter	✓	✗	✓	✓							3/4
L Scott	✓	✓									2/2
S Chopdat	✗	✗									0/2
R Chadwick	✓	✓	✓	✓	✓	✓	✓				7/7

REMUNERATION REPORT 2015/2016

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

The Trust follows the NHS Improvement guidance on senior appointments. The Remuneration Committees approve all Director salaries, with reference to NHS Improvement to ensure they are within the national benchmark.

A) Remuneration

2015-16						
(A) SALARY (BANDS OF £5000)	(B) EXPENSE PAYMENTS (TAXABLE) TOTAL TO NEAREST £100	(C) PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(D) LONG TERM PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(E) ALL PENSION RELATED BENEFITS (BANDS OF £2,500)	(F) TOTAL (A TO E) (BANDS OF £5,000)	
£000	£00	£000	£000	£000	£000	
NON-EXECUTIVE DIRECTORS						
Jules Preston, Chairman	35-40	4	0	0	0	35-40
Terry Carter, Non-Executive Director to 31 July 2015	0-5	0	0	0	0	0-5
Trevor Lake, Non-Executive Director to 30 September 2015	0-5	2	0	0	0	0-5
Louise Scott, Non-Executive Director to 31 May 2015	0-5	1	0	0	0	0-5
David Hicks, Associate Non-Executive Director to 31 March 2015, Non-Executive from 1 April 2015	5-10	1	0	0	0	5-10
Charlotte Sweeney, Non-Executive Director	5-10	0	0	0	0	5-10
Prew Lumley, Non-Executive Director to 31 March 2015	0	0	0	0	0	0
Shafi Chopdat, Non-Executive Director from 1 August 2014 to 31 May 2015	0-5	0	0	0	0	0-5
Simon Stone, Non-Executive Director from 1 June 2015	5-10	1	0	0	0	5-10
Terry Moran, Non-Executive Director from 8 December 2015	0-5	0	0	0	0	0-5
Julie Charge, Non-Executive Director from 8 December 2015	0-5	0	0	0	0	0-5
Nisreen Booya, Non-Executive Director from 1 June 2015	0-5	0	0	0	0	0-5
NON-EXECUTIVE DIRECTORS						
2014-15						
Jules Preston, Chairman	35-40	0	0	0	0	35-40
Terry Carter, Non-Executive Director to 31 July 2015	5-10	0	0	0	0	5-10
Trevor Lake, Non-Executive Director to 30 September 2015	5-10	0	0	0	0	5-10
Louise Scott, Non-Executive Director to 31 May 2015	5-10	0	0	0	0	5-10
David Hicks, Associate Non-Executive Director to 31 March 2015, Non-Executive from 1 April 2015	0-5	0	0	0	0	0-5
Charlotte Sweeney, Non-Executive Director	5-10	0	0	0	0	5-10
Prew Lumley, Non-Executive Director to 31 March 2015	5-10	0	0	0	0	5-10
Shafi Chopdat, Non-Executive Director from 1 August 2014 to 31 May 2015	0-5	0	0	0	0	0-5
Simon Stone, Non-Executive Director from 1 June 2015	0	0	0	0	0	0
Terry Moran, Non-Executive Director from 8 December 2015	0	0	0	0	0	0
Julie Charge, Non-Executive Director from 8 December 2015	0	0	0	0	0	0
Nisreen Booya, Non-Executive Director from 1 June 2015	0	0	0	0	0	0

	2015-16					
	(A) SALARY (BANDS OF £5000)	(B) EXPENSE PAYMENTS (TAXABLE) TOTAL TO NEAREST £100	(C) PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(D) LONG TERM PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(E) ALL PENSION RELATED BENEFITS (BANDS OF £2,500)	(F) TOTAL (A TO E) (BANDS OF £5,000)
	£000	£00	£000	£000	£000	£000
EXECUTIVE DIRECTORS						
Stephen Eames, Chief Executive (A)	205-210	156	0	0	0	220-225
Richard Jenkins, Medical Director to 31 December 2014 (B)	0	0	0	0	0	0
Karen Stone, Medical Director from 1 May 2015. Interim Medical Director from 17 November 2014 to 30 April 2015 (B)	190-195	0	0	0	67.5-70	255-260
Caroline Griffiths, Director of Corporate Planning and Projects from 1 January 2014 (C). From 1 April 2014 Director of Planning and Partnerships. From 1 May 2014 voting director. (D)	135-140	2	0	0	85-87.5	220-225
David Melia, Director of Patient and Staff Engagement from 1 November 2014 to 27 September 2015. Acting Chief Nurse and Deputy Chief Executive from 28 September 2015	120-125	0	0	0	187.5-190	310-315
Julie Bolus, Interim Director of Staff and Patient Engagement from 11 January 2016. (G)	30-35	0	0	0	0	30-35
Sally Napper, Chief Nurse	150-155	0	0	0	15-17.5	165-170
Robert Chadwick, Director of Finance and Corporate Services to 8 December 2015	110-115	0	0	0	20-22.5	130-135
Jane Hazelgrave, Director of Finance from 18 January 2016	25-30	0	0	0	10-12.5	40-45
Gary Boothby, Acting Director of Finance from 1 December 2015 to 17 January 2016	15-20	0	0	0	5-7.5	20-25
Kevin Oxley, Director of Operations (C)(E)	125-130	0	0	0	45-47.5	170-175
Mike Forster, Director of Operations from 18 May 2015 (C)(E)	95-100	0	0	0	132.5-135	225-230
Bev Reid, Director of Operations from 3 August 2015 (C)(E)	85-90	0	0	0	260-262.5	345-350
EXECUTIVE DIRECTORS						
					2014-15	
Stephen Eames, Chief Executive (A)	235-240	164	0	0	0	255-260
Richard Jenkins, Medical Director to 31 December 2014 (B)	155-160	0	0	0	47.5-50	205-210
Karen Stone, Medical Director from 1 May 2015. Interim Medical Director from 17 November 2014 to 30 April 2015 (B)	70-75	0	0	0	7.5-10	80-85
Caroline Griffiths, Director of Corporate Planning and Projects from 1 January 2014 (C). From 1 April 2014 Director of Planning and Partnerships. From 1 May 2014 voting director. (D)	120-125	0	0	0	47.5-50	170-175
David Melia, Director of Patient and Staff Engagement from 1 November 2014 to 27 September 2015. Acting Chief Nurse and Deputy Chief Executive from 28 September 2015	45-50	0	0	0	12.5-15	60-65
Julie Bolus, Interim Director of Staff and Patient Engagement from 11 January 2016. (G)	0	0	0	0	0	0
Sally Napper, Chief Nurse	155-160	0	0	0	47.5-50	205-210
Robert Chadwick, Director of Finance and Corporate Services to 8 December 2015	165-170	0	0	0	72.5-75	235-240
Jane Hazelgrave, Director of Finance from 18 January 2016	0	0	0	0	0	0
Gary Boothby, Acting Director of Finance from 1 December 2015 to 17 January 2016	0	0	0	0	0	0
Kevin Oxley, Director of Operations (C)(E)	0	0	0	0	0	0
Mike Forster, Director of Operations from 18 May 2015 (C)(E)	0	0	0	0	0	0
Bev Reid, Director of Operations from 3 August 2015 (C)(E)	0	0	0	0	0	0

- A From 11 January 2016, three days a week have been recharged to North Cumbria University Hospitals NHS Trust based on time worked, these costs have been excluded from the salary.
- B Salary includes Medical Director Payment Clinical Excellence Award, on-call allowance and Additional Programmed Activity.
- C Non-Voting Directors.
- D Salary includes additional responsibilities for Health and Social Care Transformation Programme on behalf of the Trust.

E Non-Voting Directors attending Board in 2015-16, no comparative information in 2014-15.

F Full year pension figures.

G Interim Executive Directors not paid via the Trust's payroll.

Where individuals have opted to take advantage of salary sacrifice schemes the equivalent amount has been included within salary costs.

REMUNERATION REPORT 2015/2016

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS CONTINUED

B) Pension Benefits

	2015-16							
	REAL INCREASE IN PENSION AT PENSION AGE (BANDS OF £2500)	REAL INCREASE IN PENSION LUMP SUM AT PENSION AGE (BANDS OF £2500)	TOTAL ACCRUED PENSION AT PENSION AGE AT 31 MARCH 2016 (BANDS OF £5000)	LUMP SUM AT PENSION AGE RELATED TO ACCRUED PENSION AT 31 MARCH 2016 (BANDS OF £5000)	CASH EQUIVALENT TRANSFER VALUE AT 1 APRIL 2015	REAL INCREASE IN CASH EQUIVALENT TRANSFER VALUE	CASH EQUIVALENT TRANSFER VALUE AT 31 MARCH 2016	EMPLOYERS CONTRIBUTION TO STAKEHOLDER PENSION
	£000	£000	£000	£000	£000	£000	£000	£000
EXECUTIVE DIRECTORS								
Jane Hazelgrave, Director of Finance from 18 January 2016 (F)	2.5-5	7.5-10	30-35	90-95	533	54	593	0
Robert Chadwick, Director of Finance and Corporate Services to 8 December 2015 (F)	0-2.5	2.5-5	70-75	220-225	1596	43	1658	0
Sally Napper, Chief Nurse	0-2.5	0-2.5	50-55	160-165	981	23	1015	0
Caroline Griffiths, Director of Corporate Planning and Projects from 1 January 2014 (C). From 1 April 2014 Director of Planning and Partnerships. From 1 May 2014 voting director	2.5-5	10-12.5	25-30	80-85	495	88	588	0
David Melia, Director of Patient and Staff Engagement from 1 November 2014 to 27 September 2015. Acting Chief Nurse from 28 September 2015	7.5-10	22.5-25	45-50	135-140	652	150	810	0
Karen Stone, Medical Director from 1 May 2015. Interim Medical Director from 17 November 2014 to 30 April 2015 (B) (F)	2.5-5	0-2.5	45-50	140-145	778	45	833	0
Kevin Oxley, Director of Operations	0-2.5	5-7.5	40-45	120-125	768	46	823	0
Mike Forster, Director of Operations from 18 May 2015 (F)	5-7.5	12.5-15	25-30	70-75	271	99	373	0
Gary Boothby, Acting Director of Finance from 1 December 2015 to 17 January 2016 (F)	0-2.5	0-2.5	30-35	50-55	321	29	354	0
Bev Reid, Director of Operations from 3 August 2015 (F)	15-17.5	50-52.5	45-50	135-140	538	345	889	0

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

C Non-Voting Directors
F Full year pension figures.

“I can only say that the care I have been given throughout my time in Ward 34 was a positive experience. The attention given to me by all the consultants, registrars and junior medical staff was much appreciated and was kind, thorough and helpful. **”**

(Ward 34, Pinderfields)

PAY MULTIPLE STATEMENT

	2015/16	2014/15
Range – based on bands of £5,000	£15,000–£265,000	£10,000–£280,000
Highest paid director's total remuneration	£220,000–£225,000	£255,000–£260,000
Median total remuneration	£25,000–£30,000	£25,000–£30,000
Ratio	8.54	9.88

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

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of the total staff in the Trust, excluding the highest paid director. This is based on the annualised full time equivalent remuneration as at the reporting period date.

The remuneration of the highest paid director excludes the associated charges for pension and other costs of employment which are required to be included in the remuneration report.

The banded remuneration of the highest paid director in Mid Yorkshire Hospitals NHS Trust in the financial year 2015-16 was £220,000 to £225,000 (£255,000 to £260,000 in 2014-15). This was 8.54 times (2014-15, 9.88) the median remuneration of the workforce, which was £25,000 to £30,000 (£25,000 to £30,000 in 2014-15).

There has been a change to the remuneration of the highest paid director due to a sharing arrangement from 11 January 2016 to 31 March 2016 therefore the cost to the entity has reduced.

In 2015/16 four employees received remuneration in excess of the highest paid director. Remuneration ranged from £215,000 to £265,000 (in 2014/15 there were two employees ranging from £265,000 to £280,000).



CHAPTER SIX

ANNUAL GOVERNANCE STATEMENT 2015/16

The purpose of the Annual Governance Statement is for NHS Trust Accountable Officers to provide the Accountable Officer of the NHS, Robert Alexander, with assurance about the stewardship of their individual NHS organisations. This stewardship document supplements the annual accounts.

CONTENTS:

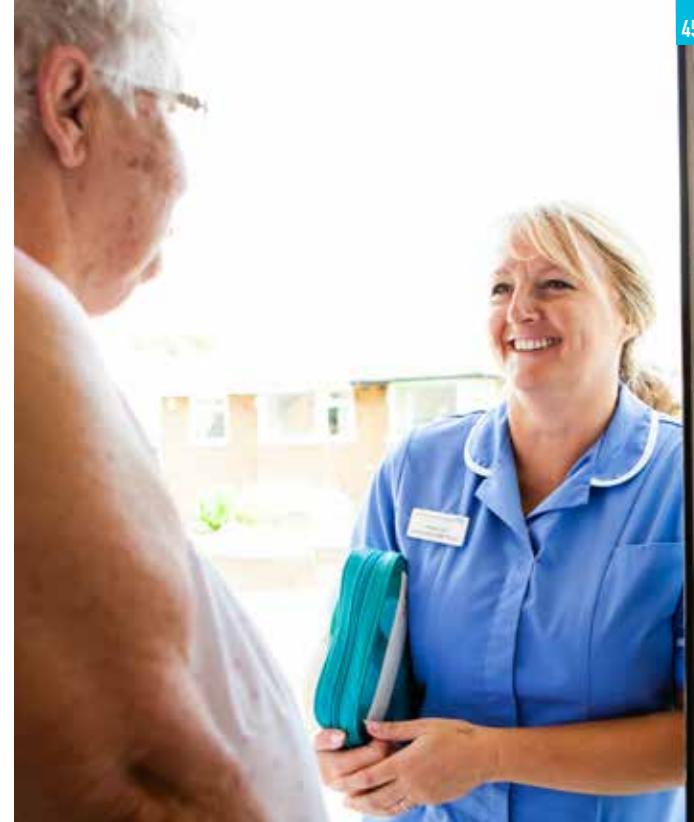
- 1. Scope of Responsibility**
- 2. The Governance Framework**
- 3. Risk Assessment**
- 4. The Risk and Control Framework**
- 5. Review of the Effectiveness of Risk Management and Internal Control**
- 6. Significant Issues**

SECTION 1

SCOPE OF RESPONSIBILITY

The Chief Executive is the Accountable Officer of the Trust and has responsibility for maintaining a sound system of internal control to support the achievement of the Trust's strategic direction, its policies, aims and objectives. This is against the backdrop of safeguarding public funds.

The Accountable Officer is responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. The full responsibilities are set out in the Accountable Officer Memorandum.



“ I have to praise Sister Alex and the nurse for their care, compassion and friendly attitude. ”

Scoping Unit, Pontefract

SECTION 2 THE GOVERNANCE FRAMEWORK

The Trust is governed by the Trust Board comprising of six Non-Executive Directors including the Chairman, two Associate Non-Executive Directors and five Executive Directors, including the Chief Executive.

In addition four other Directors attend the Board in a non-voting capacity, along with the Company Secretary. The arrangements are set out in detail in the Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

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

The Trust Board consider performance against national priorities set out in the the NHS Trust Development Authority (TDA) publication, Delivering for Patients: the 2015/16 Accountability Framework for NHS trust boards, which sets out how the TDA works alongside trusts to support the delivery of high quality and sustainable services for patients.

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

During the 2015/16 year, the Trust commissioned a Board Effectiveness and Governance Review.

They identified a number of areas of good practice including:

- The leadership of the Chair and Chief Executive
- Strong input from Executive Directors particularly outside their portfolios

- Open chairing which encourages participation
- Good reflection at the end of the meeting.

The overall findings included:

- Observation that patient safety and quality are overriding priorities
- Open and accountable culture
- Leadership in the local health economy
- Strong commitment to delivering Trust Strategy.

Areas for further attention were identified and have been developed into an action plan which is being implemented. A key area for further attention was around the Committee structure and specifically the removal of the Risk Management, Finance and Workforce Committees after 31 March 2016, to be replaced by a Resource and Performance Committee and to ensure that risk management is an inherent part of all Committee business and not reviewed separately.

Quality, Finance and Workforce governance are all overseen by Tier 1 Committees to provide assurance to the Trust Board. In addition, an Executive Driving Clinical Standards Group has been established, which reports into the Clinical Executive Group, chaired by the Chief Executive and the Quality Committee, chaired by one of the Non-Executive Directors, both ensure that the projects in the Quality Improvement Strategy are on track and delivered effectively. This Group has also assumed responsibility for oversight of the 'must' and 'should' do actions identified by the Care Quality Commission in their re-inspection visits in 2015.

COMMITTEES OF THE TRUST BOARD

As at 31 March 2016, there were seven Tier 1 Committees of the Trust Board and their roles and responsibilities were set out in Terms of Reference approved by the Board and described in the Trust Scheme of Delegation and Reservation.

Each Committee has an annual work plan and minutes are provided for the Board to review progress and decisions. Three committees are Statutory and four are Assurance. In addition there is an Executive Committee.



“ I am writing to share my wonderful experience in the hospital and want you to know that each and every staff member in the ward and delivery suite was amazing. The care and attention I received was 100 per cent. ”

Ward 18 at Pinderfields

TIER 1 **COMMITTEE ANNUAL REPORTS**

Audit Committee (Statutory)

The Audit Committee, which meets five times per year, reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities that support the achievement of the Trust's objectives.

The Committee is a Non-Executive Committee made up of three Non-Executive Directors at least one of whom has recent, relevant financial experience.

The Director of Finance (lead Executive Director), Associate Director of Finance – Financial Control and the Company Secretary attend the meetings. Representatives of the external auditor and internal audit also attend.

Individual Executive Directors and other senior managers are invited to attend as required where the Committee is discussing items relevant to their areas and where there is concern or further assurance is required. The Chief Executive attends the Committee once per year.

Principal areas of review include the following:

- Internal audit plan, progress reports and recommendations.
- External audit updates, reports and recommendations.
- Review of the Annual Accounts, external audit opinion and internal audit opinion.
- Review of the Annual Report and Annual Governance Statement.
- Counter Fraud policy and legislation and investigations.
- Accounting procedures and issues.
- Governance developments and the system of internal control.
- The process of risk management.
- Related business of the Quality Committee, Risk Management Committee and Finance Committee.
- Tender exceptions.
- Use of the Company Seal.
- Losses and special payments.

Membership of the Committee has changed significantly during the year and current members have not been members of the Committee for a long enough period to carry out the self-assessment of the Committee's effectiveness.

However, in Autumn 2015, an external review of the Audit Committee concluded that there was much good practice and identified some areas for development. The areas for development largely related to the changing membership of the Committee in 2015/16 and the attendance of Executive colleagues at the meeting.

The Committee has carried out an annual review of the Terms of Reference and no changes have been proposed, these will be recommended to Trust Board for approval. The Committee annual work plan is approved annually by the Trust Board and has been completed in full.

Charitable Funds Committee (Statutory)

The Charitable Funds Committee acts on behalf of the Board and reports to the Board in its role as Corporate Trustee of the Charitable Funds.

The Committee is chaired by the Trust Chair and the membership includes a further Non-Executive Director, a member of the Stakeholder Forum, the Director of Planning and Partnerships, the Director of Finance and the Associate Director of Finance - Financial Control. During 2015/16 the committee met four times.

As a matter of routine, the committee reviews:

- The charitable fund's financial activities including performance of the investments, acceptance of legacies and review of any expenditure proposals above £25,000.
- Previously approved expenditure items costing over £5,000 to confirm whether the originally planned benefits of the expenditure have been delivered.

Remuneration and Terms of Service Committee (Statutory)

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

The Committee oversees, via quarterly reviews, the performance management and appraisal of the Chief Executive and Executive Directors. The Committee also approves financially significant contractual severance payments.

Membership of the Committee is restricted to Non-Executive members of the Trust Board. Executive Directors have no involvement in determining their own remuneration.

The Remuneration and Terms of Service Committee met five times during 2015/16 and considered the following key matters:

- The performance management and appraisal of the Chief Executive and Executive Directors.
- Review of its Terms of Reference.
- Review of all VSM salaries as requested by Secretary of State.

The Committee fulfilled its objectives for the year and the Chair of the Committee drew to the attention of the Trust Board any issues that required disclosure to the Board, or required executive action.

Finance Committee (Assurance)

The role of the Finance Committee is to provide assurance to the Trust Board on matters of financial performance, including delivery of the capital programme and cost improvement.

The Finance Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to co-operate with any request made by the Committee.

A Non-Executive Director chairs the meeting, with a further two within the membership. The Director of Finance and the Chief Nurse are also part of the main membership.

During 2015/16 individual membership has varied as Executive roles changed and in line with a revised finance structure. However, each meeting has been attended by at least 2 senior finance staff. The committee formally met 11 times.

In addition the Chairman of the Finance committee left the Trust in September 2015 necessitating the chair being taken up on an interim basis by the Chairman of the Trust.

“ The services provided at the Pain Clinic in Dewsbury are first class and should be applauded. You must be proud of the fine reputation you have. A great deal of the credit for the work you do must be given in part to Dr Wilson for his treatment and support.

Pain Clinic, Dewsbury **”**

TIER 1 **COMMITTEE** **ANNUAL** **REPORTS** **CONTINUED**

Workforce Committee (Assurance)

The Workforce Committee is chaired by a Non-Executive Director of the Trust and the membership comprises of executive directors and senior operational leaders from clinical divisions and corporate services and representation from our stakeholder forum.

The scope of the Committee covers all operational and corporate workforce matters and strategic workforce issues, including operational HR and workforce services; organisational development; staff engagement and wellbeing; and nurse staffing and medical staffing.

The purpose of the Committee is to agree our workforce strategies and delivery plans, to monitor the delivery and impact in relation to Trust priorities; and to provide governance in relation to any workforce risks.

The Committee receives monthly performance updates on key workforce indicators such as absence, turnover, mandatory and statutory training and appraisal rates. It takes assurance on any emergent risks and the delivery of mitigating actions and recovery plans.

The Committee has reviewed its terms of reference and carried out a review of its effectiveness. From May 2016, the Workforce Committee will become part of an integrated Resources and Performance Committee, providing a forum to consider performance and risk in relation to workforce, activity and finance collectively.

Quality Committee (Assurance)

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

The Committee has met monthly throughout 2015/16. The role of the committee is to:

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

The Terms of Reference were reviewed along with the Divisional Governance Groups' Terms of Reference to reinforce assurance mechanisms and were later approved by the Trust Board. The Non-Executive Committee Chair reports a summary of the committee's activity each month to the Trust Board, which happens with all Tier 1 Committees.

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

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

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

- Monitoring of the delivery CQC Chief Inspector of Hospital Improvement Plan and provision of the assurance to Trust Board.
- Improvements in the Serious Incident reporting and closure process with commissioners.
- Improvement in divisional governance arrangements.
- Focus on areas for improvement; pressure ulcers, falls prevention and medicines management.
- Focused review on Serious Incidents within Maternity Services.
- Identifying any specific risks that need to be escalated to the Trust Board.

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

Clinical Executive Group (Executive)

The Clinical Executive Group (CEG) meets twice per month and was established to provide members with an opportunity to discuss areas of concern, provide assurance and gain approval for items such as policies and business cases.

The purpose of the CEG is to ensure the delivery of corporate objectives and the mitigation of corporate risks. It ensures that there is a focus on clinical quality, performance and delivery. It agrees actions needed to define and deliver the Trust's agenda.

It is the key forum for development and implementation of major strategies and operational plans and programmes. It is responsible for operational decisions affecting multiple directorates that are not delegated to individual Directors or Clinical Directors.

These include, but are not limited to, Clinical Services Strategy, budget setting, capital programme spend, directorate operational agreements, policy approval and risk management in line with the scheme of delegation set by the Trust Board.

During 2015/16, a monthly review of the Trust Level risk register and all divisional risk registers continued, as introduced in 2014/15 to ensure a clear oversight of key risks faced by the Trust and how they are being managed.

The Committee has carried out an annual self-assessment and is taking forward actions arising. The Committee has also carried out an annual review of the Terms of Reference which have been amended and were approved by the Trust Board.

Risk Management Committee (Assurance)

The main role of the Risk Management Committee is to oversee delivery of the Risk Management Strategy, to take an overview of the risk management agenda and ensure a strategic approach to the management and mitigation of corporate and clinical risks and ensure effective coordination and performance management.

The Risk Management Committee reviews the content of the Trust Level Risk Register, Divisional Risk Registers and Board Assurance Framework.

The Committee has been provided with information on recommendations following the Chief Inspector of Hospitals visit in relation to risk management and has overseen the introduction of improved way of risk management from ward to board.

Risks are reviewed at every level of Trust management from ward meetings, Specialty and department level, Divisional level, Clinical Executive Group, Risk Management Committee and Trust Board. All Tier 1 Committee meetings are asked to consider any risks arising during their meetings and any assurances.

In 2015/16 the Trust requested that Internal Audit provide independent input into the effectiveness of the Trust's Risk Register system and process. The Internal Audit Report awarded the Trust 'Significant Assurance' for Risk, the report summarised that reporting and management systems are effective in tracking risks.

In 2015/16 the Trust initiated a 'risk deep dive' system whereby all levels of risks are reviewed to ensure entries are in full compliance with the requirements laid down in the policy. This has been an effective way of ensuring that all risk register entries are of the appropriate quality and in providing assurance to the Risk Management Committee.

SECTION 3

RISK ASSESSMENT

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks throughout the organisation via structured risk assessments. Identified risks are documented on the Trust Risk Register using the Datix reporting system.

Risks are analysed to identify their relative importance using a risk scoring matrix in line with the Trust's Risk Management Strategy.

The Trust Level Risk Register includes significant risks which cover the following areas and which have been discussed at the Clinical Executive Group and Risk Management Committee and presented to Trust Board:

- Nurse Staffing and high level of vacancies/recruitment
- Use of Medical Locums
- Outpatient backlog
- Trust financial position
- Patient flow

The Trust has a Board Assurance Framework which is based on six key elements which reflect Striving for Excellence:

- Become one of the best NHS provider organisations in the country.
- Keep our patients safe.
- Live and grow within the resources we have.
- Develop one another to achieve the best for us and our patients.
- Surpass expectations and build on our reputation.

Significant strategic risks which are also included in the Board Assurance Framework are:

- Response to the Chief Inspector of Hospitals Inspection recommendations.
- Winter pressures and impact on all Trust activities.

Information Governance risks are assessed using the Information Governance Toolkit. For 2015/16, the Trust has been assessed at Information Governance Toolkit Level 2, Satisfactory. There has been no data security breaches reported to the Information Commissioner during the year.

“ My wife and I can both relate so many instances where we have experienced first class treatment in the medical world. Dr Ventastesh offered advice on what to do if there were any problems. Extremely efficient. Thank you very much.

Neurology and Stroke Unit, Pinderfields

SECTION 4 THE RISK AND CONTROL FRAMEWORK

The Risk Management Strategy provides a framework for managing risks across the Trust and is consistent with best practice and Department of Health guidance. The Strategy provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The Strategy sets out the role of the Board and its Committees together with the individual responsibilities of the Chief Executive, Executive Directors and all staff, in managing risk. In particular, the Risk Management Committee has provided a mechanism for managing and monitoring risk throughout the Trust and reporting through to the Board.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2016 and up to the date of the approval of the annual report and accounts.

The Audit Committee oversees the systems of internal control and overall assurance process associated with managing risk. The risk profile of the Trust is presented in different levels of the Risk Register, a Trust Level Risk Register which brings together the highest scoring risks in the organisation, during 2015/16 there have typically been 15 - 20 risks in this register and these have been reported to the Board quarterly.

Arrangements are in place to further strengthen Risk Management:

- Monthly review of Trust Level and Divisional Risk Registers at Clinical Executive Group.
- Review of all new risks at Divisional Management Team meetings.
- Review of all divisional risks at Divisional Governance Team meetings.
- Review of specialty/directorate risks at individual team meetings.
- Fortnightly Improving Risk Group (GRIP).
- Ongoing risk deep dive reviews of divisional risk registers.

The Board of Directors routinely receives the minutes of all Committees, as well as a summary of the key issues and assurances from the meetings to be brought to the whole Board's attention.

SECTION 5

REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

The Trust continues to work closely with Internal Audit to further develop the Risk Management and Internal Control Framework. The Head of Internal Audit has concluded that the system of internal control in place during 2015/16 offered Significant Assurance.

This is based on a range of work undertaken as part of the annual internal audit plan, including assessment of the Board Assurance Framework and an assessment of the range of individual opinions arising from risk based audit assignments throughout the year.

Internal Audit issued seven limited assurance reports during the year (seven were also issued in 2014/15):

- Locum Doctors – Appointment and Attendance Follow Up Reports.
- Audiology Follow Up.
- National Confidential Enquiry into Patient Outcome and Death - Clinical Governance half days.
- National Institute for Health and Care Excellence (NICE) Guidance.
- Absence Management.
- Staff Training and CPD.
- IT Strategy.

Internal Audit has issued 15 significant assurance reports during the year.

SECTION 6

SIGNIFICANT ISSUES

The Trust continues to work closely with Internal Audit to further develop the Risk Management and Internal Control Framework. The Head of Internal Audit has concluded that the system of internal control in place during 2015/16 offered Significant Assurance.

This is based on a range of work undertaken as part of the annual internal audit plan, including assessment of the Board Assurance Framework and an assessment of the range of individual opinions arising from risk based audit assignments throughout the year.

The following significant issues have arisen during 2015/16:

- **Financial position, including capital to revenue transfers:**
The Trust has reported a deficit £20.53m which includes the benefit of a £2.8m VAT adjustment for the Trusts PFI assets and a £5m capital to revenue transfer. After allowing for these technical changes this is £13.5m worse than the planned deficit of £14.8m. This financial position represents a significant deterioration in performance and can be explained, in high level terms by a failure to deliver on our income plan (zero year on year growth), pay growth of £11.8m (3.8%) which includes agency spend growth of £8m (27%) and non-pay growth of £3.3m (2%). The two main clinical divisions account for the majority of the overspend as a result of increased attendances at A&E, more complex patients being cared for in the hospital leading to an increase in length of stay and increased pay costs, in particular agency costs.

The financial position has been closely scrutinised by the Trust Board and its Committees and additional controls have been implemented during the year. The trend experienced by the Trust has been experienced across the majority of the Acute Trust sector nationally. Divisional recovery plans have not managed to recover the Trust's position during 2015/16. A new approach to financial recovery is being implemented in 2016/17 which will look at delivering efficiency savings through clinical and non-clinical service transformation rather than transactional and short term savings measure.

Urgent Care performance: Over 2015/16 performance against the A&E 4 hour access standard has seen a steady decline due to a number of reasons primarily associated with increased attendance, issues with managing patient flow within the Trust and challenges around discharging patients safely.

Because of the challenges facing the Trust the Emergency Care Improvement Programme team have been working alongside senior clinicians and managers to support changes to the way in which patients move through the organisation. A comprehensive recovery plan is in development across the health and care system and there is positive engagement with all partners to ensure high quality care and a positive patient experience

CQC requires improvement following re-inspection: Following publication of the CQC report following the re-inspection, the Trust developed an approach to improve on the 'must do' and 'should do' improvement actions. The actions and plans which will lead to the improvement in care for our patients are monitored by the Executive Driving Clinical Standards Group (EDCSG). This group reports to Trust Board via the Quality Committee. The EDCSG is chaired by the Chief Executive and requires project leads to present their improvement plans, trajectory and attainment of improvement to the group.

Workforce issues in relation to nurse staffing and medical vacancies: During 2015/16 the Trust operated with a 12% vacancy factor within Consultant/Specialty and Associate Specialist Grades and a 14% vacancy factor within junior/training grades. This combined with additional bed capacity opened to support demand pressures resulted in increased workload on existing staff and a significant use of temporary medical staff (locum doctors). Since the publication of NHS Improvement rules identifying maximum price caps that can be spent on agency staff, the Trust has struggled to secure locum doctor support at compliant rates, however, the Trust is continuing to work with its supply chain partner

to address this and compliance rates have increased. The Trust is the subject of a 'deep dive' carried out by NHS Improvement into this area of medical workforce management. In order to address issues relating to locum doctors the Trust has undertaken significant work to strengthen management arrangements governing the requesting and booking of locum doctors including a review and revision of Trust policy and the centralisation of the Medical Staffing Rota Coordination function. The Trust has successfully recruited in excess of 30 Consultants across a range of specialties during the year but recognise the challenging nature of the workforce market and continue to strive to improve recruitment processes and material to make the Trust the preferred choice for prospective candidates.

Future governance arrangements and working across the health system: All governance systems within the Trust are audited and reviewed each year.

During 2015/16 the Trust engaged Capsticks to carry out an external view of our governance arrangements – this enabled us to ensure that there was an objective view of the Board's effectiveness and a direction for improvement.

The Trust complies with providing governance assurance to our commissioners and regulators.

Staff survey results: The Trust has struggled with the outcome of the national staff survey over recent years. The 2015 national results put the Trust in position 137 out of a 137 Trusts for its engagement with staff. Quarterly internal staff surveys are also carried out, with results showing that staff score the Trust relatively highly for care and treatment, however this has not translated into the national staff survey results.

There are no further significant gaps in assurance to report from the Board Assurance Framework.

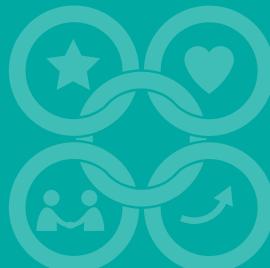
Chief Executive and Accountable Officer: Martin Barkley

Organisation: The Mid Yorkshire Hospitals NHS Trust

Signature:

MJ Barkley
27/5/16

Date:



CHAPTER SEVEN

FINANCIAL REPORT

Financial Report 2015-16

In the report last year, we highlighted the financial issues, challenges and opportunities that we would need to address in 2015-16 and we are pleased to be able to report that we have made significant progress in transforming our hospital sites to facilitate the opportunity to reconfigure our services further.

The year proved to be very challenging with an increase in the number of patients accessing our services against zero year on year growth in our income, a higher pay bill and higher non-pay costs to deliver safe and quality care for our patients.

The impact of this is that we are reporting a deficit of £20.53m, deterioration from our planned deficit of £14.8m. In trying to tackle the financial pressures we have been engaged in many work streams within the local health economy to improve efficiency and we have also been involved in the national efficiency project led by Lord Carter.

Our Investments

We have invested over £22.3m in capital infrastructure, making improvements to our buildings to create additional space for clinical services, improve the flow between services and to make the environment better for our patients. We made significant investment of £12.8m as part of our Acute Hospital Reconfiguration programme. We have continued to invest in maintaining our existing estate (£3.9m), taking advantage of advancements or replacements of medical equipment (£2.6m) and information technology (£3.0m).

Our Financial Position

The Trust's deficit of £20.5m for the year is the recognised measure of financial performance for which the Trust is held to account. The impact of changes to the basis of valuation of our assets resulted in an impairment charge of £20.8m. These are excluded from the reported financial position as a technical adjustment.

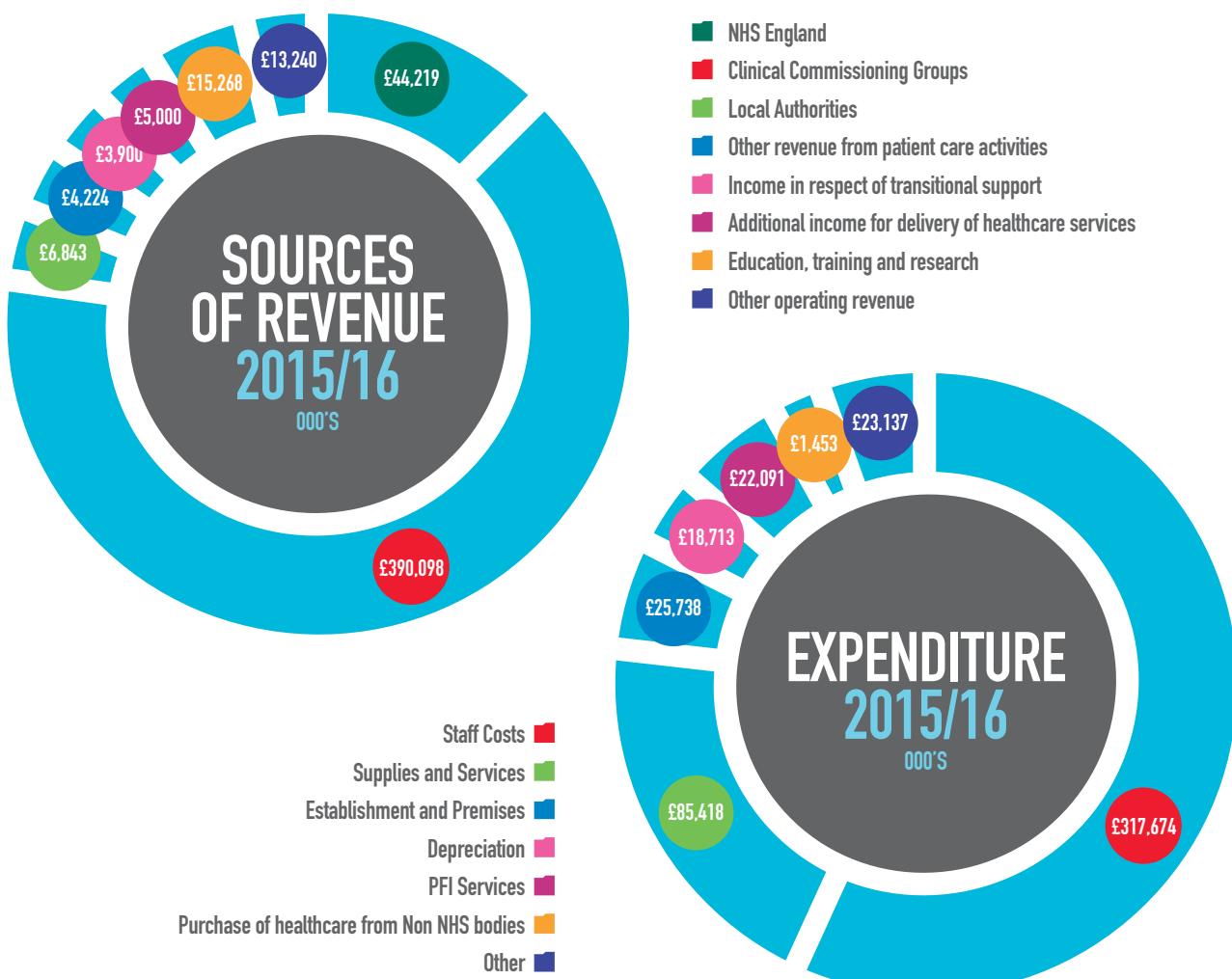
Revenue

In 2015-16 we received revenue of £482.8m a reduction from the prior year of £483.4m. Revenue in 2015-16 includes £5.0m for additional healthcare services which resulted in us having less to spend on capital than we planned to. Similar to the previous year we also received £3.9m in respect of local health economy support.

CHAPTER SEVEN

FINANCIAL REPORT

CONTINUED



Expenditure

Our operating expenses excluding financing costs and impairments are £494.2m. The most significant category of expenditure is our staff costs of £317.7m. Our pay costs have continued to present a challenge and we have seen a further significant increase in agency costs, which come at a premium, to cover vacancies in both the medical and nursing workforce and to support the increased level of activity.

Within operating expenses is a charge of £20.8m for impairments. We commissioned the District Valuers of the Valuation Office Agency to undertake a revaluation of the Trust's estate which overall resulted in a reduction to the asset values. Impairments are a technical adjustment and do not form part of the measure of the Trust's financial performance.

“ I came for an ultrasound and an X-ray. I was so respected and treated with kindness and care by everyone...their attitudes were commendable.

X-ray and Ultrasound at Pinderfields

”

CHAPTER SEVEN

FINANCIAL REPORT

CONTINUED

Financing cost

In 2015/16 we incurred financing and dividend costs of £12.3m. The main element of this cost £10.2m, are a consequence of how we account for our Private Finance Initiative (PFI) buildings and this is paid as part of the unitary charge to our PFI providers.

We have also incurred additional financing costs this year due to changes in the NHS financing regime. Our initial plan for 2015/16 assumed that we would receive revenue Public Dividend Capital to support our planned deficit. This was not approved and we had to use a temporary borrowing facility to maintain liquidity in 2015-16. This borrowing facility attracted interest at 3.5%. To enable us to repay the temporary borrowing, in March 2016 the Department of Health agreed a term loan of £18.7m with interest payable at 1.5%. We did benefit from a lower dividend payment of £0.8m due to a reduction in our asset values resulting from the revaluation exercise.

Gains and losses

As part of our reconfiguration strategy and to support our investment in services we sold areas of land that were surplus to requirement and reinvested the proceeds for the benefit of our patients. This has resulted in a gain on disposal of £3.2m.

Looking forward to 2016/17

In 2016/17 we will implement further phases of our hospital reconfiguration plan with additional clinical space being brought into operation. This will provide the opportunity to take a new approach to financial recovery and look at delivering greater efficiency savings through clinical and non-clinical service transformation rather than transactional and short term measures.

We have planned to receive Sustainability and Transformation funding in 2016-17 but also foresee that the demand for healthcare services will continue to increase and this will present a significant challenge to our ability to return to financial surplus. We anticipate that we will still require support from local commissioners and we will also need to make significant cost improvements above the national efficiency targets.

We continue to work with our stakeholders and we are supporting initiatives to drive efficiencies and transform healthcare services across the health economy to enable us to provide safe, quality and sustainable care for our patients.



FINANCIAL STATEMENTS 2015/16

The next section (pages 60 to 96) are the Trust's full financial statements for the year 2015/16.

Going concern statement

In line with the requirements of International Accounting Standard (IAS 1), the Trust Board at its May 2016 meeting undertook a review of whether it considered the organisation to be a going concern for at least the 12 months to the end of May 2017.

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

FINANCIAL STATEMENTS 2015/16

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority.

These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- Value for money is achieved from the resources available to the Trust;
- The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- Effective and sound financial management systems are in place; and
- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed  Chief Executive

Date 27/5/16

“ There is absolutely no doubt whatsoever in my mind that the excellent work the team provide have most definitely given me a quality of life back that was greatly lacking ”

Physiotherapy at Pinderfields

FINANCIAL STATEMENTS 2015/16

STATEMENT OF DIRECTORS' RESPONSIBILITIES

RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year.

In preparing those accounts, directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- Make judgements and estimates which are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

27/5/16 Date M J Babley Chief Executive

27/5/2016 Date J Hazlegrave Finance Director

FINANCIAL STATEMENTS 2015/16 CONTINUED

Statement of Comprehensive Income for the year ended 31 March 2016

	2015-16	2014-15	
	NOTE	£000s	£000s
Revenue from patient care activities	4	445,384	442,401
Income in respect of transitional support	4	3,900	3,900
Additional income for delivery of healthcare services	4	5,000	8,000
Other operating revenue	5	28,508	29,127
Gross employee benefits	9.1	(317,598)	(305,834)
Other operating costs	7.2	(176,626)	(173,351)
Impairments	16.1	(20,784)	(4,060)
Operating surplus/(deficit)		(32,216)	183
Investment revenue	11	88	60
Other gains and (losses)	12	3,235	(34)
Finance costs	13	(11,443)	(10,947)
Surplus/(deficit) for the financial year		(40,336)	(10,738)
Public dividend capital dividends payable		(830)	(2,503)
Retained surplus/(deficit) for the year		(41,166)	(13,241)
OTHER COMPREHENSIVE INCOME			
Impairments and reversals taken to the revaluation reserve		(8,434)	0
Net gain/(loss) on revaluation of property, plant and equipment		13,880	664
Total comprehensive income for the year		(35,720)	(12,577)
FINANCIAL PERFORMANCE FOR THE YEAR			
Retained surplus/(deficit) for the year		(41,166)	(13,241)
IFRIC 12 adjustment (including IFRIC 12 impairments)		21,254	0
Impairments (excluding IFRIC 12 impairments)		(470)	4,060
Adjustments in respect of donated asset reserve elimination		(148)	125
Adjusted retained surplus/(deficit)		(20,530)	(9,056)

A NHS Trust's reported financial performance position is its retained surplus/(deficit) adjusted for items which the Department of Health (DH) does not consider to be part of the organisation's financial performance.

In 2015-16, the Trust was required to adjust for impairments of £20,784k (2014-15: £4,060k) and the impact of eliminating the donated asset reserve of £148k (2014-15: £125k).

The notes on pages 65 to 93 form part of this account.

Statement of Financial Position as at 31 March 2016

	31 MARCH 2016	31 MARCH 2015	
	NOTE	£000s	£000s
NON-CURRENT ASSETS			
Property, plant and equipment			
Intangible assets	14	416,881	429,750
Total non-current assets		419,437	432,335
CURRENT ASSETS			
Inventories			
Trade and other receivables	19	8,891	9,101
Cash and cash equivalents	20.1	18,034	18,906
Sub-total current assets		28,007	28,708
Non-current assets held for sale	21	1,082	701
Total current assets		29,664	34,108
Total assets		449,101	466,443
CURRENT LIABILITIES			
Trade and other payables			
Provisions	22	(44,667)	(42,819)
Borrowings	23	(1,641)	(1,564)
DH capital loan	24	(9,161)	(9,395)
Total current liabilities		(56,469)	(54,778)
Net current assets/(liabilities)		(26,805)	(20,670)
Total assets less current liabilities		392,632	411,665
NON-CURRENT LIABILITIES			
Provisions			
Borrowings	25	(5,936)	(6,547)
DH revenue support loan	26	(294,435)	(303,410)
DH capital loan	27	(18,650)	0
Total non-current liabilities		(327,521)	(319,457)
Total assets employed		65,111	92,208
FINANCED BY			
Public Dividend Capital			
Retained earnings		196,144	187,523
Revaluation reserve		(193,287)	(156,441)
Other reserves		59,569	58,441
Total taxpayers' equity		2,685	2,685
Total assets employed		65,111	92,208

The Financial statements on pages 62 to 93 were approved by the Board and signed on its behalf by:

Signed

Date

27/5/16

Statement of Changes in Taxpayers' Equity For the year ending 31 March 2016

	PUBLIC DIVIDEND CAPITAL	RETAINED EARNINGS	REVALUATION RESERVE	OTHER RESERVES	TOTAL RESERVES
	£000s	£000s	£000s	£000s	£000s
BALANCE AT 1 APRIL 2015	187,523	(156,441)	58,441	2,685	92,208
CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2016					
Retained surplus/(deficit) for the year		(41,166)			(41,166)
Net gain/(loss) on revaluation of property, plant and equipment			13,880		13,880
Impairments and reversals			(8,434)		(8,434)
Transfers between reserves		4,320	(4,320)		0
Permanent Public Dividend Capital received - cash	13,621				13,621
Permanent Public Dividend Capital repaid in year	(5,000)				(5,000)
Other movements			2		2
Net recognised revenue/(expense) for the year	8,621	(36,846)	1,128	0	(27,097)
Balance at 31 March 2016	196,144	(193,287)	59,569	2,685	65,111

In 2015-16, the Trust received £13,621k of permanent Public Dividend Capital (PDC) for capital expenditure. The Trust repaid £5,000k of permanent PDC and received additional income to transfer capital to revenue.

BALANCE AT 1 APRIL 2014	175,832	(145,685)	60,262	2,685	93,094
CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015					
Retained surplus/(deficit) for the year		(13,241)			(13,241)
Net gain/(loss) on revaluation of property, plant and equipment			664		664
Transfers between reserves		2,485	(2,485)		0
New temporary and permanent Public Dividend Capital received - cash	32,191				32,191
New temporary and permanent Public Dividend Capital repaid in year	(20,500)				(20,500)
Net recognised revenue/(expense) for the year	11,691	(10,756)	(1,821)	0	(886)
Balance at 31 March 2015	187,523	(156,441)	58,441	2,685	92,208

In 2014-15, the Trust received £4,889k of permanent PDC for liquidity and £6,802k for capital expenditure. During the year the Trust received and repaid £12,500k of temporary and £8,000k of permanent PDC.

The notes on pages 65 to 93 for part of the financial statements.

FINANCIAL STATEMENTS 2015/16 CONTINUED

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit)		(32,216)	183
Depreciation and amortisation	7	18,713	20,444
Impairments and reversals	16	20,784	4,060
Donated assets received credited to revenue - non-cash	5	(274)	0
Interest paid		(11,447)	(10,983)
PDC dividend (paid)/refunded		(2,160)	(2,608)
(Increase)/decrease in inventories		210	828
(Increase)/decrease in trade and other receivables		2,214	1,589
Increase/(decrease) in trade and other payables		(308)	2,787
Provisions utilised	27	(984)	(1,434)
Increase/(decrease) in movement in non cash provisions		472	(759)
Net cash inflow/(outflow) from operating activities		(4,996)	14,107
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		86	61
(Payments) for property, plant and equipment		(19,156)	(18,701)
(Payments) for intangible assets		(797)	(665)
Proceeds of disposal of assets held for sale (property, plant and equipment)		8,182	163
Net cash inflow/(outflow) from investing activities		(11,685)	(19,142)
Net cash inflow/(outflow) before financing		(16,681)	(5,035)
CASH FLOWS FROM FINANCING ACTIVITIES			
Gross temporary (2014/15 only) and permanent PDC received		13,621	32,191
Gross temporary (2014/15 only) and permanent PDC repaid		(5,000)	(20,500)
Loans received from DH - working capital loan		29,825	0
Loans received from DH - revenue support loan		18,650	0
Loans repaid to DH - capital investment loan repayment of principal		(1,000)	(1,000)
Loans repaid to DH - working capital loans		(29,825)	0
Capital element of payments in respect of finance leases and on-SOFP PFI		(9,209)	(7,685)
Net cash inflow/(outflow) from financing activities		17,062	3,006
Net increase/(decrease) in cash and cash equivalents		381	(2,029)
Cash and cash equivalents at beginning of the period		701	2,730
Cash and cash equivalents at year end	21	1,082	701

The notes on pages 65 to 93 for part of the financial statements.



NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury.

Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below.

They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Charitable Funds

Under the provisions of IAS27 Consolidated and Separate Financial Statements, those charitable funds that fall under common control with the Trust are consolidated within its financial statements. The Trust is the Corporate Trustee of the Mid Yorkshire Hospitals NHS Trust Charitable Fund (the Charity), registered number 1067163 and is required to consolidate the funds of the Charity. Transactions of the Charity are immaterial in the context of the group (Trust and Charity) and therefore the Trust has not consolidated the Charity in its financial statements.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical judgements in applying accounting policies

Section 1.4.3 sets out the critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.4.2 Key sources of estimation uncertainty

In section 1.4.3 are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.4.3 Summary of critical judgements and estimation uncertainty

In preparing the financial statements, management of the Trust are required to make estimates and judgements. A summary of significant areas of estimation and judgements in preparing the statements are described below.

Revaluation of property, plant and equipment

Property, plant and equipment and intangible assets are revalued on a periodic basis and tested for indications of impairment. Judgements are required to make an assessment as to whether there is an indication of impairment. The impairment tests involve estimation to determine the value in use of an asset.

The Trust has undertaken a desktop revaluation of its estate using an officer from the District Valuers of the Valuation Office Agency to carry out the exercise.

Private Finance Initiative (PFI) scheme

The PFI scheme has been accounted for on the basis of current detailed guidance issued by the Department of Health.

The operator's PFI model has been used as the basis for estimating the value and profiling the service costs and lifecycle costs for each year of the contract with the remaining value of the unitary payment being allocated to finance lease rental. The finance lease rental is split further into repayment finance lease principal, finance costs and contingent rent, which represents inflation increase.

Details of the scheme are in note 29 and the accounting policies are in note 1.14.

Dual accounting as measured in the Trust's breakeven duty

Prior to 2012-13, the Trust was permitted to make an adjustment for dual accounting on the Trust's Breakeven Duty in order to recognise the difference between PFI costs recorded under IFRS accounting compared to costs recorded under UK GAAP accounting. From 2012-13, this adjustment is only permitted where the costs are higher under IFRS than UK GAAP. The Trust uses judgements to maintain a separate accounting assessment of the costs that would otherwise have been recorded under the UK GAAP regime.

Details are provided in note 30.

Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event (notes 1.17 and 27). The timing of recognition requires the application of judgement to existing facts and circumstances, which can be subject to change.

Estimates of the amounts of provisions recognised can differ to the actual outflows due to uncertain future events and changes in laws, regulations and conditions. The carrying amounts of provisions are regularly reviewed and adjusted to take account of such changes.

In determining the amounts of the provisions, the directors have taken legal advice where applicable. Where the amount of the obligation cannot be reliably estimated it is disclosed as a contingent liability.

Leasing arrangements

In applying IAS 17 Leases and IFRIC 4 Determining Whether an Arrangement Contains a Lease, judgements have been made to assess whether an arrangement is or contains an operating or finance lease.

Where the implicit interest rate cannot be determined in an arrangement containing a lease the long term real rate of interest from Treasury Tables has been used as an estimate.

Deferred income

The Trust has exercised judgement in deferring income based on its understanding of future services to be provided and costs to be incurred before it earns the right to consideration.

Accruals and accrued income

Revenue and expenditure for transactions or events that have occurred during the year are initially estimated where the actual amount is unknown at the date of preparing the financial statements. Actual inflows and outflows can differ from estimates as a result of uncertainties inherent in the estimation techniques.

Operating segments

The Trust has made a judgement to report a single segment of healthcare, as revenue is reported to Trust Board on a Trust-wide basis.

Retention of Employment Model for affected staff in the PFI scheme

Under the PFI Project Agreement, some designated cohorts of Trust staff work under a nationally agreed framework called Retention of Employment ("RoE").

These members of staff work under instruction from Project Co. but retain contractual rights as Mid Yorkshire Hospitals NHS Trust employees. Project Co. pays all the payroll costs associated with such employees and charges a monthly service fee to the Trust (an arm's length Unitary Charge for the costs described in the PFI Project Agreement).

Prior period adjustments

The Trust has made a judgement in determining the impact of changes in accounting guidance on previous year's accounts in compiling comparative information. No prior year adjustments have been made in 2015-16 in relation to changes in accounting guidance.

Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Financial position

In preparing the financial statements the directors have considered the Trust's overall financial position and expectations of future financial support. The Trust has submitted a financial plan for 2016/17 to NHS Improvement which delivers a surplus of £4.2m in line with the Sustainability and Transformation Fund conditions. The plan assumes receipt of the following non-recurrent resources; Sustainability and Transformation Funding (STF) of £16.7m, financial support (Legacy) of £3.9m from our main commissioners (Wakefield & North Kirklees) as a contribution towards the excess costs of services provided on multiple sites (A&E and Midwife Led Units), £4.2m to cover the transitional costs associated with Acute Hospital Reconfiguration (AHR) programme and funding to maintain the infrastructure required for winter pressures/surge of £1.1m. The plan also requires the Trust to deliver cost improvement savings of £26.1m (5.3%). There is a requirement to access cash support via the Revolving Working Capital (RWC) facility throughout the year to maintain in-year liquidity. The cash borrowings can be managed within the Trust's approved RWC borrowing facility.

1.5 Revenue

Revenue in respect of services provided is recognised when and to the extent that, performance occurs or goods have been transferred and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred. Maternity pathways and incomplete spells are recognised in the year of receipt.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim.

The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

Short-term employee benefits

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust provides certain employees, who are not enrolled into the NHS Pensions Scheme, with cover from the defined contributions scheme which is managed by the National Employment Savings (NEST). The cost to the Trust is taken as equal to the contributions payable to the scheme for the accounting period.

1.7 Other expenses

Other operating expenses are recognised when and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, plant and equipment Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and
- The item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed with sufficient regularity (note 14.3) to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost.

PFI assets are valued in accordance with the Trust's approach for each relevant asset class.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided, an alternative site can be valued. In the Trust's case no alternative site has been sought and the valuation covers all of the existing hospital sites.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust has obtained an independent valuation from the Office of the District Valuer for assets where both the remaining lives are greater than 5 years and a remaining net book value of greater than £250,000 to ensure that high-value and long-life assets are carried at fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as Other Comprehensive Income in the Statement of Comprehensive Income (SoCI).

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure is incurred on an asset to restore operational capacity, through replacing

components of the original asset, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets - Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

1.10 Depreciation, amortisation and impairments

Freehold land properties under construction and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed

Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.11 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus or deficit.

Operating lease payments are recognised as an expense on a straight line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The cost to the Trust of services received in the year is recorded within 'operating expenses' under 'other'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17 Leases. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16 Property, Plant and Equipment.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are not expected to meet the Trust's criteria for capital expenditure. Lifecycle replacement costs are recognised as an expense.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate in real terms of 1.37% for employee early departure obligations.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Clinical negligence costs

The NHS Litigation Authority (NHLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHLA on behalf of the Trust is disclosed at note 27.

1.19 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.20 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO₂ emissions. The Trust is registered with the CRC scheme and is required to surrender to the Government an allowance for every tonne of CO₂ emitted during the financial year. A liability and a related expense are recognised in respect of this obligation as CO₂ emissions are made.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

The classification of financial assets depends on the nature and purpose of the financial asset and is determined at the time of initial recognition. The Trust has financial assets in the category of loans and receivables.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques detailed in note 31 Financial Instruments.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.23 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.24 Value Added Tax

Most of the activities of the Trust are outside the scope of Value Added Tax (VAT) and in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.25 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus or deficit in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 37 to the accounts.

1.27 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.28 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses, gains and losses, assets, liabilities and reserves and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

From 2013-14, the Trust has been required to consolidate the results of The Mid Yorkshire Hospitals NHS Trust Charitable Fund over which it considers it has the power to exercise control in accordance with IFRS10 requirements. However, the transactions are immaterial in the context of the group and the transactions have not been consolidated. Details of the transactions with the Charity are included in note 33, the related party note.

1.30 Joint arrangements

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure, gains and losses, assets and liabilities and cashflows.

1.31 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is

calculated on the same basis as depreciation, on a monthly basis.

1.32 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19 and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of the individual specialty components included therein. The majority of the Trust's revenue originates from the UK Government and expenditure mainly relates to staff costs, supplies and overheads. The activities which earn revenue and incur expenses are of one broad, combined nature to deliver healthcare.

The Trust's chief operating decision maker is deemed to be the Board. The finance report considered monthly by the Board contains summary figures for the whole Trust together with divisional budgets and their cost improvement plans. The statement of financial position, statement of comprehensive income and cash flow statement are considered for the Trust as a whole. Therefore one segment of healthcare is considered in its decision making process.

The single segment of 'healthcare' is deemed appropriate and is consistent with the core principles of IFRS8 to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. Income generation activities are not considered to be material and no one activity had a full cost over £1m.

“I found the care at the Boothroyd Centre for my colonoscopy to be excellent. The staff were very professional and extremely caring. Thank you for your care at what could be a worrying time.

Boothroyd Centre at Dewsbury

4. Revenue from patient care activities

	2015-16	2014-15
	£000s	£000s
NHS Trusts	187	707
NHS England	44,219	47,814
Clinical Commissioning Groups	390,098	385,344
Foundation Trusts	278	395
NON-NHS:		
Local authorities	6,843	4,752
Private patients	46	49
Overseas patients (non-reciprocal)	46	25
Injury costs recovery	2,881	2,621
Other	786	694
Total revenue before transitional support	445,384	442,401
Income in respect of transitional support	3,900	3,900
Additional income for delivery of healthcare services	5,000	8,000
Total revenue from patient care activities	454,284	454,301

Revenue from patient care activities includes £3,900k (2014-15: £3,900k) of transitional support from the local health economy.

Injury cost recovery income is subject to a provision for impairment of receivables of 21.9% (2014-15: 18.9%) to reflect expected rates of collection.

In 2015-16, the Trust transferred £5,000k from capital to revenue. This was received as additional income from the Department of Health for the delivery of healthcare services. In 2014-15, the Trust received additional income of £8,000k from the Department of Health for the delivery of healthcare services conditional on achieving financial performance targets.

5. Other operating revenue

	2015-16	2014-15
	£000s	£000s
Recoveries in respect of employee benefits	328	523
Education, training and research	15,268	15,041
Charitable and other contributions to revenue expenditure - NHS	327	318
Receipt of donations for capital acquisitions - charity	135	158
Receipt of non-cash donations for capital acquisitions - charity	274	0
Non-patient care services to other bodies	5,493	6,395
Income generation (other fees and charges)	4,068	3,770
Rental revenue from operating leases	487	500
Other revenue	2,128	2,422
Total other operating revenue	28,508	29,127

6. Overseas visitors disclosure

	2015-16	2014-15
	£000s	£000s
Income recognised during the year (invoiced amounts and accruals)	46	25
Cash payments received in-year (for receivables at 1 April)	2	9
Cash payments received in-year (for invoices issued during the year)	15	3
Amounts added to provision for impairment of receivables (for receivables at 31 March)	0	0
Amounts added to provision for impairment of receivables (for invoices issued during the year)	31	22
Amounts written off in-year (irrespective of year of recognition)	0	0

7. Operating expenses

	2015-16	2014-15
	£000s	£000s
7.1 EMPLOYEE BENEFITS		
Employee benefits excluding Board members	315,980	304,618
Board members	1,618	1,216
Total employee benefits	317,598	305,834

	2015-16	2014-15
	£000s	£000s
7.2 OPERATING EXPENSES		
Services from other NHS Trusts	170	189
Services from CCGs/NHS England	0	394
Services from other NHS bodies	20	0
Total Services from NHS bodies	190	583
Purchase of healthcare from non-NHS bodies	1,453	3,849
Trust Chair and Non-executive Directors	76	82
Supplies and services – clinical	81,458	76,915
Supplies and services – general	3,960	3,596
Consultancy services	2,036	3,402
Establishment	4,478	4,849
Transport	687	757
Service charges – on-SOFP PFIs and other service concession arrangements	22,091	23,923
Business rates paid to local authorities	3,773	3,590
Premises	16,731	15,679
Hospitality	48	62
Insurance	488	525
Legal fees	708	496
Impairments and reversals of receivables	426	847
Inventories write down	16	56
Depreciation	17,697	19,548
Amortisation	1,016	896
Internal audit fees	140	0
Audit fees	109	114
Other auditor's remuneration	15	0
Clinical negligence	15,756	10,166
Education and training	1,089	1,163
Change in discount rate	(34)	276
Other	2,219	1,977
Total operating expenses (excluding employee benefits)	176,626	173,351

	2015-16	2014-15
	£000s	£000s
7.3 IMPAIRMENTS		
Impairments and reversals of property, plant and equipment	20,634	4,060
Impairments and reversals of non current assets held for sale	150	0
	20,784	4,060
Total operating expenses	515,008	483,245

7.4 Total operating expenses

The increase in employee benefits relating to Board members in 2015-16 is due to the inclusion of non-voting Directors of Operations which were previously included in employee costs.

In 2015-16 the Trust revalued its land and buildings as at the 1st April 2015 and 31st March 2016. In 2015-16 and 2014-15, the Trust reclassified some areas of land and buildings. The impacts of these accounting treatments led to impairments of £20,784k (2014-15: £4,060k).

In 2014-15, internal audit fees were included in other operating expenses.

8. Operating leases

	2015-16	2014-15
	£000s	£000s
8.1. TRUST AS LESSEE		
Payments recognised as an expense	£000s	£000s
Minimum lease payments		
Payable		
No later than one year	36	693
Between one and five years	0	3
After five years	0	0
Total	36	696
8.2. TRUST AS LESSOR		
Recognised as revenue		
Rental revenue		
Contingent rents		
Total	407	420
Receivable		
No later than one year		
Between one and five years		
Total	200	200

	2015-16	2014-15
	£000s	£000s
8.2. TRUST AS LESSOR		
Recognised as revenue		
Rental revenue		
Contingent rents		
Total	407	420
Receivable		
No later than one year		
Between one and five years		
Total	200	200

9. Employee benefits and staff numbers

	2015-16 TOTAL	2015-16 PERMANENTLY EMPLOYED	2015-16 OTHER	2014-15 TOTAL	2014-15 PERMANENTLY EMPLOYED	2014-15 OTHER
9.1. EMPLOYEE BENEFITS	£000s	£000s	£000s	£000s	£000s	£000s
Employee Benefits – Gross Expenditure						
Salaries and wages	274,220	230,566	43,654	264,231	228,322	35,909
Social security costs	16,618	16,618	0	16,661	16,661	0
Employer Contributions to NHS BSA – Pensions Division	27,175	27,175	0	26,595	26,595	0
Other pension costs	228	228	0	116	116	0
Termination benefits	0	0	0	(1,231)	(1,231)	0
Total – including capitalised costs	318,241	274,587	43,654	306,372	270,463	35,909
Employee costs capitalised	(643)	(263)	(380)	(538)	(219)	(319)
Gross employee benefits excluding capitalised costs	317,598	274,324	43,274	305,834	270,244	35,590

	2015-16 TOTAL	2015-16 PERMANENTLY EMPLOYED	2015-16 OTHER	2014-15 TOTAL
9.2 AVERAGE STAFF NUMBERS	Whole time equivalent	Whole time equivalent	Whole time equivalent	Whole time equivalent
Medical and dental	917	746	171	895
Administration and estates	1,458	1,153	305	1,353
Healthcare assistants and other support staff	642	642	0	620
Nursing, midwifery and health visiting staff	3,239	2,829	410	3,204
Nursing, midwifery and health visiting learners	14	14	0	23
Scientific, therapeutic and technical staff	917	860	57	855
Healthcare Science Staff	291	286	5	294
Other	4	4	0	4
Total	7,482	6,534	948	7,248
Of the above – staff engaged on capital projects	10	5	5	9

	2015-16	2014-15
9.3. STAFF SICKNESS ABSENCE AND ILL HEALTH RETIREMENTS	Number	Number
Total Days Lost	73,245	72,539
Total Staff Years	6,725	6,766
Average working days Lost	10.89	11

9.3. STAFF SICKNESS ABSENCE AND ILL HEALTH RETIREMENTS	2015-16	2014-15
	Number	Number
Number of persons retired early on ill health grounds	11	9
Total additional pensions liabilities accrued in the year	£000s	£000s
	799	633

Staff sickness absence data is based on full-time equivalent days for the calendar year January 2015 to December 2015 (2014-15: January 2014 to December 2014) as provided by the Health and Social Care Information Centre, Electronic Staff Record Data Warehouse.

**NOTES TO
THE ACCOUNTS CONTINUED**

9.4. EXIT PACKAGES AGREED IN 2015-16	2015-16 NUMBER OF COMPULSORY REDUNDANCIES	2015-16 COST OF COMPULSORY REDUNDANCIES	2015-16 NUMBER OF OTHER DEPARTURES AGREED	2015-16 COST OF OTHER DEPARTURES AGREED	2015-16 TOTAL NUMBER OF EXIT PACKAGES	2015-16 "TOTAL COST OF EXIT PACKAGES
	Number	£s	Number	£s	Number	£s
Exit package cost band (including any special payment element)						
Less than £10,000	0	0	51	158,472	51	158,472
£10,001 - £25,000	0	0	1	10,584	1	10,584
£25,001 - £50,000	0	0	1	31,200	1	31,200
£50,001 - £100,000	0	0	1	55,250	1	55,250
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total	0	0	54	255,506	54	255,506

9.4. EXIT PACKAGES AGREED IN 2015-16	2014-15 NUMBER OF COMPULSORY REDUNDANCIES	2014-15 COST OF COMPULSORY REDUNDANCIES	2014-15 NUMBER OF OTHER DEPARTURES AGREED	2014-15 COST OF OTHER DEPARTURES AGREED	2014-15 TOTAL NUMBER OF EXIT PACKAGES	2014-15 "TOTAL COST OF EXIT PACKAGES
	Number	£s	Number	£s	Number	£s
Exit package cost band (including any special payment element)						
Less than £10,000	0	0	0	0	0	0
£10,001 - £25,000	0	0	1	17,619	1	17,619
£25,001 - £50,000	2	71,472	0	0	2	71,472
£50,001 - £100,000	1	80,535	1	69,601	2	150,136
£100,001 - £150,000	1	135,610	0	0	1	135,610
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	1	235,000	0	0	1	235,000
Total	5	522,617	2	87,220	7	609,837

This note provides an analysis of exit packages agreed with staff during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

9.5. EXIT PACKAGES - OTHER DEPARTURES ANALYSIS	2015-16 AGREEMENTS	2015-16 TOTAL VALUE OF AGREEMENTS	2014-15 AGREEMENTS	2014-15 TOTAL VALUE OF AGREEMENTS
	Number	£000s	Number	£000s
Early retirements in the efficiency of the service contractual costs	0	0	1	48
Contractual payments in lieu of notice	52	169	2	39
Exit payments following Employment Tribunals or court orders	2	87	0	0
Total	54	256	3	87

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

A single exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in note 9.4 which will be the number of individuals.

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

9.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and are accepted as providing suitably robust figures for financial

reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience) and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

10. Better Payment Practice Code

10.1. MEASURE OF COMPLIANCE	2015-16	2015-16	2014-15	2014-15
NHS payables	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	78,402	208,659	75,708	154,390
Total non-NHS trade invoices paid within target	67,686	188,063	69,891	143,627
Percentage of non-NHS trade invoices paid within target	86.33%	90.13%	92.32%	93.03%
NHS payables	2015-16	2015-16	2014-15	2014-15
	Number	£000s	Number	£000s
Total NHS trade invoices paid in the year	2,474	37,448	2,461	34,172
Total NHS trade invoices paid within target	2,404	36,846	2,246	32,946
Percentage of NHS trade invoices paid within target	97.17%	98.39%	91.26%	96.41%

The Better Payment Practice Code requires the NHS body to aim to pay 95% all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10.2. The Late Payment of Commercial Debts (Interest) Act 1998

Interest of £92 (2014-15: £30) was paid for late payments under The Late Payment of Commercial Debts (Interest) Act 1998.

11. Investment revenue

	2015-16	2014-15
	£000s	£000s
Bank interest	88	60

12. Other gains and losses

	2015-16	2014-15
	£000s	£000s
Gain/(loss) on disposal of assets other than by sale (PPE)	223	(29)
Gain/(loss) on disposal of assets held for sale	3,012	(5)
Total	3,235	(34)

14.1. Property, plant and equipment 2015/16

COST OR VALUATION:	
	At 1 April 2015
Additions of assets under construction	
Additions purchased	
Additions – non cash donations (i.e. physical assets)	
Additions – purchases from cash donations and government grants	
Reclassifications	
Reclassifications as held for sale and reversals	
Disposals other than for sale	
Upward revaluation/positive indexation	
Impairment/reversals charged to operating expenses	
Impairments/reversals charged to reserves	
	At 31 March 2016

DEPRECIATION:	
	At 1 April 2015
Reclassifications as held for sale and reversals	
Disposals other than for sale	
Upward revaluation/positive indexation	
Impairment/reversals charged to reserves	
Impairments/reversals charged to operating expenses	
Charged during the year	
	At 31 March 2016

ASSET FINANCING:	
	Owned – purchased
	Owned – donated
	Owned – government granted
	Held on finance lease
	On-SOFP PFI contracts
	PFI residual: interests
	Total at 31 March 2016

REVALUATION RESERVE BALANCE FOR PROPERTY, PLANT AND EQUIPMENT	
	At 1 April 2015
Movements – revaluations and disposals	
	At 31 March 2016

ADDITIONS TO ASSETS UNDER CONSTRUCTION IN 2015-16	
	Land
	Buildings excl Dwellings
	Dwellings
	Plant and Machinery
	Balance as at YTD

13. Finance Costs

INTEREST	2015-16		2014-15	
	£000s	£000s	£000s	£000s
Interest on loans and overdrafts	1,093		321	
Interest on obligations under finance leases	25		35	
Interest on obligations under PFI contracts:				
Main finance cost	10,247		10,483	
Total interest expense	11,365		10,839	
Provisions – unwinding of discount	78		108	
Total	11,443		10,947	

LAND	BUILDINGS EXCLUDING DWELLINGS	DWELLINGS	ASSETS UNDER CONSTRUCTION AND PAYMENTS ON ACCOUNT	PLANT AND MACHINERY	TRANSPORT EQUIPMENT	INFORMATION TECHNOLOGY	FURNITURE AND FITTINGS	TOTAL
£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
55,123	470,323	4,675	9,649	68,488	30	22,407	3,782	634,477
0	0	0	12,952	0	0	0	0	12,952
0	2,802	103	0	3,377	0	1,469	258	8,009
0	0	0	0	0	0	274	0	274
0	126	0	0	9	0	0	0	135
288	20,606	0	(20,894)	0	0	0	0	0
(385)	(355)	(632)	0	0	0	0	0	(1,372)
0	(82)	0	0	(2,169)	0	(8)	0	(2,259)
911	2,004	31	0	0	0	0	0	2,946
10	(50,871)	0	0	0	0	0	0	(50,861)
(2,245)	(4,037)	(41)	0	0	0	0	0	(6,323)
53,702	440,516	4,136	1,707	69,705	30	24,142	4,040	597,978

1,624	139,476	1,958	0	44,528	21	15,107	2,013	204,727
(3)	0	(39)	0	0	0	0	0	(42)
0	(82)	0	0	(2,145)	0	(8)	0	(2,235)
(2,245)	(8,345)	(344)	0	0	0	0	0	(10,934)
547	1,500	64	0	0	0	0	0	2,111
77	(30,309)	0	0	5	0	0	0	(30,227)
0	7,938	93	0	6,502	2	2,843	319	17,697
0	110,178	1,732	0	48,890	23	17,942	2,332	181,097
53,702	330,338	2,404	1,707	20,815	7	6,200	1,708	416,881

53,702	98,191	2,404	1,695	20,116	7	5,375	1,656	183,146
0	2,154	0	0	404	0	276	22	2,856
0	0	0	0	0	0	0	0	0
0	0	0	0	295	0	549	30	874
0	229,993	0	12	0	0	0	0	230,005
0	0	0	0	0	0	0	0	0
53,702	330,338	2,404	1,707	20,815	7	6,200	1,708	416,881

| £000's |
|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 36,249 | 16,045 | 1,509 | 0 | 36 | 0 | 0 | 0 | 53,839 |
| 83 | 4,218 | (130) | 0 | (18) | 0 | 0 | 0 | 4,153 |
| 36,332 | 20,263 | 1,379 | 0 | 18 | 0 | 0 | 0 | 57,992 |

0
12,924
0
28
12,952

14.2. Property, plant and equipment 2014/15

	LAND	BUILDINGS EXCLUDING DWELLINGS	DWELLINGS	ASSETS UNDER CONSTRUCTION AND PAYMENTS ON ACCOUNT	PLANT AND MACHINERY	TRANSPORT EQUIPMENT	INFORMATION TECHNOLOGY	FURNITURE AND FITTINGS	TOTAL
COST OR VALUATION:	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	56,859	465,144	4,673	4,400	63,430	30	20,159	3,773	618,468
Additions of assets under construction	0	0	0	8,152	0	0	0	0	8,152
Additions purchased	0	2,282	2	0	5,767	0	2,254	8	10,313
Additions – purchases from cash donations and government grants	0	147	0	0	11	0	0	0	158
Reclassifications	0	2,750	0	(2,903)	36	0	(6)	1	(122)
Reclassifications as held for sale and reversals	(2,400)	0	0	0	0	0	0	0	(2,400)
Disposals other than for sale	0	0	0	0	(756)	0	0	0	(756)
Upward revaluation/ positive indexation	664	0	0	0	0	0	0	0	664
At 31 March 2015	55,123	470,323	4,675	9,649	68,488	30	22,407	3,782	634,477
DEPRECIATION									
At 1 April 2014	0	127,567	1,864	0	38,413	19	12,248	1,698	181,809
Disposals other than for sale	0	0	0	0	(690)	0	0	0	(690)
Revaluation	0	0	0	0	0	0	0	0	0
Impairments/negative indexation charged to operating expenses	1,624	2,436	0	0	0	0	0	0	4,060
Charged during the year	0	9,473	94	0	6,805	2	2,859	315	19,548
At 31 March 2015	1,624	139,476	1,958	0	44,528	21	15,107	2,013	204,727
Net Book Value at 31 March 2015	53,499	330,847	2,717	9,649	23,960	9	7,300	1,769	429,750
ASSET FINANCING:									
Owned – purchased	53,499	72,445	2,717	5,956	23,009	9	6,611	1,708	165,954
Owned – donated	0	1,956	0	0	562	0	18	27	2,563
Owned – government granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	389	0	671	34	1,094
On-SOFP PFI contracts	0	256,446	0	3,693	0	0	0	0	260,139
PFI residual interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	53,499	330,847	2,717	9,649	23,960	9	7,300	1,769	429,750

14.3. Property, plant and equipment (continued)

Land and buildings were revalued as at 1 April 2015 and as at 31 March 2016 by the District Valuers of the Valuation Office Agency. Valuations are at depreciated replacement cost using the Modern Equivalent Asset (MEA) approach (Note 1.8).

The PFI buildings are revalued net of VAT, reflecting the cost at which the service potential would be replaced by the PFI operator. All other valuations are at a replacement cost inclusive of VAT, as VAT is not usually recoverable.

As part of the valuation exercise, the valuers advised changes to asset lives. Building lives which had previously ranged from 3 to 49 years now vary between 4 and 51 years.

Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the Valuer. Leaseholds are depreciated over the primary lease term. Buildings (excluding dwellings) are depreciated over 10 to 80 years. Dwellings are depreciated over 30 to 50 years.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

Software licences	2 to 10
Plant and machinery	3 to 25
Transport equipment	5 to 10
Information technology	2 to 10
Furniture and fittings	5 to 15

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset held for sale, an impairment is charged to bring the value of the asset to its value at the point of sale.

No property is currently held at existing use value with an open market value which is materially different to its existing use value. Further details describing the values and nature of impairments are in note 16.

Included in property, plant and equipment are the following amounts where the Trust is the lessor of assets on short term operating leases.

	LAND	BUILDINGS	DWELLINGS
	£000's	£000's	£000's
Net book value as at 31 March 2016	269	2,554	84

15.1. Intangible non-current assets 2015–16

	COMPUTER LICENSES	DEVELOPMENT EXPENDITURE – INTERNALLY GENERATED	TOTAL
	£000's	£000's	£000's
At 1 April 2015	5,634	83	5,717
Additions purchased	987	0	987
Disposals other than by sale	(1)	0	(1)
At 31 March 2016	6,620	83	6,703
AMORTISATION			
At 1 April 2015	3,049	83	3,132
Disposals other than by sale	(1)	0	(1)
Charged during the year	1,016	0	1,016
At 31 March 2016	4,064	83	4,147
Net Book Value at 31 March 2016	2,556	0	2,556

ASSET FINANCING: NET BOOK VALUE AT 31 MARCH 2016 COMPRISSES:				
Purchased	2,345	0	2,345	
Donated	52	0	52	
Finance Leased	159	0	159	
Total at 31 March 2016	2,556	0	2,556	

REVALUATION RESERVE BALANCE FOR INTANGIBLE NON-CURRENT ASSETS	£000's	£000's	£000's
At 1 April 2015	0	0	0
Movements	0	0	0
At 31 March 2016	0	0	0

“ The nurses were very professional, very competent, attitude excellent, inspired confidence in their ability. I called out for assistance and the nurses were there very quickly. 24 hour NHS! ”

Community nurses

15.2. Intangible non-current assets 2014-15

	COMPUTER LICENSES	DEVELOPMENT EXPENDITURE - INTERNALLY GENERATED	TOTAL
Cost or valuation:	£000's	£000's	£000's
At 1 April 2014	4,835	83	4,918
Additions – purchased	677	0	677
Reclassifications	122	0	122
At 31 March 2015	5,634	83	5,717
Amortisation			
At 1 April 2014	2,153	83	2,236
Charged during the year	896	0	896
At 31 March 2015	3,049	83	3,132
Net book value at 31 March 2015	2,585	0	2,585
Net book value at 31 March 2015 comprises:			
Purchased	2,203	0	2,203
Donated	76	0	76
Finance Leased	306	0	306
Total at 31 March 2015	2,585	0	2,585

15.3. Intangible non-current assets

Purchased computer software is amortised and charged to the income statement on a straight line basis over the shorter of the term of the licence and their useful lives.

The remaining lives for purchased computer software are 2 to 10 years. Amortisation periods and methods are reviewed annually and adjusted if appropriate to reflect fair value.

The Trust has no internally generated intangible assets or intangible assets acquired through Government grants.

16.1. Analysis of impairments and reversals recognised in 2015-16

	2015-16	2014-15
PROPERTY, PLANT AND EQUIPMENT IMPAIRMENTS AND REVERSALS TAKEN TO SOCI	TOTAL £000's	TOTAL £000's
Loss or damage resulting from normal operations	5	0
Total charged to Departmental Expenditure Limit	5	0
Other	817	4,060
Changes in market price	19,812	0
Total charged to Annually Managed Expenditure	20,629	4,060
Total impairments of property, plant and equipment charged to SoCI	20,634	4,060
NON-CURRENT ASSETS HELD FOR SALE – IMPAIRMENTS AND REVERSALS CHARGED TO SOCI		
Changes in market price	150	0
Total charged to Annually Managed Expenditure	150	0
Total impairments of non-current assets held for sale charged to SoCI	150	0
Total impairments charged to SoCI - DEL	5	0
Total impairments charged to SoCI - AME	20,779	4,060
Overall total impairments	20,784	4,060

16.2. Analysis of impairments and reversals recognised in 2015–16

2015–16 Events and circumstances giving rise to impairments	TOTAL		CHARGED TO REVALUATION	CHARGED TO EXPENDITURE
	£000's	£000's	£000's	£000's
An asset held for sale has been revalued by the District Valuer of the Valuation Office Agency to reflect current market value	150	0		150
Impairment resulted from the initial recognition of a building brought into use from assets under construction	385	0		385
Land, buildings and dwellings were revalued by the District Valuer of the Valuation Office Agency as at 1 April 2015 and 31 March 2016	28,246	8,434		19,812
Impairment resulted from evidence of physical damage to an asset – this affected an asset classified as plant and machinery	5	0		5
Reclassification of buildings from operational to non-operational has been revalued by the District Valuers of the Valuation Office Agency to reflect change in value	432	0		432
Total	29,218	8,434		20,784

2014–15 Events and circumstances giving rise to impairments	TOTAL		CHARGED TO REVALUATION	CHARGED TO EXPENDITURE
	£000s	£000s	£000s	£000s
Non operational buildings held for sale have been revalued by the District Valuer of the Valuation Office Agency to reflect the current market value	217	0		217
Reclassification of land from operational to non-operational has been revalued by the District Valuers of the Valuation Office Agency to reflect change in value	1,624	0		1,624
Operational buildings where there has been significant capital investment have been revalued by the District Valuer to reflect the current value	2,219	0		2,219
Total	4,060	0		4,060

17. Capital commitments

Contracted capital commitments at 31 March
not otherwise included in these financial statements:

	31 March 2016		31 March 2015	
	£000s	£000s	£000s	£000s
Property, plant and equipment		1,249		11,443
Total		1,249		11,443

18. Intra-Government and other balances

	CURRENT RECEIVABLES	NON-CURRENT RECEIVABLES	CURRENT PAYABLES	NON-CURRENT PAYABLES
	£000's	£000's	£000's	£000's
Balances with other central government bodies	1,962	0	8,917	0
Balances with local authorities	399	0	19	0
Balances with NHS bodies outside the departmental group	0	0	59	0
Balances with NHS bodies inside the departmental group	5,761	0	5,040	27,150
Balances with public corporations and trading funds	0	0	2,567	0
Balances with bodies external to government	9,912	0	38,226	294,435
At 31 March 2016	18,034	0	54,828	321,585

PRIOR PERIOD:				
Balances with other central government bodies	1,412	0	9,060	0
Balances with local authorities	990	0	46	0
Balances with NHS bodies outside the departmental group	0	0	60	0
Balances with NHS bodies inside the departmental group	6,947	0	3,353	9,500
Balances with public corporations and trading funds	0	0	2,282	0
Balances with bodies external to government	9,557	0	38,413	303,410
At 31 March 2015	18,906	0	53,214	312,910

19. Inventories

	DRUGS	CONSUMABLES	ENERGY	TOTAL
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	2,901	5,970	230	9,101
Additions	42,469	35,578	0	78,047
Inventories recognised as an expense in the period	(42,088)	(36,135)	(18)	(78,241)
Write-down of inventories (including losses)	0	(16)	0	(16)
Balance at 31 March 2016	3,282	5,397	212	8,891

20.1. Trade and other receivables

	CURRENT	
	31 MARCH 2016	31 MARCH 2015
	£000s	£000s
NHS receivables - revenue	3,584	6,541
NHS prepayments and accrued income	742	301
Non-NHS receivables - revenue	1,633	3,346
Non-NHS prepayments and accrued income	4,571	3,782
PDC dividend prepaid to DH	1,435	105
Provision for the impairment of receivables	(1,559)	(1,865)
VAT	1,962	1,412
Interest receivables	4	2
Other receivables	5,662	5,282
Total current receivables	18,034	18,906
Included in NHS receivables are prepaid pension contributions:	0	0

There are no non-current trade and other receivables.

The majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Included in the balance of NHS receivables is £1,152k (2014-15: £3,300k) due from Clinical Commissioning Groups.

20.2 RECEIVABLES PAST THEIR DUE DATE BUT NOT IMPAIRED	31 MARCH 2016	31 MARCH 2015
	£000s	£000s
By up to three months	331	357
By three to six months	3	69
By more than six months	77	572
Total	411	998

This represents balances past their due date but not impaired within other trade receivables. These balances have been assessed for recoverability and the Trust believes that their credit quality remains intact. The Trust does not hold collateral over these balances.

20.3. PROVISIONS FOR IMPAIRMENT OF RECEIVABLES	2015-16	2014-15
	£000s	£000s
Balance at 1 April 2015	(1,865)	(1,722)
Amount written off during the year	732	704
Amount recovered during the year	586	35
(Increase)/decrease in receivables impaired	(1,012)	(882)
Balance at 31 March 2016	(1,559)	(1,865)

Trade receivables are reviewed for impairment on an individual basis, depending on the size of the receivable and the period for which it is overdue. Where trade receivables are estimated to be less than their carrying values, provisions have been made to write them down to their estimated recoverable amounts.

21. Cash and Cash Equivalents

	31 MARCH 2016	31 MARCH 2015
	£000s	£000s
OPENING BALANCE	701	2,730
Net change in year	381	(2,029)
Closing balance	1,082	701
Made up of		
Cash with Government Banking Service	1,002	665
Commercial banks	74	33
Cash in hand	6	3
Cash and cash equivalents as in statement of financial position and statement of cashflows	1,082	701
Third Party Assets – Monies not included above	1	2

22. Non-current assets held for sale

	LAND	DWELLINGS	TOTAL
	£000s	£000s	£000s
BALANCE AT 1 APRIL 2015	5,400	0	5,400
Plus assets classified as held for sale in the year	737	593	1,330
Less assets sold in the year	(4,330)	(593)	(4,923)
Less impairment of assets held for sale	(150)	0	(150)
Balance at 31 March 2016	1,657	0	1,657
Balance at 1 April 2014	3,052	78	3,130
Plus assets classified as held for sale in the year	2,400	0	2,400
Less assets sold in the year	(52)	(78)	(130)
Balance at 31 March 2015	5,400	0	5,400
Revaluation reserve balances in respect of non-current assets held for sale were:	£000s		
At 31 March 2016	1,577		
At 31 March 2015	4,603		

23. Trade and other payables

	CURRENT	
	31 MARCH 2016	31 MARCH 2015
	£000s	£000s
NHS payables - revenue	3,568	2,275
NHS payables - capital	3	0
NHS accruals and deferred income	519	138
Non-NHS payables - revenue	12,496	12,397
Non-NHS payables - capital	5,365	3,237
Non-NHS accruals and deferred income	13,593	15,604
Social security costs	2,527	2,521
Accrued Interest on DH Loans	25	0
Tax	2,643	2,825
Other	3,928	3,822
Total current payables	44,667	42,819
Included above: Outstanding pension contributions at the year end	3,747	3,711

In 2015-16 two areas of non-operational land were sold. Ten dwellings and their associated land were reclassified as assets held for sale and were all sold within the year. The Trust has option agreements in place to sell two of the remaining land areas and expects to complete the sales during 2016-17.

In 2014-15 a non-operational building and its associated land and two other areas of non-operational land were reclassified as assets held for sale. The assets were identified as being surplus to requirements. There were no gains or losses on recognition of assets being classified as held for sale.

There are no non-current trade and other payables. Trade payables are generally settled on 30 day terms and are not interest bearing unless a supplier makes a claim and has grounds to under The Late Payment of Commercial Debts (Interest) Act 1998. In 2015-16 £93 (2014-15: £30) interest for late payments was paid during the year. Accruals and deferred income are not interest bearing.

24. Borrowings

	CURRENT		NON-CURRENT	
	31 MARCH 2016		31 MARCH 2015	
	£000s	£000s	£000s	£000s
Loans from Department of Health	1,000		1,000	27,150
PFI liabilities: Main liability	8,725		8,888	294,114
Finance lease liabilities	436		507	321
Total	10,161		10,395	321,585
Total other liabilities (current and non-current)	331,746		323,305	

BORROWINGS/ LOANS - REPAYMENT OF PRINCIPAL FALLING DUE IN:	31 MARCH 2016		31 MARCH 2016	
	DEPARTMENT OF HEALTH - CAPITAL LOAN	DEPARTMENT OF HEALTH - INTERIM REVENUE LOAN	31 MARCH 2016 OTHER	31 MARCH 2016 TOTAL
	£000s	£000s	£000s	£000s
0-1 Years	1,000	0	9,161	10,161
1 - 2 Years	1,000	0	8,954	9,954
2 - 5 Years	3,000	18,650	27,877	49,527
Over 5 Years	4,500	0	257,604	262,104
Total	9,500	18,650	303,596	331,746

The capital loan from the Department of Health is a fixed rate (2.98%) interest bearing loan repayable over 15 years. The expected date of settlement is 15 September 2025.

The interim revenue loan from the Department of Health is a fixed rate (1.5%) interest bearing loan repayable not later than 18 February 2019.

The finance lease liabilities and PFI liabilities are disclosed in notes 26 and 29 respectively.

25. Deferred income

	CURRENT	
	31 MARCH 2016	
	£000s	£000s
OPENING BALANCE AT 1 APRIL	1,689	1,586
Deferred revenue addition	888	1,114
Transfer of deferred revenue	(1,008)	(1,011)
Current deferred income at 31 March	1,569	1,689

There is no non-current deferred income.

“ District nurses listen and go out of their way to help. Suggest things that can help me, and when possible do that for me. I understand they are workers but to me were friends. ”

District Nurses

26.1. Finance lease obligations as lessee

Details of the PFI basis of accounting are excluded from this note and included in note 30.

The Trust uses finance leases or arrangements containing finance leases to acquire plant and equipment.

Where the implicit rate of interest cannot be determined, the long term real rate of interest, at the date of inception of the contract, has been applied. The long term real rate of interest has been sourced from Treasury interest rate tables.

	MINIMUM LEASE PAYMENTS		PRESENT VALUE OF MINIMUM LEASE PAYMENTS	
	31 MARCH 2016 £000s	31 MARCH 2015 £000s	31 MARCH 2016 £000s	31 MARCH 2015 £000s
AMOUNTS PAYABLE UNDER FINANCE LEASES (OTHER)				
Within one year	446	526	436	507
Between one and five years	328	579	321	571
Less future finance charges	(17)	(27)		
Minimum lease payments /present value of minimum lease payments	757	1,078	757	1,078
INCLUDED IN:				
Current borrowings			436	507
Non-current borrowings			321	571
			757	1,078
FINANCE LEASES AS LESSEE			31 March 2016	31 March 2015
Contingent rents recognised as an expense			£000s	£000s
			(427)	(397)

26.2. Finance Lease Commitments

The Trust has entered into an arrangement containing finance leases whereby assets will be made available for use for a series of phased implementations. Finance leases are included in note 26 for completed phases and a commitment is disclosed for incomplete phases. The remaining commitments are phased over a period of 4 years and the minimum payments total £1,646k (2014-15: £1,875k) and excludes PFI.

The total obligation for the PFI finance lease is disclosed in note 29.

“ I cannot begin to thank the staff...enough. They have and are continuing to provide the most expert and compassionate care to my son. I will never ever forget the kindness they have shown our entire family. **”**

Children's Regional Burns Unit at Pinderfields

27. Provisions

	TOTAL	EARLY DEPARTURE COSTS	LEGAL CLAIMS	OTHER	REDUNDANCY
	£000s	£000s	£000s	£000s	£000s
BALANCE AT 1 APRIL 2015	8,111	4,093	515	3,460	43
Arising during the year	1,394	317	473	604	0
Utilised during the year	(984)	(431)	(229)	(281)	(43)
Reversed unused	(988)	(89)	(120)	(779)	0
Unwinding of discount	78	48	0	30	0
Change in discount rate	(34)	(13)	0	(21)	0
Balance at 31 March 2016	7,577	3,925	639	3,013	0

EXPECTED TIMING OF CASH FLOWS:

No later than one year	1,641	434	639	568	0
Later than one year and not later than five years	2,193	1,737	0	456	0
Later than five years	3,743	1,754	0	1,989	0

AMOUNT INCLUDED IN THE PROVISIONS OF THE NHS LITIGATION AUTHORITY IN RESPECT OF CLINICAL NEGLIGENCE LIABILITIES:

As at 31 March 2016	153,310
As at 31 March 2015	97,592

28. Contingencies

CONTINGENT LIABILITIES	31 MARCH 2016	31 MARCH 2015
	£000s	£000s
NHS Litigation Authority legal claims	(165)	(172)

Contingent assets

As at the 31 March 2016, the Trust has two option agreements in respect of potential land sales in 2016-17. The values are not disclosed as this may prejudice any future sale values.

29. PFI – additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

	2015-16	2014-15
	£000s	£000s
CHARGES TO OPERATING EXPENDITURE AND FUTURE COMMITMENTS IN RESPECT OF ON-SOFP AND OFF-SOFP PFI		
Service element of on-SOFP PFI charged to operating expenses in year	22,091	23,923
Total	22,091	23,923

PAYMENTS COMMITTED TO IN RESPECT OF THE SERVICE ELEMENT OF ON-SOFP PFI		
No later than one year	23,583	26,307
Later than one year, no later than five years	106,865	112,817
Later than five years	970,946	1,158,119
Total	1,101,394	1,297,243

The commitment assumes inflation at 2.5% (2014-15: 2.5%) for the remaining life of the contract. This is the rate used in the contractors model.

	2015-16	2014-15
	£000s	£000s
IMPUTED "FINANCE LEASE" OBLIGATIONS FOR ON-SOFP PFI CONTRACTS DUE		
No later than one year	18,812	19,270
Later than one year, no later than five years	73,936	74,016
Later than five years	362,533	381,264
Subtotal	455,281	474,550
Less: Interest Element	(152,442)	(162,825)
Total	302,839	311,725

	2015-16	2014-15
	£000s	£000s
PRESENT VALUE IMPUTED "FINANCE LEASE" OBLIGATIONS FOR ON-SOFP PFI CONTRACTS DUE ANALYSED BY WHEN PFI PAYMENTS ARE DUE		
No later than one year	8,725	8,887
Later than one year, no later than five years	36,510	35,411
Later than five years	257,604	267,427
Total	302,839	311,725

	2015-16
	£000s
NUMBER OF ON-SOFP PFI CONTRACTS	
Total number of on-SOFP PFI contracts	1

Number of on-SOFP PFI contracts which individually have a total commitment value in excess of £500m

	2015-16	2014-15
	£000s	£000s
FAIR VALUE OF THE PFI LIABILITY – THE ESTIMATE OF THE FAIR VALUE OF THE PFI LIABILITY DUE		
Implicit interest rate	3.33%	3.33%
Interest rate at 31 March	1.97%	2.06%
Carrying value at 31 March	302,839	311,725
Fair value at 31 March	354,466	362,465
	(51,627)	(50,740)

The fair value has been obtained by applying the National Loans Fund interest rate at 31 March assuming a fixed repayment amount over 27 years (2014-15: 28 years).

30. Impact of IFRS treatment – current year

The information below is required by the Department of Heath for budget reconciliation purposes.

	2015-16	2014-15
	Expenditure £000s	Expenditure £000s
REVENUE COSTS OF IFRS: ARRANGEMENTS REPORTED ON-SOFP UNDER IFRIC12 (PFI)		
Depreciation charges	5,150	6,464
Interest expense	10,247	10,483
Impairment charge – AME	21,254	0
Other expenditure	23,258	25,062
Impact on PDC dividend payable	(1,916)	(1,972)
Total IFRS expenditure (IFRIC12)	57,993	40,037
Revenue consequences of PFI schemes under UK GAAP/ESA95 (net of any sublease revenue)	40,583	40,886
Net IFRS change (IFRIC12)	17,410	(849)

CAPITAL CONSEQUENCES OF IFRS: PFI AND OTHER ITEMS UNDER IFRIC12

UK GAAP capital expenditure 2015-16 (reversionary interest)	2,387	2,305
--------------------------------------------------------------------	-------	-------

	2015-16	2015-16
	Income/ Expenditure IFRIC 12 YTD	Income/ Expenditure ESA 10 YTD
	£000s	£000s
REVENUE COSTS OF IFRS12 COMPARED WITH ESA10		
Depreciation charges	5,150	
Interest expense	10,247	
Impairment charge – AME	21,254	
OTHER EXPENDITURE		
Service charge	15,956	40,583
Contingent rent	6,098	
Lifecycle	1,204	
Impact on PDC dividend payable	(1,916)	
Net revenue cost under IFRIC12 vs ESA10	57,993	40,583

31. Financial Instruments

31.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust drew down a £15m capital loan on 15 December 2010, repayable over 14 years and 9 months. The interest rate is fixed, for the life of the loan, at the National Loans Fund rate applicable on the date that the loan documents were issued by the Department of Health. The interest rate charged is 2.98% based on an issue date of 24 November 2010.

The Trust accessed an interim revenue loan from the Department of Health. It is a fixed rate (1.5%) interest bearing loan repayable no later than 18 February 2019.

The Trust invests cash in other liquid resources at the National Loans Fund rate. The Trust is therefore susceptible to movements in current interest rates.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

		LOANS AND RECEIVABLES
		£000s
31.2. FINANCIAL ASSETS		
Receivables – NHS		4,326
Receivables – non-NHS		3,453
Cash at bank and in hand		1,082
Total at 31 March 2016		8,861
Receivables – NHS		6,842
Receivables – non-NHS		3,758
Cash at bank and in hand		701
Total at 31 March 2015		11,301

		OTHER
		£000s
31.3. FINANCIAL LIABILITIES		
NHS payables		3,637
Non-NHS payables		35,860
Other borrowings		28,150
PFI and finance lease obligations		303,596
Total at 31 March 2016		371,243
NHS payables		2,413
Non-NHS payables		35,060
Other borrowings		10,500
PFI and finance lease obligations		312,805
Total at 31 March 2015		360,778

The fair value of financial liabilities is not materially different to the carrying value. The fair value of the PFI liability is in note 29.

32. Events after the end of the reporting period

There are no events after the reporting period.

33. Related party transactions

Details of related party transactions are as follows:

2015-16	PAYMENTS TO RELATED PARTY	RECEIPTS FROM RELATED PARTY	AMOUNTS OWED TO RELATED PARTY	AMOUNTS DUE FROM RELATED PARTY
	£000s	£000s	£000s	£000s
Dr David Hicks, Associate Non-Executive Director, specialist advisor to the Care Quality Commission	112	0	0	0
Nisreen Booya, Associate Non-Executive Director from 1 June 2015, specialist advisor to the Care Quality Commission				
Dr David Hicks, Associate Non-Executive Director, Interim Deputy Medical Director at Rotherham NHS Foundation Trust	3	36	1	10
Nisreen Booya, Associate Non-Executive Director from 1 June 2015, Associate Consultant Advisor to Grant Thornton	27	0	12	0
Nisreen Booya, Associate Non-Executive Director from 1 June 2015, husband is a consultant surgeon at Calderdale and Huddersfield NHS Foundation Trust	1,045	333	115	26
Julie Bolus, Interim Director of Staff and Patient Engagement from 11 January 2016, Director to Bolus Consulting Limited	32	0	12	0
Sally Napper, Chief Nurse from 5 May 2013, sister is an associate at Hempsons Solicitors	10	0	0	0
Stephen Eames, Chief Executive, Interim Chief Executive (part-time) to North Cumbria University Hospitals NHS Trust	1	42	0	42
Board Members Corporate Trustee to the Mid Yorkshire Hospitals NHS Trust Charitable Fund	0	543	0	133

2014-15	PAYMENTS TO RELATED PARTY	RECEIPTS FROM RELATED PARTY	AMOUNTS OWED TO RELATED PARTY	AMOUNTS DUE FROM RELATED PARTY
	£000s	£000s	£000s	£000s
Dr David Hicks, Associate Non-Executive Director, specialist advisor to the Care Quality Commission	103	0	0	0
Sally Napper, Chief Nurse from 5 May 2013, sister is an associate at Hempsons Solicitors	27	0	0	0
Robert Flack, Director of Operations – Community Services from 1st February 2014. Left 30th September 2014, Chief Executive at Locala Community Partnerships	231	252	7	37
Board Members Corporate Trustee to the Mid Yorkshire Hospitals NHS Trust Charitable Fund	0	558	0	33

The Department of Health is regarded as a related party. During the year, Mid Yorkshire Hospitals NHS Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are NHS England, NHS Wakefield CCG, NHS Kirklees CCG, NHS Leeds CCG.

Services were also purchased from: Yorkshire Ambulance Service NHS Trust, Leeds Teaching Hospitals NHS Trust, National Blood and Transplant Authority, NHS Litigation Authority, NHS Professionals.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Wakefield Metropolitan District Council and Kirklees Council.

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity (The Mid Yorkshire Hospitals NHS Trust Charitable Fund), it effectively has the power to exercise control so as to obtain economic benefits. The transactions are immaterial in the context of the group and transactions have not been consolidated. The transactions with the charity are disclosed in the table above and the audited accounts of The Mid Yorkshire Hospitals NHS Trust Charitable fund are included in the Trust's Annual Report.

34. Losses and special payments

THE TOTAL NUMBER OF LOSSES CASES IN 2015-16 AND THEIR TOTAL VALUE WAS AS FOLLOWS:	TOTAL VALUE OF CASES	TOTAL NUMBER OF CASES	THE TOTAL NUMBER OF LOSSES CASES IN 2014-15 AND THEIR TOTAL VALUE WAS AS FOLLOWS:	TOTAL VALUE OF CASES	TOTAL NUMBER OF CASES
	£s			£s	
Losses	750,960	1,382	Losses	760,383	1,442
Special payments	417,354	162	Special payments	877,474	125
Total losses and special payments	1,168,314	1,544	Total losses and special payments	1,637,857	1,567

35. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

35.1. Breakeven performance

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
	£000s									
Turnover	309,100	390,354	397,006	395,875	430,417	456,954	460,792	456,810	483,428	482,792
Retained surplus/(deficit) for the year	(11,688)	767	32,706	(38,196)	(59,654)	397	(36,855)	(19,472)	(13,241)	(41,166)
Adjustment for:										
Timing/non-cash impacting distortions:										
2007/08 PPA (relating to 1997/98 to 2006/07)	0									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			3,845	35,699	62,391	(18,816)	14,870	320	4,060	20,784
Adjustments for impact of policy change re donated/government grants assets						(89)	146	(19)	125	(148)
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				3,368	(1,754)	(709)	0	0	0	0
Other agreed adjustments	1,988	0	0	0	0	0	0	0	0	0
Break-even in-year position	(9,700)	767	36,551	871	983	(19,217)	(21,839)	(19,171)	(9,056)	(20,530)
Break-even cumulative position	(63,428)	(62,661)	(26,110)	(25,239)	(24,256)	(43,473)	(65,312)	(84,483)	(93,539)	(114,069)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

MATERIALITY TEST (I.E. IS IT EQUAL TO OR LESS THAN 0.5%):	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
	%	%	%	%	%	%	%	%	%	%
Break-even in-year position as a percentage of turnover	-3.14	0.20	9.21	0.22	0.23	-4.21	-4.74	-4.20	-1.87	-4.25
Break-even cumulative position as a percentage of turnover	-20.52	-16.05	-6.58	-6.38	-5.64	-9.51	-14.17	-18.49	-19.35	-23.63

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.



35.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

35.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	17,232	5,089
Cash flow financing	16,681	5,035
Finance leases taken out in the year	229	0
External financing requirement	16,910	5,035
(Over)/underspend against EFL	322	54

35.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	22,357	19,300
Less: book value of assets disposed of	(4,947)	(196)
Less: donations towards the acquisition of non-current assets	(409)	(158)
Charge against the capital resource limit	17,001	18,946
Capital resource limit	17,843	19,678
(Over)/underspend against the capital resource limit	842	732

36. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 MARCH 2016 £000s	31 MARCH 2015 £000s
Third party assets held by the Trust	1	2

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE MID YORKSHIRE HOSPITALS NHS TRUST

We have audited the financial statements of Mid Yorkshire Hospitals NHS Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes.

These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Board of Directors of The Mid Yorkshire Hospitals NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of financial statements which give a true and fair view.

Our responsibility is to audit and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error.

This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- Give a true and fair view of the financial position of the Trust as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and
- Have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Opinion on other matters

We are required to report to you if:

- In our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- We refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- We issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- We make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or

We have nothing to report in respect of the above responsibilities.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE MID YORKSHIRE HOSPITALS NHS TRUST CONTINUED

Other matters on which we report by exception: Adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

Basis for qualified conclusion

The Trust's reported deficit position for 2015/16 was £20.5 million, which is a deterioration compared to the reported deficit for 2014/15 of £9.0m.

The final outturn for 2015/16 included £5 million of funding transferred from capital to revenue as a form of additional non-recurrent support from the Department of Health. The reported deficit for 2014/15 included non-recurrent support of £8 million from the Department of Health.

The deficit for the year is 39 per cent higher than the £14.8 million deficit originally planned. The deterioration in the Trust's financial outturn year-on-year was largely due to unplanned increases in expenditure (particularly relating to agency staff costs) and the underachievement of the cost improvement programme (CIP) as well as reduction in planned income due to lower than planned patient care activity.

Furthermore, we have concerns regarding the arrangements put in place by the Trust to devise a sustainable plan for service delivery in the future. We note that the Trust has begun to explore a number of solutions to reducing its cost base, under new leadership. However, these plans have not yet been fully developed into a clear and robust strategy, supported by sustainable operational plans and financial forecasts, to which the Trust Board and external stakeholders have committed.

Finally, due to a combination of systemic issues, rising demand and financial constraints, the Trust has struggled to hit key national performance targets over the past two years. Operating in a deficit position, with resources severely constrained, makes it difficult for the Trust to put in place measures to remediate these issues.

The Trust received a follow-up visit from the Care Quality Commission (CQC) in June 2015 following a 'Requires Improvement' rating from the previous visit. The reports arising from these visits were published in December 2015 and showed that the Trust remained rated as 'Requires Improvement' although it was acknowledged there had been improvements in some areas.

The issues set out above are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

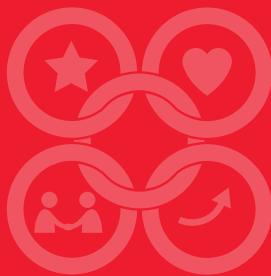
Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Mid Yorkshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

We certify that we have completed the audit of the accounts of The Mid Yorkshire Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Smith,
for and on behalf of KPMG LLP,
Statutory Auditor
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE
United Kingdom
2 June 2016



CHAPTER EIGHT LOOKING AHEAD

The Health Economy five year strategy, 'Meeting the Challenge', is entering year three, involving significant clinical service reconfiguration.

The Trust's overarching strategy 'Striving for Excellence' aims for the Trust to be known as an organisation which delivers the highest standards of safe, effective services with a strong customer focus. The Trust values - caring, respect, high standards and improving – are being embedded throughout the organisation.

The Trust recognises the value of staff and patient engagement in achieving its goals. The Trust vision was developed through consultation with patients and their families, combining them with the views and priorities of our staff and other key stakeholders. This is reflected within our vision:

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

The Trust's strategic aims are detailed below:

OUR FIVE CORE STRATEGIC AIMS

1. Keep our patients safe
2. Become one of the best in the country
3. Live and grow within the resources we have
4. Develop one another to achieve the best for us and our patients
5. Surpass expectations and build on our reputation

The Trust is in the process of reviewing its future strategic direction for the next five years within the context of the Sustainability and Transformation Plan (STP). This is being done through board development sessions.

“ The food I've eaten this week has been exceptional...the quality 5 stars. The meals were always on time. Congratulations to the catering team for their hard work. **”**

Catering at Pinderfields

KEY PRIORITIES FOR 2016/17

The Trust's 2016/17 Operating Plan identifies a number of key priorities aligned to the Trust's strategies. These are summarised in the table below:

STRATEGIC OBJECTIVE	PRIORITIES IN 2016/17
Keep our patients safe	1. Reduce hospital acquired infections 2. Reduce mortality specifically focusing on AKI and Sepsis 3. Increase 'Harm Free Care' through reducing falls and improving Fractured Neck of Femur care
Become one of the best in the country	1. Better access to services through improved performance in key areas 2. Referral to Treatment waiting times 3. Time in Emergency Department 4. Cancer Treatment waiting times 5. Diagnostic waiting times
Live and grow within the resources we have	1. Ensure activity is delivered to meet income expectations 2. Reduce agency spend significantly 3. Improve theatre efficiency and productivity 4. Utilise effective procurement to reduce costs 5. Deliver service efficiencies through CIP and Acute Hospital Reconfiguration 6. Lever benefits of technical adjustments
Develop one another to achieve the best for us and our patients	1. Provide a positive working environment for staff 2. Improve workforce experience 3. Support managers to manage absence effectively 4. Address areas of low retention specifically within nursing 5. Effective recruitment campaigns to address key vacancies and broaden diversity within the workplace
Surpass expectations and build on our reputation	1. Develop our brand as an employer 2. Explore further Carter efficiency opportunities

A summary of the Operating Plan 2016/17 is available on the Trust's website.

CHAPTER NINE

CHARITABLE FUND REPORT

Every year we are always astounded by the generosity of our patients, relatives, staff and members of the public who devote their time and effort to fundraising for our hospitals. That generosity has helped us to purchase new equipment and improve facilities across our hospitals benefitting both our patients and staff.



CHAPTER NINE

CHARITABLE

FUNDS REPORT

CONTINUED

All charitable donations are managed by The Mid Yorkshire Hospitals NHS Trust Charitable Fund (Charitable Funds) which has a specific committee, in order to safeguard donations and legacies.

This is a registered charity (number: 1067163), which is governed by the laws applicable to Trusts i.e. The Trustee Act 2000 and the Charities Act 2011. The charity's mission is to raise income and manage funds to improve patient care either directly with patients or indirectly via staff. We do this by enhancing the services provided by the Trust and funding additional items of expenditure, which would not otherwise be funded by the NHS. As a result, the aims and objectives of Charitable Funds are very simple:

- To benefit patients or towards the benefit of staff, which will result in improved patient care.

We try wherever possible to respect the wishes of those making donations about funds going to specific areas or for a specific purpose and we also have general funds to support Trustwide services or services at specific hospitals.

Some of the items of expenditure can be small, others can be large. In 2016/2017 we have plans to increase the awareness of the charity and to launch a new fundraising drive in our local communities.

This includes employing a new member of staff to look at fundraising activities and campaigns. If you are interested in making a donation you can find out how to do this on the Trust website (www.midyorks.nhs.uk).



“The room has allowed us to stay with our mother 24 hours a day. There should be more of these facilities, they are wonderful.**”**

In 2015/16 some of the projects supported by the Trust's Charitable Funds included:

- Furnishing the Forget Me Not Suites based on Ward 43. The rooms create a therapeutic environment using artefacts and resources to help evoke memories from the past. This promotes a calming atmosphere where patients can relax and relieve anxieties. Families are actively encouraged, to sit with relatives living with dementia and use the many resources available. Comments on the facility include,
"This has been lovely; my father could watch his favourite opera singer right up to the end of his life."
"The room has allowed us to stay with our mother 24 hours a day. There should be more of these facilities, they are wonderful."
"This room has allowed us to stay and support our mum when she needed us most, thank you."
■ Continuing to support music therapy provided on Ward 4 at Dewsbury. Music Therapy is a unique part of a patient's rehabilitation which other therapies cannot provide. It gives patients the chance to experience feelings of normality and to keep in touch with their individuality and sense of identity. One particular overwhelmed with how the music therapy lifted his spirits.

A quote from this patient was:

"Alan played instruments that soothed my low mood and encouraged me to have a go at them, something that I would never have dreamed of before. He captured my interest and imagination, which I thought would never return after such a life changing episode and gave me new determination and goals to aim for".

- Funding a residential visit to Grange over Sands, for children with diabetes. For many of the children it was the first time being away from their family and having to manage diabetes on their own. Everyone had to test their blood sugar, carbohydrate count and give insulin - encouraging them to be independent and improving their knowledge and skills to manage diabetes. The environment was relaxed and fun for the children and they were able to help and support each other. Comments from children include,
"We have had a fantastic time", "can we stay longer next time", "I have made new friends", "I didn't know so many children have diabetes".

If you wish to know more about charitable funds, please feel free to contact a member of the Charitable Funds team on x53293 or email us on charitablefunds@midyorks.nhs.uk







MY ANNUAL REPORT
The Mid Yorkshire Hospitals NHS Trust

2015/2016

Dewsbury and District Hospital
Halifax Road, Dewsbury WF13 4HS

Pinderfields Hospital
Aberford Road, Wakefield WF1 4DG

Pontefract Hospital
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www.midyorks.nhs.uk