GENERAL MEETING OF THE COUNCIL OF GOVERNORS
OF BARNSLY HOSPITAL NHS FOUNDATION TRUST
5.30-7.30PM, 01 OCTOBER 2015
IN THE EDUCATION CENTRE, BARNSLY HOSPITAL

AGENDA

1. Apologies & Welcome

2. To invite comments from members of the public

3. To receive any declarations for interest for the meeting

4. To approve Minutes of the meeting held on 06 August 2015 Enc 4

5. To consider any matters arising from the Minutes of the last meeting

6. To receive an introduction to Human Factors Presentation
   – Mr W Robson, Patient Safety & Quality Lead

7. To receive a briefing on the role of the Director of Finance Verbal
   – Mr M Wright, Acting Director of Finance

8. To receive a report from the Trust’s Chairman, Mr S Wragg Enc 8

9. To approve the annual review of the Trust’s Constitution (stage 1) Enc 9
   – Ms A Keeney, Assoc Director of Corporate Affairs

10. To receive a report from the Lead Governor, Mr J Unsworth Enc 10

11. To receive an update report from the Trust’s Chief Executive, Ms D Wake Enc 11

12. To receive latest update report from the Council of Governors’ sub-groups Enc 12
    – Mr Ramsey (Chair, Quality & Governance) and
    – Mr D Brannan (Chair, Finance & Performance)

13. To receive and note reports from the Board of Governors Enc 13
    – latest Board agenda and Minutes (meetings held in public)
    – latest monthly integrated performance report

14. To consider issues raised by Governors
    – items highlighted in pre-meeting

15. Any other business, including
    – matters raised by the public
    – date of the next General Meeting, 03 December 2015, 5.30-7.30pm

Signed: ………………………
Chairman
COUNCIL OF GOVERNORS – OCTOBER 2015

MINUTES OF A GENERAL MEETING OF THE COUNCIL OF GOVERNORS
HELD ON 6 AUGUST 2015, 5.30PM
IN THE EDUCATION CENTRE, BARNSEY HOSPITAL

Present:
Mr P Ardron Partner Governor, Sheffield Universities
Mr D Brannan Partner Governor, Voluntary Action Barnsley
Mrs P Butting Public Governor, Barnsley Public Constituency
Mr A Conway Staff Governor, Volunteers
Mr A Dobell Public Governor, Barnsley Public Constituency
Mrs J Gaines Public Governor, Barnsley Public Constituency
Mr A Grierson Public Governor, Barnsley Public Constituency
Mr M Jackson Partner Governor, Joint Trade Unions Committee
Mr B F Leabeater Public Governor, Barnsley Public Constituency
Mr C Millington Partner Governor, Barnsley Clinical Commissioning Group
Ms G Morritt Staff Governor, Nursing & Midwifery
Ms A Moody Public Governor, Barnsley Public Constituency
Mrs J O’Brien Public Governor, Barnsley Public Constituency
Mr H Patel Public Governor, Barnsley Public Constituency
Cllr J Platts Partner Governor, Barnsley MBC
Mr J Ramsey Staff Governor, Non Clinical Support Staff
Mr R Raychaudhuri Staff Governor, Medical & Dental
Mr F Skorrow Public Governor, Barnsley Public Constituency
Mr T Smith Public Governor, Barnsley Public Constituency
Mr J Unsworth Lead & Public Governor, Barnsley Public Constituency
Mr Z Warraich Public Governor, Barnsley Public Constituency
Mr S Wragg Trust Chairman

In attendance:
Ms C Dudley Secretary to the Board
Mr J Fernandez Associate Director of HR&OD
Dr R Jenkins Medical Director
Mrs K Kelly Director of Operations
Ms E Parkes Director of Marketing & Communications *
Mr F Patton Non Executive Director
Ms T Rastall Head of Learning & Organisational Development *
Mr R Thomas Senior Manager, PriceWaterhouse Coopers (PwC)*
Mr M Wright Acting Director of Finance
* attended part of meeting

Apologies:
Ms R Hewitt Staff Governor, Clinical Support Services
Mr P Lleshi Partner Governor, Barnsley Together
Mrs D Murray Partner Governor, Barnsley College
Mrs C Robb Public Governor, Barnsley Public Constituency
Mrs L Sanderson Staff Governor, Nursing & Midwifery
Mr L Steenson Public Governor, Public Constituency O (out of area)
Mr D Thomas Public Governor, Barnsley Public Constituency
Ms D Wake Chief Executive
APOLOGIES & WELCOME

The Chairman welcomed Governors, Directors, and senior managers to the meeting. Mr Thomas (PwC) was also thanked for attending, to present the auditors’ report to the Governors on the Quality Account.

Apologies were noted as above.

COMMENTS FROM THE PUBLIC

None.

REGISTER OF INTERESTS & DECLARATIONS OF INTEREST

The meeting received and reviewed the latest Register of Interests. Mr Warraich declared his association with the Citizens Advice Bureau. Any further changes were requested to be reported to the Secretary to the Board direct. Governors were reminded of their responsibility to ensure any interests were declared in a timely manner.

In relation to the agenda for the meeting, the Chairman and Mr Patton declared their interest in reports to be submitted under agenda item 12 (Nominations Committee reports) as applicable. No other items were declared.

MINUTES OF LAST MEETING

The Minutes of the General Meeting held on 11 June 2015 were received and accepted as a true record.

MATTERS ARISING

The following updates were noted:

- CG 15/49 – Governor Lead roles
  As agreed at the last meeting, these were finalised in discussion between the Chairman and the nominees. Agreed posts were confirmed in the Chairman’s report (agenda item 9).

- CG 15/43 – Financial position/Budget
  It was clarified that the relationship with the Clinical Commissioning Group (CCG) remained strained. To support resolution on the contract, the Trust had formally requested to go to mediation, with Monitor and NHS England. The three main issues as yet unresolved were funding for assistive technology, resilience monies (winter) and 7-day services. It was emphasised that the two organisations continued to work well together in terms of daily operational issues and driving improvements in patient care across the community. Whilst it was important to secure the best possible resolution to the contract negotiations to support patient services at the hospital, the Board was equally keen to work with the CCG to build better relations going forward and even closer working on joint developments across the community. The Chairman and Dr Jenkins emphasised the pressures being faced by both parties and the need to ensure that the agreed contact worked well for all parties involved.

  In view of the continued need for escalation wards, expansion of 7-day services and expected winter pressures, Mr Smith queried the Trust’s plans for bed reductions. Mrs Kelly advised that the reductions would be
part of the Trust’s ongoing work around bed utilisation, which, based on clinical alignment of services and patient needs had identified a clear over provision of beds. The work had also shown the areas in which the reductions and some realignment, was needed. Pressures would remain in medicine with the continuing high need for these beds and patients who are deemed medically fit for discharge (ie not needing acute medical care) unable to be transferred to community services due to current limited capacity. In discussion Governors noted the continuing increased demands on beds throughout the year and the implications for local services such as those provided at Mount Vernon. The Trust was working with the CCG to support plans for more beds to be provided in the community and had offered to provide a step down ward within the hospital’s footprint albeit other avenues were being explored by the CCG as a first option.

Mr Wright and Mrs Kelly confirmed that the expected winter pressures would be factored into the Trust’s plans, albeit possibly at risk in terms of staffing, and also reiterated the Trust’s commitment to maintaining 7-day services even if at financial risk. The CCG’s work to reduce admissions via the Emergency Department (ED) and avoid overstays would be critical. The Chairman reminded members of the Health & Wellbeing Board’s plan to reduce unplanned admission by 2.9%; to date admissions had increased and this presented a financial risk to the CCG (who could be penalised for a community-wide increase) as well as to the Trust in terms of continued demands. The Trust faced additional financial pressures following recent receipt of a letter issued by Monitor and NHS England to all Trusts, instructing them to revisit their financial plans and try to identify further savings. For BHNFT the suggested additional saving had been valued at £3.3 million. This also reflected concerns previously discussed around the change in national focus - from quality to finance.

CG/15 59 MEMBERSHIP

Ms Parkes presented the latest update report on Membership. It was her first attendance with Governors since her return from maternity leave and she said that she was looking forward to getting to know and work with the newer Governors alongside the longer serving members of the Council. The report showed membership movement throughout the year, as reported in the Trust’s 2014/15 Annual Report & Accounts and also drew attention to the timetable for the annual Elections, due to start in September.

Looking at the membership figures it was clarified that the age bracket of 0-16 years reflected national reporting requirements; the Trust’s lower age limit was actually 14 years. It was also confirmed that the staffing figures were reported differently across several reports (actual numbers of staff in some and whole time equivalents in others); there had been little change in staffing numbers over the year and the Trust valued the low turnover rates in staff. Mr Brannan pointed out the need to address disparity in representation in some areas of public membership; this was agreed and would be given more focus in future work around membership.

Ms Parkes highlighted the nearly 90% uptake of the Hospital Newsletter now available through supermarkets and other outlets across the community as well as through the Barnsley Chronicle, feedback on which had been generally very positive. There had been reservations about the new
approach but Governors were pleased that it was proving to be successful. Mr Unsworth, Lead Governor, was conscious that the launch should have been preceded by a letter to all members, enabling them to retain the option to receive copies directly by post if preferred and he expressed some concern regarding the number of members who had reportedly not received the letter. It was confirmed that the letter had been sent; the gap possibly related to members not on the database at the time of mailout but anyone wishing to receive the newsletter by post could do so on request. Mr Unsworth also suggested, and it was agreed, that it might be useful to amend the membership application form to reflect this option too. Mrs Buttling had noted that the membership form was currently only available on the website as a pdf; Ms Parkes undertook to review this as it should be available for completion and return online. Mr Ramsey also suggested awareness of the newsletter and membership could be supported through links to social networking too, which Ms Parkes undertook to arrange.

CG/15 60 LISTENING INTO ACTION (LiA) (Presentation)

Ms Rastall joined the meeting and provided an interesting overview on the progress of the LiA programme (copy attached). She reminded Governors of the background to LiA and its intent to strengthen engagement with and listening to staff and drive forward initiatives proposed by staff and delivered by them, with executive support – to make a difference to patient care. She explained the structure to support LiA within the Trust and the two key questions asked of everyone involved: what would look great in our organisation and what is stopping us from doing it?

The presentation highlighted the key steps already progressed to date – including “big conversations” and development of enabler groups, and the focus on delivering quick wins some of which had already been actioned, such as the new name badges, a virtual recycling room, a campaign to encourage all managers to say “thank you” and introduction of communication books on every ward. Bigger actions would take longer but would be equally deliverable by the teams involved and committed to the programme.

A “patient conversation” was also scheduled for October, to ask patients for their views on what the Trust does well and what it could do better. The LiA teams would work on some of feedback from service users and invite them back again later on to tell them what had been done and ask them to “pass it on” (the next stage of the programme), sharing news of progress with their friends and families.

Governors welcomed the programme and the achievements to date, and were pleased to learn that the Care Quality Commission (CQC) had also been impressed in its recent inspection visit. Dr Jenkins and Ms Rastall explained that the effectiveness of the programme would be evaluated at the end of the year but it was stressed that it was not envisaged that that would be the end of the programme. The Chairman stressed that, from a Board’s perspective, the work would not stop there: BHNFT was a learning organisation and must continue to listen and respond to its staff.

CG/15 61 EXTERNAL AUDITORS’ REPORT ON QUALITY ACCOUNT (Enc 6)

Mr Thomas provided a presentation to expand upon the External Auditors’ report on the Trust’s Quality Account (QA), previously circulated to
Governors. As Auditors appointed by the Council of Governors, PwC was required to provide a report to Governors on an annual basis, to advise on the Trust's compliance with the QA reporting requirements as defined by Monitor. Mr Thomas reminded Governors how priorities and indicators were identified for review each year, changes to the reporting requirements year on year and the focus on the two mandated priorities as well as the local indicator selected by Governors – this year, it had been falls.

Mr Thomas affirmed that overall the Auditors’ opinion found the report content to be consistent with requirements, with no significant issues of concern. Changed requirements around one indicator (for referral to treatment times) had led to the Auditors noting a disclaimer as they had been unable to fully review the data. The Trust was by no means alone in this position for 2014/15 and had since changed its data recording for RTT outcomes to ensure that the statistics were retained month on month (previously the data had been overwritten with each month’s report). He also highlighted a smaller point on Cancer reporting, although this had not impacted on the overall opinion.

Looking ahead it was noted that Monitor’s guidance might change year on year which made it difficult to plan too far ahead for the 2015/16 QA, nevertheless Mr Thomas did recommend Governors to look at a different theme for their selected indicator next year, having used falls for two consecutive years (enabling follow up on progress). The impact of falls was widely discussed and it was agreed that the focus had been useful and had identified the need for continued focus, which Governors were aware was being driven by the Board and through the Quality & Governance Committee. Mr Jackson also emphasised the assessment carried out by nursing staff on every patient on admission, to help to identify those at risk of falls. Following considerable discussion, the report was accepted and Governors thanked Mr Thomas for an informative presentation and detailed report. The Chairman reinforced those thanks, particularly as Mr Thomas had changed his plans at relatively shortly notice to step in to cover for a colleague unable to attend the meeting and had travelled from Liverpool to do so.

CG/15 62  CHAIRMAN’S REPORT

The Chairman’s report on a range of activities carried out on behalf of the Trust since the last General Meeting and items of interest for the Governors was received and noted. Key points included:

- the resignation of Mr Scattergood before taking up his seat at the Council, due to unforeseen circumstances;
- thanks extended to Mrs Robb and Mrs Buttling for their excellent work to date as vice-Chairs for the Quality & Governance and Finance & Performance sub-groups respectively;
- launch of the annual elections to the Council of Governors, to commence on 24th September – the same date as the Trust's Annual General & Public Members’ Meeting.

Mr Dobell endorsed the tribute paid to staff in section 2.3; whilst working as a “mystery shopper” on a ward recently he had been surprised when the Lead Nurses on two areas had thanked him for visiting the area and had appreciated his attention. Governors supported Mr Dobell’s suggestion that it would be good to co-ordinate more opportunities for Governors to visit
clinical and other working areas and meet staff across the Trust; with the Secretary to the Board’s assistance, he would liaise with the Director of Nursing & Quality to progress this. The Chairman thanked all the Governors who had been involved with the mystery shopper programme; it had been extremely useful and would be repeated again later.

**CG/15 63  LEAD GOVERNOR’S REPORT**

(Enc 10)

Mr Unsworth’s report on his activities as Lead Governor over the past two months was also received and noted. He had used the report to illustrate a number of areas that Governors could be involved in both locally and nationally, including the recent CQC inspection and the handwashing audits. In his report Mr Unsworth had also sought support to ask the Chairman to liaise with his counterparts across the region to pursue options to restart the programme of regional Governor meetings. These had been a useful way of engaging with Governors from other Trusts and share learning. This was agreed and the Chairman affirmed that he would progress this at his next meeting with the Regional Chairs.

**CG/15 64  CHIEF EXECUTIVE’S REPORT**

(Enc 11)

In the CEO’s absence, Dr Jenkins presented her report. Of particular interest had been informal feedback from the recent CQC inspection and Dr Jenkins provided more information on this. Overall the CEO had received generally good feedback from the inspection team for both the planned and unannounced inspections. There would, however, be some areas for improvement, most of which the Trust should already be aware of, however, no further actions could be taken until the formal report was provided. Dr Jenkins also explained that once the formal report had been published a quality summit would be convened; these were usually Chaired by the CCG, with the Trust, Monitor and NHS England in attendance to discuss the report’s findings and develop joint planning going forward.

Mrs Kelly advised that, mirroring the Trust’s ethos of transparency, during the visit the CQC had been alerted to a serious incident regarding the outpatients review list. The CQC had been told of how the backlog of patients awaiting follow up outpatients appointments had occurred and had appreciated the Trust’s robust and swift actions put in place to minimise risks to patients, validate the numbers of patients affected and redress the position as quickly as possible. The Governors also appreciated the report and noted the actions in progress.

Mrs Buttling referred to the NHS Confederation Conference and requested more information about the benefits for attendees. Dr Jenkins had been one of the four delegates attending from the Trust; it had also been his first time at the national conference and he had found it a very useful experience. Attendance by others from different roles in the Trust (including the Chairman, which the Governors agreed was expected of the Chair of an FT) had enabled extensive networking and learning from the event, which had been subsequently shared with a wide range of colleagues. The Chairman expressed his appreciation of the event but also his dislike of the associated expenses of this and other national events, many of which seemed all too frequently to be based in London. The Trust would continue to monitor attendance and expenditure at national events and ensure value for money at all times. In terms of value for money, Mr Raychaudhuri queried the costs of the CQC inspection (involving teams of up to 40-50 inspectors) and was pleased to note it was not a direct cost to the Trust. There had been some
cost incurred albeit the Chairman was pleased to report that the hospitality, which the CQC had complimented the Trust on, had been provided courtesy of the Trust’s catering contractors. Dr Jenkins advised that there continued to be considerable debate nationally about the balance of expense vs benefit of the inspections.

Mr Unsworth welcomed the report on the Abscess Pathway Award obtained by the surgical team, which was an accolade to both the team and the hospital.

CG/15 65 NOMINATIONS COMMITTEE

(Enc 12a-c)

In view of the content of the reports, Mr Patton stepped out of the meeting during discussion of reports (a) and (c) and the Chairman stepped out during discussion of reports (b) and (c). In the Chairman’s absence, Mr Unsworth assumed the Chair.

a) Non Executive Directors’ year end review, 2014/15

The Chairman’s report on the Non Executive Directors’ (NEDs) continued good performance throughout 2014/15 was reviewed and approved. The Governors appreciated the continuing strength of the NED team.

b) Chairman’s year end review, 2014/15

Mr Patton presented the Nominations Committee’s report on the Chairman’s performance for 2014/15, the review of which had been jointly led by him, as Senior Independent Director, and Mr Unsworth, Lead Governor. Mr Patton highlighted the general consensus of another year of good performance from all of the reviews undertaken on the Chairman in the year (these had arisen for the Chairman and all of the NEDs, as part of the external governance reviews progressed in year and the independent 360 review requested by the Governors as part of the annual review process). There were areas for development and these were being actioned; the Chairman had also shared his personal development programme with Mr Patton, which Mr Patton assured the meeting was both robust and appropriate.

Governors agreed that the review process had perhaps been overly intensive this year although the rationale behind the repeated reviews was accepted. In terms of the ‘regular’ review process, Mr Patton believed that this had continued to improve and was now one of the best appraisal processes in the region.

Mr Patton also confirmed that the Chairman had fully achieved all but one of his objectives for 2014/15, the latter being the Board development programme – currently ongoing. The proposed objectives for 2015/16 for the Chairman were reviewed; it was noted that these were strongly aligned with the Trust’s business plan and would also feed into the objectives to be determined for each of the NEDs.

The Chairman’s year end review and his objectives for 2015/16 were approved.

c) Annual review of the terms & conditions of service for the Non Executive Directors (NEDs) and Chairman

Mr Unsworth reminded Governors of the Council’s responsibility to review the Terms & Conditions of Service for the NEDs and Chairman annually. The proposed 1% uplift had been the result of careful deliberations by the Nominations Committee and was approved unanimously by the Governors present.
The report on the latest meetings of the Governors’ sub-group – Finance & Performance (FPSG) and Quality & Governance (QGSG) was received and noted. Mr Brannan reminded Governors of forthcoming meeting dates and repeated the open invitation for them to come along on a one-off or regular basis to any of the sub-group meetings. In addition to the Governors’ discussions on a range of topics, they were also a valued opportunity to engage with the NEDs more directly, ask any questions of them and hold them to account for delivery of the business plan.

Cllr Platts noted the briefing received on patients with Parkinson’s Disease and plans to assist them with their medication needs whilst in hospital. She was aware of previous arrangements for nursing staff to use pocket watches to remind them of these patients’ particular needs and noted with interest the plan to use bedside clocks. Ms Morritt, who had devised the initiative, advised that associated training had also been developed to help promote wider awareness of these patients’ additional needs.

Mr Ramsey, Chair of QGSG, assured the meeting that the group would continue to drive Governor involvement with the quality and safety visits. Several had been cancelled recently during the preparation for the CQC visit but it was important that when they resumed, governors continued to be involved. He would also be seeking more robust feedback from the visits. The Chairman appreciated the Governors’ continued commitment to this work.

Mr Unsworth highlighted the latest in-house training session for Governors. These sessions had been reintroduced in January 2015 on a bi-monthly basis and were proving to work very well.

The FPSG had also started work on the Governors’ Annual Development Session (ADS). A range of dates had been proposed and it was agreed that the ADS should be scheduled for 17th November. To accommodate this, it was also agreed that the Governors’ training session on 5th November would be cancelled. Suggestions for themes for the ADS were invited and should be directed to Mr Brannan (Chair of FPSG), Mr Unsworth or Ms Dudley.

The agenda (August), Minutes (July) and latest integrated performance report as presented to the Board of Directors’ meeting held in public on 6th August 2015 were received and noted.

Mr Unsworth confirmed that matters raised at the Governors’ pre-meeting had all been raised and addressed in discussions during the General meeting.

There being no further business the meeting ended at 7.25pm. The date of the next meetings was confirmed for 1st October 2015, 5.30-7.30pm.
How Enabling Executive Conversations

- The 80 roles – to listen to what really matters to you
- Starting without delay and with direct involvement from staff to take action and improve the way things work around here
- Teams – with important outcomes in mind - who pioneer adoption of LiA to engage all the right people around changes to improve patient care

Within the first 6 months

What is Listening into Action (LiA)?

- A new way of working that mobilises staff around better patient care
- Not an ‘initiative’ - a fundamental shift in the way we work
- Enabling our teams to make improvements from the ‘inside-out’
- Giving ‘permission to act’ and simple processes to help
- Cutting out non value-add activity and unblocking the way
- Working together to do our best for patients
- Feeling valued, engaged, proud

Breaking paradigms, creating ambition, raising the bar
www.listeningintoaction.co.uk

Listening into Action

It’s about...

Five big LiA Staff Conversations with 80 people at each

Trust-wide ‘Quick Wins’ and ‘Unblock the Way’ schemes

'First 10' pioneering teams to prove it works

Within the first 6 months

Listening into Action

Clinical Teams

- Standardising debrief in theatres - LiA sponsor Jo Butterworth
- Reduction in Pressure ulcers - LiA sponsor Diane Wake
- Improve the diagnostic and intervention process - LiA sponsor Ben Brewis
- Reduce the number of late starts in out patients clinics - LiA sponsor Pat McLaren
- Create an estimated date of discharge leaflet on admission - LiA sponsor Karen Kelly
- Availability of dispensary TDD’s the day before discharge - LiA Sponsor Richard Jenkins
- Reduce the incidence of falls by 50% - LiA sponsor Heather McNair
- Optimising the endoscopy pathway, reduce DNA’s by 50% - LiA sponsor Dominic Bulman
- Standardising out of hours care for EPUA - LiA sponsor Josie Foster
- Friends and family test in A&E - LiA sponsors Pat McLaren and Darren Howlett
• Baseline Information team
• Review of the escalation bed system
• Bureaucracy Reduction group
• Medical Notes are everyone’s responsibility
• Communications – multiple streams

Quick wins completed so far

• Update the telephone directory
• Have a communications booklet on each ward
• Inclusive access to courses
• Hello my name is
• Name badges for all staff
• Spotlight on
CHAIRMAN’S REPORT

1. INTRODUCTION

1.1 This report is intended to give a brief outline of some of the work and activities undertaken as Trust Chairman over the past month and highlight a number of items of interest.

1.2 The items reported are not shown in any order of priority.

2. TRUST POSITION

2.1 We must continue to give confidence to the population of Barnsley and our key stakeholders that care will not be compromised and we will turn this current situation around. I will keep reiterating this message as I think it should be constantly in people’s minds. Whilst we are bringing about our return to stability, we must not compromise on quality of care and patient safety.

2.2 We must also give confidence to our staff that the Trust is doing everything it can to improve patient experience and the quality of care our patients receive. In addition we have to pay tribute to all our staff for the work they are doing to conceive new ideas to deliver better care, but also the work that they have done to bring our transformation to life.

2.3 We must, however, also be conscious of the continuing pressures on the hospital, including activity and cost improvement plans, to ensure we keep on track to return to financial balance as soon as possible whilst protecting the quality of our services for our patients and meaningful staff engagement.

2.4 Though it will be reported in other papers it is right for me to mention the lifting of the Section 111 governance licence condition by Monitor. By doing this Monitor have demonstrated confidence in our governance to the extent they no longer feel any need to manage performance in this area. This is testament to the hard work of all our staff in addressing our issues, however, we must regather our efforts and drive forward with our 2 and 5 year plan and ensure that Monitor can feel that their confidence is well placed.

3. COUNCIL OF GOVERNORS

3.1 Nominations Committee

The Committee met on 8 September to agree the process for the recruitment of a Non-Executive Director, as Linda Christon’s second term will be complete at the end of this year. Governors decided earlier this year that at the end of the second term all NEDs would have to seek re-appointment through the full appointment process, should they wish to serve for a third term. This appointment will be going out to advert shortly.
3.2 Constitutional review
As usual the Governors and Board have an important part to play in the Trust’s Constitutional review. The constitution review working group is being led by Angela Keeney, Associate Director of Corporate Affairs, supported by the Lead Governor and I, as well as a number of other Governors.

The working group has suggested a number of recommendations for minor changes to the Constitution, reported separately to both the Board and Council of Governors for consideration and support.

In their deliberations the working group also identified the need to revise the Governors’ meeting schedule for 2016 and this will be taken forward shortly.

3.3 Annual Elections
The annual elections for the Council of Governors are now underway, with six seats available in the Barnsley Public Constituency, one in the Non Clinical Support Staff Constituency, one in Medical & Dental Staff Constituency and one in Volunteers. Whilst it is hoped that all of the Governors currently in these seats will stand for re-election, the Trust is also keen to encourage interest from other members within these Constituencies.

Members have been invited to come along to the candidates’ workshops being held on 7th and 14th October, to learn more about the role of a governor and how to stand for election. More information is available on the Trust’s website, from the Governors’ office, and from the independent election scrutineers, UK-Engage. If you know someone who might be interested in joining the Council of Governors, please encourage them to come forward. Our Governors play an important role in the hospital’s development. Nominations must be submitted to UK-Engage before 5pm on Monday 2nd November 2015.

4. NEWS & EVENTS
4.1 As mentioned at the last Board meeting, the annual Volunteers Evening took place on 1st September, and I was joined at the event by the Chief Executive and Director of Nursing & Quality as well as my Non Executive Director colleague Suzy Brain-England. This is a special event in the Board’s calendar each year and is always well supported by Directors. It was, as always, a great opportunity for us to meet more of our terrific team of volunteers and tell them personally how very much they are appreciated, and to present a number of long service awards.

4.2 On 13 September I was pleased to be able to join staff from Sainsbury’s as they began their cycle ride to raise funds for the Tiny Hearts Charity appeal.

4.3 On 16 September I joined the Director of Nursing & Quality to present certificates to our Health Care Assistants on completion of their Infection Prevention and Control training.

4.4 On 17 September I attended the NHS Providers Chairs and Chief Exec Network meeting, the slides from this are appended to this report. Once again the main messages from this were about money, with the outgoing Chair/CEO of Monitor reflecting that the drive towards quality was not balanced against the finances. The news that the sector will see a significant deficit over the whole sector this year led to a prolonged discussion on what is expected in the comprehensive spending review. The tariff proposals for 2016/17 are not expected until late December, which is likely to hinder planning throughout the sector for the coming financial year.

4.5 On 23 September I attended an NHS Employers conference on equality and diversity in the workforce, and listened to presentations on how we might better use the diversity dividend in our organisations.

4.6 On 24 September saw our Annual General Members Meeting, which was well attended and the Board was closely challenged by our membership.
5. BARNSLEY HOSPITAL CHARITY

5.1 The generosity of local people and the support for our Charity continues to grow.

5.2 The Charity’s social media presence has continued to grow gradually. Although many posts still have a relatively low reach (this is in line with the ‘fans’ and is slowly increasing), the Charity continues to monitor insights to identify which posts work well, if there are specific times which work best etc, and to tweak the scheduling and posts. This month our maximum reach was 3,000; this was a post about our volunteer, Janet, who did a sponsored silence in aid of the Tiny Hearts Appeal.

5.3 Other successful posts included some fundraisers who did a sponsored walk. These further posts also received substantial interaction with the fans, with shares and comments engaging with the post which maximised the reach.

5.4 The Charity’s website has been updated with all news releases, which are also automatically published on the Charity’s Facebook and Twitter feeds. This not only keeps the Charity website active and increases its value in the search engines, but it instantly publishes new stories.

5.5 A full page was submitted for the latest BH News to promote the Charity and the Tiny Hearts Appeal.

5.6 The Barnsley Hospital Charity Lottery has continued to increase membership. A communications plan has been devised and implemented internally to promote this to all staff.

5.7 The donations for April-August total £104,824, which will continue to be used to benefit our patients and staff. In addition a generous legacy donation (reported several months ago) was also received in this period.

Stephen Wragg
CHAIRMAN
October 2015
REVIEW OF CONSTITUTION

1. INTRODUCTION

1.1. The Trust’s Constitution was last revised in 2013, at which time extensive changes were made to reflect new requirements under the Health & Social Care Act 2012 (to amend the National Health Service Act 2006 – the NHS Act), closer alignment with Monitor’s Model Constitution, changes in the local economy (including abolition of the Primary Care Trust and establishment of the Clinical Care Commissioning Group), the merging of the five ward-based Constituencies across the community into one Barnsley Public Constituency, and reduction in the size of the Council from 35 to 29 Governors.

1.2. In 2014, mindful of the significant changes made in the previous year, it was agreed that the revised Constitution was working well and should be allowed to continue without further amendment at that time.

1.3. As a matter of good practice and good governance, it was agreed that the Constitution should be subject to review in 2015 and this work has been led with input invited from the Board, Executive Team and Governors.

1.4. In accordance with the NHS Act (Section 37), any changes must be subject to approval of more than half of the Governors present and voting and more than half of the Board of Directors voting. If any amendments proposed would affect the powers and duties of the Council of Governors, they would also require the further approval by the FT’s membership at the next Annual Members Meeting.

1.5. Once approved, any changes would come into immediate effect.

1.6. Approval by Monitor, the sector regulator, is no longer a requirement but FTs are required to provide to Monitor “copies of any document establishing or amending its constitution within 28 days of being adopted” (Condition FT1, under section 6 of the Provider Licence).

1.7. As part of the work group’s discussions, but not directly Constitutional issues, it was identified that changes were also required for the Governors’ 2016 meeting schedule and the Governors’ Code of Conduct (to be updated to reflect in year changes). Work on these will commence shortly and be reported in November/December.

2. REVIEW PROCESS

2.1. An open invitation was extended for all Governors and Directors to be directly involved with or to submit comments to the Constitution review working group, to be led by Ms Keeney, Associate Director of Corporate Affairs.
2.2 The working group met on 8th September and was attended by the Chairman, the Lead Governor, 1 Staff Governor (Ms Morritt), 3 Partner Governors (Mr Brannan, Mr Millington and Cllr Platt) and the Secretary to the Board & Governors. Ms Keeney was unable to attend but has since progressed the proposals mooted.

3. PROPOSED CHANGES

3.1 A wide range of issues were considered, including:

3.1.1 Request to consider extending Governors’ terms of office from 3 to 4 years

*Not recommended:* this could not be progressed as it would contravene the NHS Act, which specifies a term of up to three years, after which Governors may seek a further term of office by election (but gives no collective maximum period)

3.1.2 Rescheduling elections, to be held every three years (all seats)

*Not recommended:* there was a consensus that this would leave the Council vulnerable to a loss of knowledge and experience if too many governors left or were not re-elected at the same time. It would also increase the risk of by-elections in the intervening period.

3.1.3 Change of election rules

*Recommended:* NHS Providers has issued some revised “model election rules”, which have been endorsed by Monitor. It is anticipated that these will help to simplify the process. However, the Trust’s current independent scrutineers have recommended some further aspects for consideration, which would support election by e-mail and other means. The working group was also conscious that the Trust was about to go to annual election (on 24th September) with the current Rules so would not wish any amendments to be made until 2016, after completion of this year’s elections. The working group emphasised that the Trust should retain the need for nominations to be supported by two members; whilst many FTs have abandoned this requirement, it was felt it was still a sensible step in the election process, pending complete checks on candidates carried out after election.

The working group would like the intent to change the Model Rules to be noted and supported and a draft wording is flagged up in the Constitution so that all proposed changes can be approved as soon as possible.

3.1.4 Revert Board numbers to previous levels

*Not recommended:* whilst there was no immediate need to increase the size of the Board in terms of Non Executive or Executive Directors, the option to vary the numbers of Non Executive Directors (and Executive Directors pro rata) could be of use in the future and it would be helpful to retain that flexibility.

3.1.5 Factor in “Fit & Proper Person Requirements” (FPPR)

*Recommended:* whilst FPPR is currently only applicable for Directors it had been agreed within the Trust that it should be equally valid for Governors. The Working Group recommends the need for Directors to meet FPPR criteria be stated in the Constitution (within section 9.6). For Governors it should be stated within the Code of Conduct for Governors, cross referenced to section 8.8.i(l) of the Constitution.
3.1.6 **Remove reference to “the initial Chief Executive”**  
(section 9.5.2, final sentence)  
*Recommended*: This was applicable at the time of authorisation only and should be removed.

3.1.7 **Enable Staff Governor to stand as Lead Governor**  
*Not recommended*: Section 8.5.5 of the Constitution stipulates that a lead governor shall be appointed from among the Public Governors. Whilst no legislation or guidance was identified that would preclude a Staff Governor being appointed, it was acknowledged that the role of a Staff Governor is different to that of a Public or Partner Governor and carries some unique challenges. In the role of a Lead Governor, a Staff Governor could inadvertently face considerable conflicts of interest and added pressures. It was acknowledged that public perception could also be a factor.

3.1.8 **Modify the approval requirements for Governors to approach the media to ensure that it referred to Trust-related matters only**  
*Not recommended*: Although this was raised by a Public Governor, the working group could not identify it as a Constitution issue (Annex 4 refers). Guidance on contacting the press or other media is contained within the Governors’ Code of Conduct (Clause 10); it requires that “Governors should consult the Chairman/Secretary to the Board/Associate Director of Communications before speaking or writing to the media on matters relating to the Trust”, and seemed reasonable.

### 4. RECOMMENDATIONS

4.1 The Author is mindful that (a) this report will be presented to both the Council of Governors and Board of Directors on the same day – ie 1st October, allowing little reporting between the two bodies if any other points are raised at either meeting, (b) a copy of the revised Constitution is required to be submitted to Monitor 28 days after approval, and (c) by 1st October, the Trust’s annual elections will have commenced and proposed changes for the election rules will not have been properly explored with either the independent scrutineers or the working group.

4.2 **It is recommended that**

i) the Council and Board consider and endorse the recommendations outlined above at 3.1.3, 3.1.5 and 3.1.6 in principle – as shown in the draft revised Constitution attached.

ii) the proposed new election rules be reviewed with the independent scrutineers in October, and proposed changes subsequently considered by the working group, and

iii) the Constitution be re-presented for final approval at the Board and Governors’ meetings in December.

---

Angela Keeney  
Assoc Director of Corporate Affairs  
September 2015
BARNESLEY HOSPITAL NHS FOUNDATION TRUST
(A Public Benefit Corporation)

Constitution

June 2013 (September) December 2015

TABLE OF CONTENTS

1 Definitions 3
2 Name 4
3 Principal Purpose 4
4 Other Purposes 5
5 Powers 5
6 Framework 5
7 Members 5
8 Council of Governors 7
9 Board of Directors 14
10 Meetings of Directors 17
11 Conflicts of Interest of Directors 17
12 Registers 18
13 Public Documents 19
14 Auditor 20
15 Accounts 20
16 Annual Reports, Forward Plans and Non-NHS Work 21
17 Presentation of the Annual Accounts and Reports to the Governors and Members 22
18 Indemnity 22
19 Instruments etc 22
20 Dispute Resolution Procedures 22
21 Amendment of the Constitution 23
22 Mergers, etc and Significant Transactions 23

Annex 1 Public Constituencies of the Trust 24
Annex 2 Staff Constituencies of the Trust 25
Annex 3 Composition of the Council of Governors 26
Annex 4 Practice and Procedure for Meetings 27
Annex 5 Conduct of Elections 30
Annex 6 Governors and Directors: Communication and Conflict 53
Annex 7 Register of Directors and Governors Interests 56
Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act as amended by the Health and Social Care Act 2012.

Words importing the masculine gender only shall include the feminine gender, words important the singular shall import the plural and vice versa.

References in this Constitution to legislation include all amendments, replacements, or re-enactments made.

References to legislation include all regulations, statutory guidance or directions.

Headings are for ease of reference only and are not to affect interpretation.

1. **DEFINITIONS**

1.1 In this Constitution:

- "2006 Act" means the National Health Service Act 2006;
- "2012 Act" means the Health and Social Care Act 2012;
- "Accounting Officer" means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
- "Annual Members Meeting" is defined in paragraph 7.6 of the Constitution;
- "Area of the Trust" means the area specified in Annex 1 and the attached map;
- "Board of Directors" means the board of directors as constituted in accordance with this Constitution;
- "Chairman" means the chair of the Trust (the term is not gender specific);
- "Constitution" means this constitution together with the annexes attached hereto;
- "Director" means a director on the Board of Directors;
- "Financial Year" means:
  (a) the period beginning with the date on which the Trust is authorised and ending with the next 31st March; and
  (b) each successive period of twelve months beginning with 1st April.

- "Fit and Proper Person Requirements (FPPR)" means those requirements stipulated under Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations);
- "Council of Governors" means the Council of Governors as constituted in accordance with this Constitution. This is the body referred to as the Council of Governors in the 2006 Act, as amended by the 2012 Act;
- "Licence" means the Trust's licence granted by Monitor under the 2012 Act;
- "Local Authority Governor" means a member of the Council of Governors appointed by a local authority whose area includes the whole or part of an area specified in Annex 1 as an area for a public constituency;
- "Member" means a member of the Trust;
- "Monitor" means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;
- "Partnership Governor" means a member of the Council of Governors appointed by a partnership organisation specified in Annex 3;
- "Public Governor" means a member of the Council of Governors elected by the members of the relevant class within the public constituency;
- "Secretary" means the secretary of the Trust or any other person appointed to perform the duties of the secretary of the Trust, including a joint, assistant or deputy secretary;
- "Staff Governor" means a member of the Council of Governors elected by the members of the relevant class of the staff constituency;
- "Staff Class" means those classes of the staff constituency set out in Annex 2;
- "Trust" means the Barnsley Hospital NHS Foundation Trust.

2. **NAME**

2.1 The name of this Trust is to be Barnsley Hospital NHS Foundation Trust.

3. **PRINCIPAL PURPOSE**

3.1 The Trust's principal purpose is the provision of goods and services for the purposes of the health service in England.
3.2 The Trust does not fulfil its principal purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

4 OTHER PURPOSES

4.1 The Trust may provide goods and services for any purposes related to:

4.1.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

4.1.2 the promotion and protection of public health.

4.2 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

5 POWERS

5.1 The Trust is to have all the powers of an NHS foundation trust set out in the 2006 Act subject to any restrictions in its Licence.

6 FRAMEWORK

6.1 A Board of Directors will be responsible for the management of the Trust and a Council of Governors will ensure that the Trust takes account of local needs and complies with the terms of its legal framework. Members of the Council of Governors will be drawn from those membership constituencies described in paragraph 7 of this Constitution and representatives from organisations closely connected with the services and goods of the Trust.

7 MEMBERS

7.1 The Trust is to have 2 membership constituencies, namely:

(a) a "public constituency"; and

(b) a "staff constituency".

7.2 Public constituency

7.2.1 Members of the Trust who are members of the public constituencies listed in Annex 1 are to be individuals:

(a) who live in the Area of the Trust;

(b) who are not eligible to become a member of the staff constituency and are not Members of any other constituency or otherwise disqualified for membership under paragraph 7.4; and

(c) who have each made an application for membership to the Trust.

7.2.2 The minimum number of Members required in each area of the public constituency is specified in Annex 1.

7.3 Staff constituency

7.3.1 The staff constituency is to be divided into 5 classes as specified in Annex 2.

7.3.2 All staff are eligible to be a Member of one class or another.

7.3.3 Members of the Trust who are Members of the staff constituency are to be individuals:

(a) who are employed under a contract of employment by the Trust; or

(b) who are not so employed but who nevertheless exercise functions for the purposes of the Trust; and

(c) who satisfy the minimum duration requirements set out in paragraph 3(3) of Schedule 7 to the 2006 Act, that is to say:

(i) in the case of individuals described at (a) above

(aa) who are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or

(bb) who have been continuously employed by the Trust for at least 12 months;

(ii) in the case of individuals described at (b) above, who have exercised the functions for the purposes of the Trust for at least a continuous period of 12 months and do so either under an honorary contract with the Trust and are acknowledged in writing by the Trust as so doing for the purposes of this paragraph or who are the staff of contractors who work full time at the Trust providing services that the Trust would otherwise provide itself; and

(d) who are not disqualified for membership under paragraph 7.4 below;

(e) who in the case of individuals described at (b) above have each made an application for membership to the Trust, or in the case of all other staff and for the avoidance of doubt this will include the volunteer staff class, have been invited by the Trust to become a Member of the relevant staff class within the staff constituency and have not notified the Trust that they do not wish to do so.

7.3.4 The minimum number of Members required for each staff class of the staff constituency is as specified in Annex 2.
7.4 Disqualification for membership

7.4.1 A person may not be a member of the Trust or continue to be a member of the Trust if at the time of their application for membership of the Trust or at any time during the duration of their membership they do not meet the criteria for membership set out in paragraphs 7.2 or 7.3.

7.4.2 It is the responsibility of the Member to ensure their eligibility and not the Trust, but where the Trust is on notice that a Member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

7.4.3 A person may not become a Member of the Trust if at the time of their application for membership of the Trust they have not attained the age of 14.

7.5 Termination of membership

7.5.1 A Member shall cease to be a Member if he or she:

(a) resigns by notice to the Foundation Trust Chairman or their nominated officer;

(b) ceases to fulfil the requirements of paragraph 7.2 or 7.3;

(c) is deemed to be disqualified by the application of paragraph 7.4;

(d) dies.

7.6 Annual Members’ Meetings

7.6.1 The Trust shall hold an annual meeting of its Members (‘Annual Members’ Meeting’). The Annual Members’ Meeting shall be open to members of the public.

7.6.2 This shall be combined with a general meeting of the Council of Governors described in paragraph 8.17.

7.6.3 Members shall be invited to attend the meeting by public notice issued by the Trust.

8 COUNCIL OF GOVERNORS

8.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

8.2 The composition of the Council of Governors is specified in Annex 3.

8.2.1 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of constituency, is specified in Annex 1 (Public Governors) and Annex 2 (Staff Governors).

8.2.2 The number of Public Governors is to be more than half the total membership of the Council.

8.3 Co-opted Advisors

8.3.1 Up to a maximum of two Members may be co-opted to the Council of Governors as advisors at any one time to provide additional support or expertise to the Council.

8.3.2 Co-opted advisors will be appointed for an agreed period, not to exceed the usual terms of office of an elected governor as set out in 8.6 below. The appointment (and removal) of a co-opted advisor will be subject to approval at a general meeting by a majority of the Council of Governors present and voting.

8.3.3 Co-opted advisors shall not have voting rights at general meetings nor be counted in the quorum.

8.4 The organisations specified as partnership organisations that may appoint a member to the Council of Governors are described in Annex 3.

8.5 Election of governors

8.5.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Election Rules attached at Annex 5.

8.5.2 The Election Rules, based on those published nationally and supported by Monitor from time to time, form part of this Constitution. The Election Rules current at the date of the Trust’s authorisation are attached at Annex 5.

8.5.3 A subsequent variation of the Election Rules issued by the Department of Health or any national body and supported by Monitor shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 21 of the Constitution (amendment of the Constitution).

8.5.4 If contested, the election must be by secret ballot.

8.5.5 A lead governor shall be appointed from among the Public Governors in accordance with the process determined by the Chairman and Council of Governors and subject to approval at a general meeting by a majority of the Council of Governors present and voting.

8.6 Terms of office

8.6.1 Elected Governors:

(a) may hold office for a period of up to three years;

(b) are eligible for re-election at the end of that period;

(c) shall cease to hold office if they cease to be a member of the constituency, or class by which he or she was elected.

8.6.2 Appointed governors:

(a) may hold office for a period of 3 years;

(b) are eligible for reappointment at the end of that period;

(c) shall cease to hold office if the appointing organisation withdraws its sponsorship of them.
8.7 Termination of tenure

8.7.1 A governor may resign from that office at any time during the term of that office by giving notice in writing to the Chairman or his or her nominated officer.

8.7.2 If a governor fails to attend 2 consecutive meetings of the Council of Governors, his or her tenure of office is to be immediately terminated unless the other governors are satisfied that:

(a) the absence was due to a reasonable cause; and
(b) he or she will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

8.7.3 If the Council of Governors determines that a Public or Staff Governor is at any time not representative of the constituency or class which they represent having regard to the manifesto of the governor then they may, acting reasonably, terminate, upon notice to him or her, his or her tenure of office.

8.7.4 If a governor fails to attend a training session for governors as recommended by the Chairman or his or her nominated officer and approved by the Council of Governors, within 6 months of becoming a governor, his or her tenure of office is to be terminated within one month unless in the meantime the governor has satisfied the Council of Governors that:

(a) the absence was due to a reasonable cause; and
(b) he or she will be able to attend a training session within such a period as they consider reasonable.

8.7.5 The Council of Governors may by a resolution terminate a governor’s tenure of office for reasonable cause if it considers that his or her continuing as a governor would or would be likely to:

(a) prejudice the ability of the Trust to fulfill its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or
(b) harm the Trust’s work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods and services; or
(c) adversely affect public confidence in the goods or services provided by the Trust; or
(d) otherwise bring the Trust into disrepute.

8.7.6 The governor concerned will have the opportunity to make representations on his or her own behalf to the Governing Body but shall not be entitled to vote on the issue of his or her removal.

8.8 Disqualification of Governors

8.8.1 A person may not become or continue as a governor of the Trust if:

(a) he or she has not attained the age of 16;
(b) in the case of an elected governor he or she ceases to be a member of the constituency he or she represents;
(c) in the case of an appointed governor, the appointing organisation withdraws their sponsorship of him or her;
(d) he or she has been adjudged bankrupt or his or her estate has been sequestrated and in either case he or she has not been discharged;
(e) he or she has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it;
(f) he or she has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not, without the option of a fine) was imposed on him or her;
(g) he or she has within the preceding two years been dismissed, otherwise than by reason of redundancy, end of fixed term contract or ill health, from any paid employment with a health service body;
(h) he or she is a person whose tenure of office as the chairman or as a member or director of a health service body has been terminated on the grounds that his or her appointment is not in the interests of the health service, or for non-disclosure within 6 months of becoming a governor, his or her tenure of office is to be terminated within one month unless in the meantime the governor has satisfied the Council of Governors that:
(i) he or she is an executive or non-executive Director of the Trust, or a non-executive director, chairman, chief executive officer of another NHS foundation trust;
(j) he or she is incapable by reason of mental disorder, illness or injury of managing and administering his or her property and affairs;
(k) he or she is a registered sex offender pursuant to the Sex Offenders Act 2003;
(l) he or she has failed to abide by the Trust’s Code of Conduct for Governors and accountability and any Code of Values and principles in such form as the Trust may publish from time to time.
(m) the Chairman of the Council of Governors and/or the Council of Governors if necessary, resolves that disclosures revealed by a Criminal Records Bureau or Disclosure & Barring Service check are such that it would be inappropriate for him or her to become or continue as a governor and would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.
(n) he or she has failed to comply with or otherwise contravened the Trust’s Withholding Treatment Policy (as amended from time to time) and has been so notified to that effect by the Chief Executive.

8.8.2 Where a person has been elected or appointed to be a governor and he or she becomes disqualified for appointment under paragraph 8.8.1, he or she shall notify the Chairman or his or her nominated officer in writing of such disqualification.

8.8.3 If it comes to the notice of the Chairman at the time of his or her appointment or later that the governor is so disqualified, he or she shall immediately declare that the person in question is disqualified and notify him or her in writing to that effect.
8.8.4 Upon receipt of any such notification, that person’s tenure of office, if any, shall be terminated and he or she shall cease to act as a governor.

8.9 Vacancies

8.9.1 Where membership of the Council of Governors ceases for one of the reasons set out in paragraphs 8.7 or 8.8 above, Public and Staff Governors shall be replaced in accordance with the relevant electoral schemes as detailed in paragraph 8.9.2 below. Appointed governors are to be replaced in accordance with the processes agreed and set out in Annex 3.

8.9.2 Where the vacancy arises amongst elected governors, the Trust shall be at liberty to:

(a) invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will vacate and be subject to election for any unexpired period of the term of office.

(b) if no-one is available to take office under the preceding sub-paragraph, the seat will remain vacant until the next scheduled election, unless there is no longer a majority of governors on the Council of Governors from the public constituencies.

(c) if, as a result of the vacancy, there is no longer a majority of Public Governors and providing that the outstanding period of office is six months or more, to call an election within three months to fill the seat for the remainder of that term of office.

8.10 Duties, Roles and responsibilities of Governors

8.10.1 The general duties, roles and responsibilities of the governors are:

(a) to hold the non-executive Directors individually and collectively to account for the performance of the Board of Directors;

(b) to represent the interests of the Members of the Trust as a whole and the interests of the public;

(c) at a general meeting:

(i) to appoint or remove the chairman and the other non-executive directors. The removal of a non-executive Director requires the approval of three-quarters of all the members of the Council of Governors;

(ii) to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors;

(iii) to appoint or remove the Trust’s auditor at a general meeting of the Council of Governors in accordance with the protocol determined by the Council of Governors;

(iv) to be presented with the annual accounts, any report of the auditor on them and the annual report;

(d) to approve (by a majority of the Council of Governors present and voting) an appointment (by the non-executive directors) of the Chief Executive;

(e) to give the views of the Council of Governors to Directors for the purposes of the preparation (by the Directors) of the document containing information as to the Trust’s forward planning in respect of each Financial Year to be given to Monitor;

(f) to consider the annual accounts, any report of the auditor on them and the annual report;

(g) to respond as appropriate when consulted by the Directors;

(h) to act as a source of ideas about how the Trust can provide its services in a way that meets the needs of the communities in its Area;

(i) to approve amendments to the Trust's Constitution in accordance with paragraph 21 of this Constitution;

(j) to approve referral of a question to the Panel by a governor in accordance with paragraph 8.16 of this Constitution;

(k) to approve the implementation of a proposal to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England in accordance with paragraph 16.7 of this Constitution;

(l) to approve entering into a significant transaction or approve an application for a merger, acquisition, separation or dissolution of the Trust in accordance with paragraph 22 of this Constitution.

8.10.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

8.11 Expenses

8.11.1 The Trust may pay travelling and other expenses to governors at such rates as it decides. These rates are to be published in the annual report.

8.11.2 The remuneration and allowances for non-executive Directors set by the governors are also to be published in the annual report.

8.12 Remuneration

8.12.1 Governors are not to receive remuneration.

8.13 Meetings

8.13.1 The Chairman of the Trust (ie the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 9.4 or 9.5 below) or, in his absence the Deputy Chairman (appointed in accordance with the provisions of paragraph 9.4.3 below), shall preside at meetings of the Council of Governors and will have the casting vote, unless there is a conflict of interests, in which case the lead governor, or in his or her absence a Public Governor chosen by the members of the Council of Governors present and in accordance with Annex 4, will preside at the meeting and will have the casting vote.
8.13.2 Meetings of the Council of Governors are to be open to members of the public unless the Council of Governors resolves to exclude the public (for either the whole or part of the proceedings) where it considers that publicity would be prejudicial to the Trust by reason of the confidential nature of the business to be transacted or for other exceptional reasons stated in the resolution.

8.13.3 For the purposes of 8.13.2 the Council of Governors may treat the following as examples of matters of a confidential nature:
(a) any matter arising from a contract of employment with the Trust;
(b) any matter which involves the consideration of confidential information held by the Trust;
(c) commercial matters;
(d) legal matters;
(e) actual or anticipated litigation, including any arbitration or dispute resolution process;
(f) recommendations or advice from sources other than the Board of Directors and any committee or sub-committee referred to in this Constitution.

8.13.4 The Council of Governors is to meet at least 3 times per year.

8.13.5 For the purposes of obtaining information about the Trust’s performance of its functions or the Directors’ performance of their duties (and deciding whether to propose a vote on the Trust’s or Directors’ performance), the Council of Governors may require one or more of the Directors to attend a meeting.

8.13.6 At the annual general meeting of the Council of Governors which shall take place on or before 30 September in every year the Council of Governors is to receive and consider the annual accounts, any report of the auditor on them, and the annual report.

8.13.7 The Council of Governors may adopt its own standing orders for its practice and procedure, in particular for its procedure at meetings (including general meetings), but these shall be in accordance with Annex 4.

8.13.8 An elected governor may not vote at a meeting of the Council of Governors unless he or she has made a declaration in the period commencing with the date of the publicised nomination date and ending with the date of the relevant election for which he or she has made his or her nomination, in the form specified in the paragraph below stating which constituency or class he or she is a member of and is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or paragraph 8.18 of this Constitution.

8.13.9 The form referred to in paragraph 8.13.8 is more particularly described in Annex 5 to this Constitution.

8.14 Committees and sub-committees

8.14.1 The Council of Governors may appoint committees consisting of its members to assist it in carrying out its functions. A committee appointed under this paragraph may appoint a sub-committee.

8.14.2 These committees or sub-committees may call upon outside advisers to help them in their tasks.

8.15 Conflicts of interest of Governors

8.15.1 If a governor has a pecuniary, relevant or material interest, whether direct or indirect, in any contract or proposed contract or other matter which is under consideration by the Council of Governors, he or she shall disclose that to the Council as soon as he or she is aware of it and retire from the meeting. The Board of Directors, in consultation with the Council of Governors, shall comply with Annex 7, which will specify arrangements for excluding governors or Directors from discussion or consideration of the contract or other matter as appropriate.

8.16 Referral to the Panel

8.16.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing:

8.16.1 to act in accordance with its constitution; or

8.16.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

8.16.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

9 BOARD OF DIRECTORS

9.1 The Trust is to have a Board of Directors. It is to consist of executive and non-executive Directors.

9.2 Composition

9.2.1 The Board is to include:
(a) the following non-executive Directors:
(i) a Chairman;
(ii) a minimum of 4 and a maximum of 6 other non-executive Directors;
(b) the following executive Directors:
(i) a Chief Executive (and Accounting Officer);
(ii) a Finance Director; and
(iii) a minimum of 2 and a maximum of 4 other executive Directors, one of whom is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and another of whom is to be a registered nurse or registered midwife.
9.5 Terms of office

9.5.1 The Nominations Committee of the Council of Governors will undertake and oversee the appointment and terms and conditions of non-executive Directors including the Chairman. Final ratification of appointments will be subject to approval of the majority of the Council of Governors present and voting at a general meeting.

9.5.2 The Chief Executive (and Accounting Officer) shall hold office for a period in accordance with the terms and conditions of office decided by an appointment committee of non-executive Directors supported by appropriate advice and guidance from a human resources specialist although the appointment will be required to be approved by a majority vote at a general meeting of the Council of Governors. If appropriate the appointment process may also include the services of another external agency and such other independent expert as may be considered necessary. The Chairman and non-executive Directors will also be responsible for establishing the terms and conditions for the Chief Executive via a further committee (the Remuneration Committee). This shall not apply to the initial Chief Executive who shall be invited to continue in post on his or her current terms and conditions of employment.

9.5.3 The executive Directors, other than the Chief Executive, shall hold office for a period in accordance with the terms and conditions decided by an appointment committee consisting of the Chairman, the Chief Executive and the other non-executive Directors. The appointment committee will be supported by appropriate advice and guidance from a human resources specialist. If appropriate the appointment process may also include the services of another external agency and such other independent expert as may be considered necessary.

9.6 Disqualification of Directors

9.6.1 A person may not be a director of the Trust if—

(a) he or she has been adjudged bankrupt or his or her estate has been sequestrated and in either case he or she has not been discharged;

(b) he or she has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it;

(c) he or she has within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not, without the option of a fine) was imposed on him or her;

(d) in the case of a non-executive Director, he or she no longer satisfies paragraph 9.3;

(e) he or she is a person whose tenure of office as a Chairman or as a member or director of a health service body has been terminated on the grounds that his or her appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest;

(g) he or she has within the preceding two years been dismissed, otherwise than by reason of redundancy, end of fixed term contract or ill health from any paid employment with a health service body;

(h) disclosures revealed by a Criminal Records Bureau or Disclosure & Barring Service check are such that it would be inappropriate for him or her to become or continue as a Director and would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

(i) he or she no longer meets the regulatory Fit and Proper Person Requirements (FPPR).
9.7 Duties, roles and responsibilities

9.7.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

9.7.2 The powers of the Trust are to be exercisable by the Board of Directors on its behalf.

9.7.3 Any of those powers may be delegated to a committee of Directors or to an executive Director.

9.7.4 A committee of non-executive Directors established as an audit committee is to monitor, review and carry out such other functions in relation to the Auditor as are appropriate.

9.7.5 It is for the non-executive Directors to appoint (subject to the approval of the Council of Governors) or remove the Chief Executive (and Accounting Officer).

9.7.6 It is for a committee consisting of the Chairman, the Chief Executive (and Accounting Officer) and the other non-executive Directors to appoint or remove the executive Directors.

9.7.7 The Trust shall establish a committee of non-executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the executive Directors.

9.7.8 The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust’s forward planning in respect of each Financial Year to be given to Monitor.

9.7.9 The Directors are to present to the Council of Governors at a general meeting the annual accounts, any report of the auditor on them, and the annual report.

9.7.10 The functions of the Trust under paragraph 15 below are delegated to the Chief Executive as Accounting Officer.

10 MEETINGS OF DIRECTORS

10.1 The Board of Directors, in consultation with the Council of Governors, is to adopt standing orders for the Trust covering the regularity, proceedings and business of its meetings. These are to include setting a quorum for meetings, both of executive and non-executive directors. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director’s appointment.

10.2 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, as set out in the Trust’s standing orders.

10.3 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

11 CONFLICTS OF INTEREST OF DIRECTORS

11.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

11.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

11.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

11.2 the duty referred to in sub-paragraph 11.1.1 is not infringed if:

11.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

11.2.2 the matter has been authorised in accordance with the Constitution.

11.3 the duty referred to in sub-paragraph 11.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

11.4 In sub-paragraph 11.1.2, “third party” means a person other than;

11.4.1 the Trust; or

11.4.2 a person acting on its behalf.

11.5 If a Director of the Trust has in any way a direct of indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

11.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

11.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

11.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

11.9 A Director need not declare an interest:

11.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

11.9.2 if, or to the extent that, the Directors are already aware of it;

11.9.3 if, or to the extent that, it concerns terms of the Director’s appointment that have been or are to be considered:

(a) by a meeting of the Board of Directors; or

(b) by a committee of the Directors appointed for the purpose under the Constitution.
12 REGISTERS

12.1 The Trust is to have:
(a) a register of Members showing, in respect of each Member, the constituency and where there are classes within it, the class to which he or she belongs;
(b) a register of members of the Council of Governors;
(c) a register of interests of the Council of Governors;
(d) a register of Directors;
(e) a register of interests of the Directors, and maintained in accordance with the standing orders and standing financial instructions of the Trust.

12.2 The Chairman or their nominated officer shall:
12.2.1 admit to the Members Register the name and constituency of a Member as soon as reasonably possible following receipt of a completed declaration of the Member confirming their eligibility as a Member;
12.2.2 remove from the Members Register as soon as reasonably possible upon this being determined or upon being so advised, the name of any Member who ceases to be entitled to be a Member under the provisions of this Constitution;
12.2.3 admit to the Register of Governors as soon as reasonably possible upon this being determined or upon being so advised, the name and constituency of those members who have been elected or appointed as a governor of the Trust;
12.2.4 remove from the Register of Governors those governors who have not been re-elected or who have had their sponsorship withdrawn, as soon as reasonably possible, notice having been given to the Chief Executive or their nominated officer to that effect;
12.2.5 maintain the respective registers of interests of Directors and governors and undertake a review of the same at least twice in every year by notice to that effect to all Directors and governors.

13 PUBLIC DOCUMENTS

13.1 The following documents of the Trust are to be available for inspection by members of the public free of charge at all reasonable times:
(a) a copy of the current Constitution;
(b) a copy of the latest annual accounts and of any report of the auditor on them;
(c) a copy of the latest annual report;

13.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:
(a) a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65K (action following Secretary of State’s rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;
(b) a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;
(c) a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;
(d) a copy of any draft report published under section 65F (administrator’s draft report) of the 2006 Act;
(e) a copy of any statement provided under section 65F (administrator’s draft report) of the 2006 Act;
(f) a copy of any notice published under section 65F (administrator’s draft report), 65G (consultation plan), 65J (consultation requirements), 65K (power to extend time), 65Ka (Monitor’s decision), 65KB (Secretary of State’s response to Monitor’s decision), 65KC (action following Secretary of State’s rejection of final report) or 65KD (Secretary of State’s response to re-submitted final report) of the 2006 Act;
(g) a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;
(h) a copy of any final report published under section 65I (administrator’s final report);
(i) a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State’s rejection of final report) of the 2006 Act;
(j) a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

13.3 Any person who requests it is to be provided with a copy or extract from any of the above documents.

13.4 The registers mentioned in the paragraph 12.1 are also to be made available for inspection by members of the public, except in circumstances prescribed by regulations made under the Public Benefit Corporation (Register of Members) Regulations 2004 (SI 2004 No 539 as amended) and, so far as those registers are required to be available;
(a) they are to be available free of charge at all reasonable times,
(b) a person who requests it is to be provided with a copy of or extract from them.

13.5 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for providing the copy or extract.

14 AUDITOR

14.1 The Trust is to have an auditor and is to provide the auditor with every facility and all information which he or she may reasonably require for the purposes of his or her functions under Part 1 of the 2006 Act.
14.2 A person may only be appointed auditor if he or she (or in the case of a firm each of its members) is a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 7 to the 2006 Act.

14.3 Appointment of the Auditor by the Council of Governors is covered in paragraph 8.10, and monitoring of the auditor’s functions by a committee of non-executive directors is covered in paragraph 9.7.4.

14.4 An officer of the Audit Commission may be appointed with the agreement of the Commission.

14.5 The Auditor is to carry out his or her duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by Monitor on standards, procedures and techniques to be adopted.

15 ACCOUNTS

15.1 The Trust must keep proper accounts and proper records in relation to the accounts.

15.2 Monitor may, with the approval of the Secretary to the State, give directions to the Trust as to the content and form of its accounts.

15.3 The accounts are to be audited by the Trust’s auditor.

15.4 The following documents will be made available to the Comptroller and Auditor General for examination at his or her request:

(a) the accounts;
(b) Any records relating to them; and
(c) any report of the auditor on them.

15.5 The Trust (through its Chief Executive and Accounting Officer) shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

16 ANNUAL REPORTS, FORWARD PLANS AND NON-NHS WORK

16.1 The Trust is to prepare annual reports and send them to Monitor.

16.2 The reports are to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual Membership of its/any public constituency is representative of those eligible for such membership;
   i) Information on any occasions in the period to which the report relates on which the Council of Governors exercised its power under paragraph 8.17.5
   ii) Information on the Trust’s policy on pay and on the committee established under paragraph 9.7.7
   iii) Information on the remuneration of the directors and on the expenses of the governors and the directors, and
   (b) any other information Monitor requires.

16.3 The Trust is to comply with any decision Monitor makes as to –

(a) the form of the reports;
(b) when the reports are to be sent to it;
(c) the periods to which the reports are to relate.

16.4 The Trust shall give information as to its forward planning in respect of each financial year to Monitor. This information is to be prepared by the directors, who must have regard to the views of the Council of Governors (paragraph 9.7.8 above).

16.5 Each forward plan must include information about:

16.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and
16.5.2 the income it expects to receive from doing so.

16.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 16.5.1 the Council of Governors must:

16.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions; and
16.6.2 notify the Directors of the Trust of its determination.

16.7 If the Trust proposes to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the provision of goods and services for the purposes of the health service in England, it may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.
17. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

17.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

17.1.1 the annual accounts;
17.1.2 any report of the auditor on them; and
17.1.3 the annual report.

17.2 The documents shall also be presented to the Members of the Trust at the Annual Members’ Meeting by at least one member of the Board of Directors in attendance.

17.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 17.1 with the Annual Members’ Meeting.

18 INDEMNITY

18.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Trust functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust and the Trust has the power to purchase suitable insurance in order to cover such costs.

19 INSTRUMENTS ETC.

19.1 A document purporting to be duly executed under the Trust’s seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

19.2 The Trust is to have a seal, but this shall not be affixed except under the authority of the Board of Directors.

20 DISPUTE RESOLUTION PROCEDURES

20.1 Disputes between the Board of Directors and the Council of Governors are to be resolved in accordance with Annex 6.

21 AMENDMENT OF THE CONSTITUTION

21.1 The Trust may make amendments to this Constitution only if:

21.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments; and

21.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments.

21.2 Amendments made under paragraph 21.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

21.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

21.3.1 at least one member of the Council of Governors must attend the next Annual Members’ Meeting and present the amendment; and

21.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment.

21.4 Amendments by the Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor’s functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

21.5 The Constitution shall be reviewed periodically at the request of either the Board of Directors or the Council of Governors.

22 MERGERS, ETC AND SIGNIFICANT TRANSACTIONS

22.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

22.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

22.3 “Significant transaction” means a transaction greater in value than 25% of the Trust’s existing gross assets or income.
Annex 1

AREA OF THE TRUST AND PUBLIC CONSTITUENCY OF THE TRUST
(Paragraph 7.2)

1. The area of the Trust shall be the Barnsley Public Constituency, encompassing the whole of the area of Barnsley Metropolitan Borough as determined by the electoral wards of the Local Authority of Barnsley (see also map below) and
Constituency O covering the area of England and Wales excluding the given areas mentioned above.

2. The minimum number of Members shall be 500 for the Barnsley Public Constituency and shall be 50 for the constituency class known as O.

3. The total number of Public Governors shall be 16, comprising 15 governors for the Barnsley Public Constituency and 1 governor for Constituency O.

Annex 2

THE STAFF CONSTITUENCY

1. The staff constituency is to be divided into 5 classes, with six governors in total, as specified below:
   (a) the medical and dental staff class (one governor);
   (b) the nursing and midwifery staff class (two governors);
   (c) the clinical support staff class (one governor);
   (d) the volunteer staff class (one governor); and
   (e) the non clinical support staff class (one governor)

2. The Members of the medical and dental practitioners’ staff class are individuals who are Members of the staff constituency who are fully registered persons within the meaning of the Medicines Act 1956 and, in the case of medical practitioners, who hold a licence to practise. For the avoidance of doubt the medical and dental practitioners’ staff class shall also include junior doctors who are not yet fully registered within the meaning of the Medicines Act 1956.

3. The Members of the nursing and midwifery staff class are individuals who are Members of the staff constituency who are not fully registered persons within the meaning of the Medicines Act 1956, but whose regulatory body falls within the remit of the Council for the Regulation of Health Care Professions established by section 25 of the NHS Reform and Health Care Professionals Act 2002. For the avoidance of doubt the nursing and midwifery staff class shall also include nursing auxiliaries and health care assistants.

4. The Members of the volunteer staff class are individuals who provide voluntary support in pursuance of an honorary agreement or who work on behalf of a voluntary organisation within the meaning of the 2006 Act and are in either case acknowledged in writing by the Trust as doing so for the purposes of this paragraph.

5. The Members of the other staff classes as described in paragraphs 1 (c) and (e) above are individuals who are Members of the staff constituency who do not come within paragraphs 1 (a), (b) or (d).

6. The minimum number of Members required for each staff class of the staff constituency is as follows:
   (a) the medical and dental staff class – 50
   (b) the nursing and midwifery staff class – 200
   (c) the clinical support staff class – 75
   (d) the volunteer staff class – 50
   (e) the non clinical support staff class – 150.

7. A person who is eligible to be a Member of the staff constituency (see paragraph 7.3) may not become or continue as a Member of any constituency other than the staff constituency and may not become or continue as a Member of more than one staff class.
Annex 3

Composition of the Council of Governors

1. The Council of Governors is to include:
   
   (a) 16 Public Governors as specified in Annex 1
   
   (b) 6 Staff Governors, as specified in Annex 2:
   
   (c) 1 Local Authority Governor
   
   (d) 6 other Partnership Governors as specified below:

   (i) Barnsley Together
   
   (ii) Barnsley College;
   
   (iii) Joint Trade Unions Committee (JTUC);
   
   (iv) Sheffield Hallam University or The University of Sheffield (shared seat)
   
   (v) Voluntary Action Barnsley
   
   (vi) Barnsley Clinical Commissioning Group

2. If and to the extent that a partnership organisation fails to make an appointment within three months of being invited to do so by the Trust the Trust may seek an appointment from an alternative partnership organisation which in the Trust’s opinion has similar objects or provides similar goods or services to the partnership organisation it shall stand in substitution for.

Annex 4

Practice and Procedure for Meetings of the Council of Governors

1. 

   1.1. Admission of the Public and the Press – The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

   “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with 8.17 of this Constitution.”.

   1.2. The Chairman (or Deputy-Chairman or lead governor) shall give such directions as he or she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors’ business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the Council of Governors may resolve as follows:

   “That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public in accordance with 8.17 of this Constitution.”

   1.3. Nothing in this Annex 4 shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without prior agreement of the Council of Governors.

   1.4. Meetings of the Council of Governors shall be determined at the first meeting of the Council of Governors or at such other times as the Council of Governors may determine and at such places as they may from time to time appoint.

   1.5. The Chairman may call a meeting of the Council of Governors at any time. If he or she refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of Governors has been presented to him or her, or if, without so refusing, the Chairman does not call a meeting within seven days after such a requisition has been presented to him or her, such one third or more members may forthwith call a meeting.

   1.6. Notice of Meetings – Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer of the Trust authorised by the Chairman to sign on his or her behalf shall be delivered to every Governor, or sent by post to the usual place of residence of such persons, so as to be available to him or her at least three clear days before the meeting.

   1.7. Lack of service of the notice on any person as described in paragraph 1.6 shall not affect the validity of the meeting.

   1.8. In the case of a meeting called by Governors in default of the Chairman, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified on the notice.

   1.9. Failure to serve such a notice on more than 6 Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

   1.10. Quorum – At least 10 Governors must be present at a meeting of the Council of Governors for the meeting to be quorate.
1.1. Setting the Agenda – The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

1.2. A governor desiring a matter to be included on an agenda shall make the request in writing to the Chairman at least 7 clear days before the meeting. Requests made less than 7 clear days before a meeting may be included on the agenda at the discretion of the Chairman.

1.3. Chairman of Meeting – At any meeting of the Council of Governors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy-Chairman, if there is one and he or she is present, shall preside. If the Chairman and the Deputy-Chairman are absent the lead governor shall preside or in his or her absence such Public Governor as the Governors present shall choose shall preside.

1.4. If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chairman, if present, shall preside. The Chairman may appoint any governor or Public Governor to preside as substitute. If the Chairman is absent for any reason or is disqualified from presiding the Deputy-Chairman, if present, shall preside. If the Chairman and the Deputy-Chairman are absent the lead governor shall preside or in his or her absence such Public Governor as the Governors present shall choose shall preside.

1.5. Notices of Motion – A governor of the Council desiring to move or amend a motion shall send a written notice thereof at least 7 clear days before the meeting to the Chairman, who shall insert the notice in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to preceding provisions.

1.6. Withdrawal of Motion or Amendments – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

1.7. Motion to Rescind a Resolution – Notice of motion to amend or rescind any resolution (or general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the governors who give it and also the signature of 4 other governors at least 2 of whom shall be as Public Governors. When any such motion has been disposed of by the Trust, it shall not be competent for any governor other than the Chairman to propose a motion to the same effect within 6 months, however the Chairman may do so if he or she considers it appropriate.

1.8. Motions – The mover of a motion shall have the right of reply at the close of any discussions on the motion or any amendment thereto.

1.9. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

- an amendment to the motion,
- the adjournment of the discussion or the meeting,
- that the meeting proceed to the next business. (*)
- the appointment of an ad hoc committee to deal with a specific item of business.
- that the motion be now put. (*)

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a governor who has not previously taken part in the debate.

No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

1.20 Chairman’s Ruling - The decision of the Chairman of the meeting on the question of order, relevancy and regularity shall be final. The Chairman of the Trust shall be the final authority in the interpretation of this Annex 4 on which he or she shall be advised by the Chief Executive or his or her nominated officer.

1.21 Voting – Every question at a meeting will be determined by a majority of the votes of the Governors present and voting on the question and, in the case of an equality of votes, the person presiding shall have a second or casting vote.

1.22 All questions put to the vote shall, at the discretion of the Chairman, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request.

1.23 If a governor so requests his or her vote shall be recorded by name upon any vote (other than by paper ballot).

1.24 Minutes - The minutes of the proceedings of a meeting shall be drawn up and appropriately recorded and shall be signed at the next ensuing meeting by the person presiding at it.

1.25 No discussion shall take place upon the minutes, except upon their accuracy, or where the Chairman considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

1.26 Minutes shall be circulated in accordance with Governor’s wishes. Where providing a record of a public meeting the minutes shall be made available to the public (required by Code of Practice on Openness in the NHS).

2. Committees

2.1. Appointment of Committees – Subject to paragraph 2.7 below and such directions as may be given by Monitor, the Council of Governors may and, if directed by him or her, shall appoint committees of the Council of Governors, consisting wholly or partly of Governors of the Council of Governors.

2.2. A committee appointed under paragraph 2.1 may, subject to such directions as may be given by Monitor or the Council of Governors appoint sub-committees consisting wholly or partly of members of the committee.

2.3. This Annex 4, as far as it is applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Council of Governors.

2.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors shall decide. Such terms of reference shall have effect as if incorporated into this Annex 4.

2.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Council of Governors.

2.6. The Council of Governors shall approve the appointments to each of the committees which it has formally constituted. Where the Council of Governors determines that persons, who are neither governors nor Directors or officers, shall be appointed to a committee, the terms of such an appointment shall be determined by the Council of Governors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Trust and/or Monitor.

2.7. Where the Council of Governors is required to appoint persons to a committee and/or to undertake statutory functions as required by Monitor, and where such appointments are to operate independently of the Council of Governors and/or the Trust such appointment shall be made in accordance with the any regulations laid down by the Chief Executive or his or her nominated officer or any directions or guidance issued by Monitor from time to time.
2.8 **Confidentiality** – A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

A governor of the Trust or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

---

**Annex 5**

**Conduct of Elections**

Elections for Public Governors and Staff Governors will be conducted in accordance with the election rules set out below which may be amended in accordance with the consent of the Returning Officer and in compliance with any further guidance or instructions issued by Monitor:-

**NHS foundation trusts (Council of Governors)**

**Model Election Rules**

**TO BE REPLACED WITH UPDATED RULES – UNDER REVIEW**

==================================================================

**Part 1 - Interpretation**

1. Interpretation

**Part 2 – Timetable for election**

2. Timetable
3. Computation of time

**Part 3 – Returning officer**

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

**Part 4 - Stages Common to Contested and Uncontested Elections**

8. Notice of election
9. Nomination of candidates
10. Candidate’s consent and particulars
11. Subscription of nomination paper
12. Declaration of interests
13. Declaration of eligibility
14. Signature of candidate
15. Decisions as to validity of nomination papers
16. Publication of statement of nominated candidates
17. Inspection of statement of nominated candidates and nomination papers
18. Withdrawal of candidates
19. Method of election

**Part 5 – Contested elections**

20. Poll to be taken by ballot
21. The ballot paper
22. The declaration of identity
23. List of eligible voters
24. Notice of poll
25. Issue of voting documents
26. Ballot paper envelope and covering envelope

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers
30. Lost ballot papers
31. Issue of replacement ballot paper
32. Declaration of identity for replacement ballot papers

Procedure for receipt of envelopes

33. Receipt of voting documents
34. Validity of ballot paper
35. Declaration of identity but no ballot paper
36. Sealing of packets

Part 6 - Counting the votes

37. Interpretation of Part 6
38. Arrangements for counting of the votes
39. The count
40. Rejected ballot papers
41. First stage
42. The quota
43. Transfer of votes
44. Supplementary provisions on transfer
45. Exclusion of candidates
46. Filling of last vacancies
47. Order of election of candidates

Part 7 - Final proceedings in contested and uncontested elections

48. Declaration of result for contested elections
49. Declaration of result for uncontested elections

Part 8 - Disposal of documents

50. Sealing up of documents relating to the poll
51. Delivery of documents
52. Forwarding of documents received after close of the poll
53. Retention and public inspection of documents
54. Application for inspection of certain documents relating to election

Part 9 - Death of a candidate during a contested election

55. Countermand or abandonment of poll on death of candidate

Part 10 - Election expenses and publicity

Expenses

56. Expenses incurred by candidates
57. Expenses incurred by other persons
58. Personal, travelling, and administrative expenses

Publicity

59. Publicity about election by the corporation
60. Information about candidates for inclusion with voting documents
61. Meaning of “for the purposes of an election”

Part 11 – Questioning elections and irregularities

62. Application to question an election

Part 12 – Miscellaneous

63. Secrecy
64. Prohibition of disclosure of vote
65. Disqualification
66. Delay in postal service through industrial action or unforeseen event
**Part 1 - Interpretation**

1. Interpretation – (1) In these rules, unless the context otherwise requires -

   “corporation” means the public benefit corporation subject to this Constitution, namely, the Barnsley Hospital NHS Foundation Trust

   “election” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors; This is the same body referred to as the Board of Governors in the 2006 Act

   “the regulator” means Monitor, the Independent Regulator for NHS foundation trusts; and

   “the 2006 Act” means the National Health Service Act 2006.

(2) Other expressions used in these rules and in Schedule 7 to the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

**Part 2 – Timetable for election**

2. Timetable - The proceedings at an election shall be conducted in accordance with the following timetable.

<table>
<thead>
<tr>
<th>Proceeding</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication of notice of election</td>
<td>Not later than the fortieth day before the day of the close of the poll.</td>
</tr>
<tr>
<td>Final day for delivery of nomination papers to returning officer</td>
<td>Not later than the twenty eighth day before the day of the close of the poll.</td>
</tr>
<tr>
<td>Publication of statement of nominated candidates</td>
<td>Not later than the twenty seventh day before the day of the close of the poll.</td>
</tr>
<tr>
<td>Final day for delivery of notices of withdrawals by candidates from election</td>
<td>Not later than twenty fifth day before the day of the close of the poll.</td>
</tr>
<tr>
<td>Notice of the poll</td>
<td>Not later than the fifteenth day before the day of the close of the poll.</td>
</tr>
<tr>
<td>Close of the poll</td>
<td>By 5:00pm on the final day of the election.</td>
</tr>
</tbody>
</table>

3. Computation of time – (1) In computing any period of time for the purposes of the timetable -

   (a) a Saturday or Sunday;
   (b) Christmas day, Good Friday, or a bank holiday, or
   (c) a day appointed for public thanksgiving or mourning,

   shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

**Part 3 – Returning officer**

4. Returning officer – (1) Subject to rule 65, the returning officer for an election is to be appointed by the corporation.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff – Subject to rule 65, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure - The corporation is to pay the returning officer –

   (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
   (b) such remuneration and other expenses as the corporation may determine.

**Part 4 - Stages Common to Contested and Uncontested Elections**

8. Notice of election – The returning officer is to publish a notice of the election stating –

   (a) the constituency, or relevant class within a constituency, for which the election is being held,
   (b) the number of members of the Council of Governors to be elected from that constituency, or relevant class within that constituency,
   (c) the details of any nomination committee that has been established by the corporation,
   (d) the address and times at which nomination papers may be obtained;
   (e) the address for return of nomination papers, and the final date that they must be delivered to the returning officer;
   (f) the date and time by which any notice of withdrawal must be received by the returning officer
   (g) the contact details of the returning officer, and
   (h) the date of the close of the poll in the event of a contest.

9. Nomination of candidates – (1) Each candidate must be nominated on a separate nomination paper.

(2) The returning officer -

   (a) is to supply any member of the corporation with as many nomination papers as may be required, and
   (b) is to prepare a nomination paper for signature at the request of any member of the corporation,

   but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate’s particulars – (1) The nomination paper must state the candidate’s -

   (a) full names,
   (b) contact address in full, and
   (c) constituency, or class within a constituency, which the candidate is a member of.

11. Subscription of nomination paper – (1) The nomination paper must be subscribed by two supporters.

(2) Each supporter must –

   (a) be a member of the same constituency, or class within a constituency, to which the candidate belongs, and
   (b) state his or her constituency, or class within a constituency, on the nomination paper.

(3) A member of the corporation must not subscribe more than one nomination paper.

(4) If a member of the corporation subscribes more than one nomination paper in contravention of paragraph (3), then the second and any further subscriptions received by the returning officer are invalid.

(5) Where a member of the corporation subscribes a nomination paper, and the candidate nominated in the paper dies or withdraws before the paper is received by the returning officer, then nothing in paragraphs (3) or (4) prevents that member from subscribing the nomination paper of another candidate.
12. Declaration of interests – The nomination paper must state –

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party,
and if the candidate has no such interests, the paper must include a statement to that effect.

13. Declaration of eligibility – (1) The nomination paper must include a declaration made by the candidate –

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8.12
(b) for a member of the public constituency, of the particulars of his or her qualification to vote as a
member of that constituency, or class within that constituency, for which the election is held.

14. Signature of candidate – The nomination paper must be signed and dated by the candidate, indicating that –

(a) the candidate consents to being nominated in the paper,
(b) the statement of the interests of the candidate in the paper, as required by rule 12, is true and correct,
(c) the declaration of eligibility required by rule 13 is true and correct.

15. Decisions as to validity of nomination papers – (1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election as nominated unless and until the

(a) decides that the nomination paper is invalid,
(b) decides that the candidate is not eligible to stand
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds -

(a) that the paper is not received on or before the final date for return of nomination papers, as specified in the notice of the election,
(b) that the paper does not contain the candidate’s particulars, as required by rule 10;
(c) that the paper is not subscribed as required by rule 11,
(d) that the paper does not contain a declaration of the interests of the candidate, as required by rule 12,
(e) that the paper does not include a declaration of eligibility as required by rule 13, or
(f) that the paper is not signed and dated by the candidate, as required by rule 14.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination paper is invalid, he or she must endorse this on the paper, stating the reasons for the decision.

(5) The returning officer is to send notice of the decision as to whether a nomination paper is valid or invalid to the
candidate, at the contact address given in the candidate’s nomination paper.

16. Publication of statement of nominated candidates – (1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election as nominated.

(a) the name, contact address, and constituency or class within a constituency of each candidate standing
as nominated, and
(b) the declared interests of each candidate standing,
as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) If a candidate has been nominated by more than one nomination paper, the returning officer is to take the particulars required by this rule from one of the papers selected by the candidate, or by the returning officer in default of the candidate.

(5) The returning officer must send a copy of the statement of nominated candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

17. Inspection of statement of nominated candidates and nomination papers – (1) The corporation is to make the statement of nominated candidates and the nomination papers supplied by the returning officer under rule 16(5) available for inspection by members of the public free of charge at all reasonable times. Rule 17 will however be subject to the provisions of the Data Protection Act 1998 and the need for the corporation to respect the confidential details of nominees and nominators.

(2) If a person requests a copy or extract of the statement of nominated candidates or the nomination papers, the corporation is to provide that person with the copy or extract free of charge.

18. Withdrawal of candidates - A candidate may withdraw from election on or before the final day for withdrawal by candidates, by giving the returning officer a written notice of withdrawal which is signed by that candidate and attested by a witness.

19. Method of election – (1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be board of governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 – Contested elections

20. Poll to be taken by ballot – (1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

21. The ballot paper – (1) The ballot paper of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify –

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

instructions on how to vote,

that the ballot paper is to be returned by post, with the address for its return and the date of the close of the poll, and

g) the contact details of the returning officer.

Each ballot paper must have a unique identifier.

Each ballot paper must have features incorporated into it to prevent it from being reproduced.

22. The declaration of identity (public constituencies) – (1) In respect of an election for a public constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter is the person to whom the ballot paper was addressed,
(b) that the voter has not marked or returned any other voting paper in the election, and
(c) for a member of the public constituency, of the particulars of that member’s qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,
(b) the address of the voter,
(c) the voter’s signature, and
(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter’s ballot paper may be invalid.

23. List of eligible voters – (1) The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who do not come within rule 27 (the “list of eligible voters”), as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

24. Notice of poll - The returning officer is to publish a notice of the poll stating–

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the address and final dates for applications for replacement ballot papers, and
(h) the contact details of the returning officer.

25. Issue of voting documents by returning officer – (1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the corporation named in the list of eligible voters–

(a) a ballot paper,
(b) a ballot paper envelope,
(c) a declaration of identity (if required),
(d) information about each candidate standing for election, pursuant to rule 60 of these rules, and
(e) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

26. Ballot paper envelope and covering envelope – (1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have–

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer–

(a) the completed declaration of identity, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

27. Eligibility to vote – An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election

28. Voting by persons who require assistance – (1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers – (1) – If a voter has inadvertently dealt with his or her ballot paper in such a manner that it cannot be conveniently be used as a ballot paper (referred to a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she –

(a) is satisfied as to the voter’s identity, and
(b) has ensured that the declaration of identity attached to the original ballot paper has not been returned.
(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”) –

(a) the name of the voter, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement ballot paper.

30. Lost ballot papers – (1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement ballot paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she –

(a) is satisfied as to the voter’s identity,
(b) has no reason to doubt that the voter did not receive the original ballot paper, and
(c) has ensured that the declaration of identity attached to the original ballot paper has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list (“the list of lost ballot papers”) –

(a) the name of the voter, and
(b) the details of the unique identifier of the replacement ballot paper.

31. Issue of replacement ballot paper – (1) If a person applies for a replacement ballot paper under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed by rules 29(3) or 30(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list (“the list of tendered ballot papers”) –

(a) the name of the voter, and
(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

32. Declaration of identity for replacement ballot papers (public constituencies)– (1) In respect of an election for a public constituency, a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and
(b) of the particulars of that member’s qualification to vote as a member of the public constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,
(b) the address of the voter,
(c) the voter’s signature, and
(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be invalid.
37. Interpretation of Part 6 – In Part 6 of these rules –

“continuing candidate” means any candidate not deemed to be elected, and not excluded,

“count” means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

“deemed to be elected” means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

“mark” means a figure, an identifiable written word, or a mark such as “X”,

“non-transferable vote” means a ballot paper –

(a) on which no second or subsequent preference is recorded for a continuing candidate, or
(b) which is excluded by the returning officer under rule 44(4) below;

“preference” as used in the following contexts has the meaning assigned below–

(a) “first preference” means the figure “1” or any mark or word which clearly indicates a first (or only) preference,
(b) “next available preference” means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on,

“quota” means the number calculated in accordance with rule 42 below,

“surplus” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable papers from the candidate who has the surplus,

“stage of the count” means –

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

“transferable paper” means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

“transferred vote” means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred, and

“transfer value” means the value of a transferred vote calculated in accordance with paragraph (4) or (7) of rule 43 below.

38. Arrangements for counting of the votes – The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

39. The count – (1) The returning officer is to –

(a) count and record the number of ballot papers that have been returned, and
(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

40. Rejected ballot papers – (1) Any ballot paper –

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

41. First stage – (1) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

42. The quota – (1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 45 has been complied with.

43. Transfer of votes – (1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped–

(a) according to next available preference given on those papers for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule 44 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1)(a) to the candidate for whom the next available preference is given on those papers.
(4) The vote on each ballot paper transferred under paragraph (3) above shall be at a value ("the transfer value") which —

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped —

(a) according to the next available preference given on those papers for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule 44 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5)(a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at —

(a) a transfer value calculated as set out in paragraph (4)(b) above, or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are —

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

44. Supplementary provisions on transfer — (1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if —

(a) the surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule 43 above —

(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare —

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule 43 or 45 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be, all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule 43 or 45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non-transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

45. Exclusion of candidates — (1) If —

(a) all transferable papers which under the provisions of rule 43 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred, and

(b) subject to rule 46 below, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where paragraph (12) below applies, the candidates with the then lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels according to their transfer value.

(a) ballot papers on which a next available preference is given, and
(b) ballot papers on which no such preference is given (thereby including ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule 44 above, transfer each sub-parcel of ballot papers referred to in paragraph (2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule 46 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.
(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule—

(a) record—

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare—

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule 43 and rule 44.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest—

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

46. Filling of last vacancies—(1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

47. Order of election of candidates—(1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 43(10) above.

(2) A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which they obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

48. Declaration of result for contested elections—(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to—

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected—

(i) where the election is held under a proposed Constitution pursuant to powers conferred on the Barnsley Hospital NHS trust by section 4(4) of the 2006 Act, to the chairman of the NHS trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make—

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 40(1),

available on request.

49. Declaration of result for uncontested elections—In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election—

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

50. Sealing up of documents relating to the poll—(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets—

(a) the counted ballot papers,

(b) the ballot papers endorsed with “rejected in part”,

(c) the rejected ballot papers, and

(d) the statement of rejected ballot papers.

(2) The returning officer must not open the sealed packets of—

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the declarations of identity,
(c) the list of spoilt ballot papers,
(d) the list of lost ballot papers,
(e) the list of eligible voters, and
(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –
   (a) its contents,
   (b) the date of the publication of notice of the election,
   (c) the name of the corporation to which the election relates, and
   (d) the constituency, or class within a constituency, to which the election relates.

51. Delivery of documents – Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 50, the returning officer is to forward them to the chair of the corporation.

52. Forwarding of documents received after close of the poll – Where –
   (a) any voting documents are received by the returning officer after the close of the poll, or
   (b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
   (c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,
the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

53. Retention and public inspection of documents – (1) The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

   (2) With the exception of the documents listed in rule 54(1), the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

   (3) A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge on a person who is not a member of the corporation for doing so.

54. Application for inspection of certain documents relating to an election – (1) The corporation may not allow the inspection of, or the opening of any sealed packet containing –
   (a) any rejected ballot papers, including ballot papers rejected in part,
   (b) any disqualified documents, or the list of disqualified documents,
   (c) any counted ballot papers,
   (d) any declarations of identity, or
   (e) the list of eligible voters,
by any person without the consent of the regulator.

   (2) A person may apply to the regulator to inspect any of the documents listed in (1), and the regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

   (3) The regulator’s consent may be on any terms or conditions that it thinks necessary, including conditions as to –
      (a) persons,
and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), –
   (a) in giving its consent, the regulator, and
   (b) in making the documents available for inspection, the corporation,
must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –
   (i) that his or her vote was given, and
   (ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

55. Countermand or abandonment of poll on death of candidate – (1) If, at a contested election, proof is given to the returning officer’s satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to –
   (a) publish a notice stating that the candidate has died, and
   (b) if the death is proved after the close of the poll, proceed with the counting of the votes as if that candidate had been excluded from the count so that –
      (i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
      (ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

   (2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 50(1)(a).

Part 10 – Election expenses and publicity

56. Election expenses – Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

57 Expenses and payments by candidates - A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to –
   (a) personal expenses,
   (b) travelling expenses, and expenses incurred while living away from home, and
   (c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

The corporation reserves the right to inspect receipts and other evidence submitted by or demanded of the candidate so as to demonstrate compliance with this requirement.
58. Election expenses incurred by other persons – (1) No person may –
   (a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate’s election, whether on that candidate’s behalf or otherwise, or
   (b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

   (2) Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 59 and 60.

59. Publicity about election by the corporation – (1) The corporation may –
   (a) compile and distribute such information about the candidates, and
   (b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

   (2) Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 60, must be –
   (a) objective, balanced and fair,
   (b) equivalent in size and content for all candidates,
   (c) compiled and distributed in consultation with all of the candidates standing for election, and
   (d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

   (3) Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

60. Information about candidates for inclusion with voting documents – (1) The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 25 of these rules.

   (2) The information must consist of a statement submitted by the candidate of no more than 150 words.

61. Meaning of “for the purposes of an election” – (1) In this Part, the phrase “for the purposes of an election” means with a view to, or otherwise in connection with, promoting or procuring a candidate’s election, including the prejudicing of another candidate’s electoral prospects; and the phrase “for the purposes of a candidate’s election” is to be construed accordingly.

   (2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

62. Application to question an election – (1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator. (2) An application may only be made once the outcome of the election has been declared by the returning officer.

   (3) An application may only be made to the regulator by –
   (a) a person who voted at the election or who claimed to have had the right to vote, or
   (b) a candidate, or a person claiming to have had a right to be elected at the election.

   (4) The application must –
   (a) describe the alleged breach of the rules or electoral irregularity, and
   (b) be in such a form as the regulator may require.

   (5) The application must be presented in writing within 21 days of the declaration of the result of the election.

   (6) If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

   (7) The Regulator shall delegate the determination of an application to a person or persons to be nominated for that purpose by the Regulator.

   (8) The determination by the person or persons nominated in accordance with 62 (7) shall be binding on and shall be given effect by the corporation, the applicant, the members of the constituency (or class within that constituency) and the candidate (if any) to which the application relates.

   (9) The Regulator may prescribe rules of procedure for the determination of an application, including costs.

63. Secrecy – (1) The following persons –
   (a) the returning officer,
   (b) the returning officer’s staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to –

   (i) the name of any member of the corporation who has or has not been given a ballot paper or voted,
   (ii) the unique identifier on any ballot paper,
   (iii) the candidate for whom any person has voted for on any particular ballot paper.

   (2) No person may obtain or attempt to obtain information as to the candidate for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

   (3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals that are affected by this provision are aware of the duties it imposes.

64. Prohibition of disclosure of vote – No person who has voted at an election shall, in any legal or other proceeding to question the election, be required to state who he or she has voted for.
65. **Disqualification** – A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is –

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

66. **Delay in postal service through industrial action or unforeseen event** – If industrial action, or some other unforeseen event, results in a delay in –

(a) the delivery of the documents in rule 25, or
(b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the regulator.

---

**Annex 6**

**Governors and Directors: Communication and Conflict**

1. **Summary**

This annex describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

2. **Informal Communications**

2.1 Informal and frequent communication between the governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

2.2 The Chairman of the Council of Governors and the Board of Directors will encourage informal methods of communication including:-

   a) Participation of the Board of Directors in the induction, orientation and training of governors.
   b) Development of special interest links between non-executive Directors and governors.
   c) Discussions between governors and the Chairman, the Chief Executive or a Director, through the office of the Chief Executive or his or her nominated officer to the Board.
   d) Involvement in membership recruitment and briefings at public events organised by the Trust.

3. **Formal Communication**

3.1 Some aspects of communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively. Communications initiated by the Council of Governors, and intended for the Board of Directors, will be conducted as follows:-

   a) Specific requests by the Council of Governors will be made through the Chairman, to the Board of Directors;
   b) Any Governor has the right to raise specific issues at a duly constituted meeting of the Council of Governors through the Chairman. In the event of disagreement, two thirds of the governors present must approve the request. The Chairman will raise the matter with the Board of Directors and provide the response to the Council of Governors.
   c) Joint meetings will take place between the Council of Governors and the Board of Directors as and when appropriate.

3.2 The Board of Directors will request the Chairman to seek the views of the Council of Governors:-

   a) on the Board of Directors proposal for the Strategic Direction, and the Annual Business Plan.
   b) on the Board of Directors proposals for developments.
   c) on Trust performance.
   d) on their involvement in service reviews and evaluation.
   e) on proposed changes, plans and developments for the Trust.
3.3 The Board of Directors will also present for the approval of the Council of Governors, the annual accounts, annual report and auditors report.

3.4 The following formal methods of communication will also be used:-

a) Attendance by the Board of Directors at a meeting of the Council of Governors.
b) Provision of formal reports or presentations by executive Directors to a meeting of the Council of Governors.
c) Inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors.
d) Reporting the views of the Council of Governors to the Board of Directors through the Chairman or Deputy Chairman.
e) Issue to the Council of Governors all agendas and minutes of meetings of the Board of Directors (to be held in confidence by the governors, in accordance with the Trust’s Code of Conduct for Governors, where such documents relate to Board’s confidential meetings and discussions.

4. Resolving Conflict

4.1 The Council of Governors and the Board of Directors must be committed to develop and maintain a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

4.2 If through informal efforts the Chairman cannot achieve resolution of a disagreement or conflict, the Chairman will follow the dispute resolution procedure described below. The aim is to resolve the matter at the first available opportunity, and only to follow this procedure if initial action fails to achieve resolution:

a) The Chairman will call a Resolution Meeting of the members of the Council of Governors and Board of Directors, to take place as soon as possible, but no later than twenty clear days following the date of the request. The meeting must comprise two thirds of the membership of the Council of Governors and two thirds of the membership of the Board of Directors. The meeting will be held in private in accordance with paragraphs 8.13 and 10.2 of this Constitution. The Agenda and any papers for the meeting will be issued in accordance with Annex 2. The aim of the meeting will be to achieve resolution of the conflict. The Chairman will have the right to appoint an independent facilitator to assist the process. Every effort must be made to reach agreement.

b) If a Resolution Meeting of the members of the Council of Governors and Board of Directors fails to resolve a conflict, the Board of Directors will decide the disputed matter.

c) If following the formal Resolution Meeting, and the decision of the Board of Directors, the Council of Governors considers that implementation of the decision will result in the Trust failing to comply with its Constitution or any provision under Chapter 5 of the 2006 Act, the Council of Governors will notify Monitor of the specific issue of non-compliance.

4.3 The right to call a Resolution Meeting rests with the following, in the sequence of escalation shown:

a) The Chairman
b) The Chief Executive
c) Two thirds of the members of the Council of Governors
d) Two thirds of the members of the Board of Directors

e) Nothing within this clause shall affect the Governors’ right of referral to the Panel in accordance with the procedure set out in paragraph 8.20 of the Constitution.

5. Review of Process

The business agenda will include a joint meeting of the Council of Governors and the Board of Directors to assess communications, and consider any changes to this procedure that might assist resolution in the event of a conflict between them.
Annex 7

Register of Directors and Governors Interests

1. Pursuant to Section 20 of Schedule 7 of the National Health Service Act 2006, a register of directors and governors' interests must be kept by each NHS Foundation Trust.

2. Declaration of Interests

2.1 All Directors (including for the purposes of this document, non-executive Directors) and governors should declare relevant and material interests.

2.2 Interests which should be regarded as "relevant and material" and which, for the guidance of doubt, should be included in the register, are:

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).
(b) Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
(f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

2.3 If Directors or governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman.

2.4 At the time the interests are declared, they should be recorded in the board minutes or governors meeting minutes as appropriate. Any changes in interests should be officially declared at the next board meeting or governors meeting as appropriate following the change occurring. It is the obligation of the Director or governor to inform the Chairman or his or her nominated officer in writing within 7 clear days of becoming aware of the existence of a relevant or material interest. The Chairman or his or her nominated officer will amend the register upon receipt within 7 clear days.

2.5 Directors directorships of companies in 2(a) above or in companies likely or possibly seeking to do business with the NHS (2(b) above) should be published in the board’s annual report. The information should be kept up to date for inclusion in succeeding annual reports.

2.6 During the course of a board meeting or governors meeting, if a conflict of interest is established, the Directors or governors concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chairman having the casting vote.

2.7 There is no requirement for the interests of directors' or governors' spouses or partners to be declared.

2.8 The above direction is in addition to the conflict of interests outlined in paragraph 11 of the Constitution.
LEAD GOVERNOR’S REPORT

1. INTRODUCTION

1.1. I am writing this report some days before the Annual General & Public Members Meeting and, as a result of an important family commitment, I had to give my apologies for missing this meeting. This is the first AGM I have missed since I became a governor in 2005. I am grateful to Pauline Buttling for standing in to present my report.

1.2. Meetings of the Council of Governors seem to come round ever more quickly these days. The period since the last Council of Governors meeting on 6th August has been relatively uneventful. As I write we await the report from the Care Quality Commission following its inspection in July, but Diane Wake, Chief Executive, writes (in the new issue of Barnsley Hospital News) that the preliminary feedback was very good.

2. ACTIVITIES AND EVENTS

2.1. I attended both the Quality and Governance sub-group on 11th August and the Finance and Performance sub-group on 8th September. I believe the sub-group structure we adopted at the start of the year is working well. The attendance by the chair of the corresponding Board committee (often with another Non-Executive Director member of that committee too) is resulting in meetings more focussed on our role of holding the NEDs to account.

2.2. I again chaired the training evening on 3rd September. Dr Richard Jenkins, Medical Director spoke on hospital mortality and the measures of mortality, HSMR and SHMI. This is not a simple topic but the governors who attended certainly had a much better understanding of it after Dr Jenkins’ presentation.

2.3. All governors were invited to attend a working group meeting to review the Trust constitution on 8th September, and a number of governors did so. The governors attending agreed that the constitutional change of two years ago establishing one single public constituency for the whole of Barnsley had worked well.

2.4. The proposal for governors to be elected for a four year term rather than three years was found not to be in compliance with the legislation which established Foundation Trusts. Some relatively minor proposed changes will be presented for approval. All amendments to the constitution require the agreement both of the Board of Directors and the Council of Governors and a more detailed report is provided separately.

2.5. Also on 8th September I attended a meeting of the Nominations Committee which has begun the process of appointing a Non-Executive Director from 1st January. This is the post currently held by Linda Christon.
3. ANNUAL DEVELOPMENT SESSION

3.1. Our annual development session is to be held on 17\textsuperscript{th} November. At the Finance & Performance sub-group meeting on 8\textsuperscript{th} September there was some initial discussion on the development session. If you have any ideas for the development session please contact the sub-group chair, David Brannan, or myself.

3.2. Carol Dudley has circulated a recent Monitor publication “Survey of NHS foundation trust governors 2014/15” and there may be some ideas for development topics from that publication.

4. ANNUAL ELECTIONS

4.1. Governors are reminded that the annual elections to the Council of Governors have commenced, with six public and three staff seats available (the former including a current vacancy). Governors whose terms of office will expire on 31\textsuperscript{st} December are all eligible to seek re-election and I very much hope they will do so. Equally, however, I would ask you all to speak to your members, friends, neighbours and colleagues to encourage their interest in standing as a Governor too.

4.2. We, as Governors, know a lot about what the role entails and why we do it. Please share your experience with others too and invite them along to the Candidates’ Workshops on 7\textsuperscript{th} October (9am and 12 noon) or 14\textsuperscript{th} October (1pm and 5.30pm).

4.3. The closing date for Nominations is 2\textsuperscript{nd} November. Members will be receiving information about the elections through the post shortly and packs can also be obtained from the Governors’ office or our independent election scrutineers:

- by phone 0345 2093770 (contact Katie Roper)
- by email Barnsleyhospital@uk-engage.org
- or online https://www.mi-nomination.com/bhnhsft

5. NHS PROVIDERS

The governor support role of NHS Providers is slowly growing. See this on [www.nhsprovides.org/members/goveror-support](http://www.nhsprovides.org/members/goveror-support), although I get the feeling that they are covering old ground covered by the former Foundation Trust Governors Association some years ago. If you are a follower of social media (which I avoid) you are invited to join their conversation on Twitter via @NHSPgovernors.

6. RECOMMENDATIONS

The Council of Governors is recommended to receive this report.

Joe Unsworth
Lead Governor
October 2015
CHIEF EXECUTIVE’S REPORT

1. INTRODUCTION

1.1 This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since last month’s report and highlight a number of items of interest.

1.2 The items below are not reported in any order of priority.

2. FALLS AWARENESS WEEK

2.1 Falls Awareness Week will place in the Trust during the week commencing 28th September 2015. Falls Awareness Week is targeted at staff, patients, carers and families and aimed to raise awareness of falls within the hospital and how these could be prevented.

2.2 Staff are encouraged to be aware of the various steps in place to prevent falls. The first step is to do a level one assessment, which will highlight high risk patients who require a more comprehensive assessment. If a patient has fallen, stickers should be placed in patient files as an immediate prompt on what actions should be taken in regards to the patient’s health. Secondary post-fall assessments should then be taken.

2.3 Guidance will be provided to help staff identify high risk patients and advice will be provided for patients and relatives in every patient locker.

2.4 During Falls Awareness week, stands will be in the restaurant and the Outpatients area.

3. WORLD SEPSIS DAY- 13TH SEPTEMBER 2015

3.1 World Sepsis Day was held on 13th September 2015 and was a good opportunity to remind ourselves what we can do to help save lives from Sepsis. Improving Sepsis care is a national priority for the NHS and that is why it is a national Commissioning Quality and Innovation (CQUIN) target this year that all hospitals must take part in.

3.2 There are around 37,000 deaths each year from Sepsis in the United Kingdom and it is estimated that 12,500 could be prevented with consistent recognition and treatment. Although the Trust has made great improvements we still see Sepsis featuring in some of our Serious Incidents.

3.3 Some short films with regards to Sepsis can be found on the UK Sepsis Trust website and the links are:

http://sepsistrust.org/professional/educational-tools/

4. BARNESLEY ASSISTIVE TECHNOLOGY TEAM OPEN DAY – 21ST SEPTEMBER 2015

4.1 The Barnsley Assistive Technology Team held an open day on 21st September 2015 to showcase the new offices and some of the many technology solutions that could be offered. Clientele are predominately those with severe disabilities including sensory,
cognitive and/or physical impairments and the team aims to improve their independence and quality of life through Assistive Technology (AT); equipment provision with emphasis on their ability to communicate, control their home environment and computer access.

4.2 The Barnsley Assistive Technology team is expanding and undergoing major changes in progression towards delivering an AT service across the Yorkshire and Humber areas.

5. WORKING TOGETHER - NHS ACUTE CARE COLLABORATION VANGUARDS

5.1 As the Governors are aware, Barnsley Hospital has been working in partnership with six other NHS Trust across South Yorkshire, Mid Yorkshire and South Derbyshire for the last 18 months to exploit opportunities for working together to achieve clinical benefits for our patients and the best use of resources which otherwise would not be possible by working in isolation.

5.2 It has been announced recently that the working partnership is to be one of 13 new NHS Vanguards (Accountable clinical networks), which will allow us to explore these opportunities further and share our learning with others in the NHS. We aim to strengthen each of our partner organisations through sharing collective expertise and knowledge so that safe, sustainable service models can be created and better care delivered to patients across the seven Trusts and multiple hospital sites.

5.3 Our collective aim, working with our Commissioners is to continue, to improve quality, safety and patient experience through the delivery of local services in the most appropriate care setting that are clinically and financially sustainable and improve health and well-being of the people being served in the most efficient and effective way.

5.4 NHS England Chief Executive Simon Stevens has said that a new approach to hospital partnerships will help sustain the viability of local hospitals, share clinical and management expertise across geographies, and drive efficiency beyond the walls of individual institutions. This is also the aim of the working partnership.

6. LIFTING OF BREACH OF LICENCE FOR GOVERNANCE

6.1 The Trust welcomed notification from Monitor in September of their decision to lift the Section 111 notice against the Trust.

6.2 In lifting this condition, Monitor has recognised that the Trust has strengthened our senior leadership team and improved the way we run the Trust. They also documented that they are satisfied the Board is functioning effectively and that the leadership team now has the skills needed to tackle the issues the trust faces.

6.3 We remain in breach of licence for our financial situation. Finances remain challenging but Monitor has acknowledged that we are taking steps to address them.

6.4 I would like to take this opportunity to reiterate sincere thanks to each and every one of our staff for pulling together to do the best for our patients and to support each other during what has been some very difficult and challenging circumstances.

7. CONSULTANT APPOINTMENTS

7.1 Interviews for the two new posts in Urology were undertaken on 3rd September 2015 and I am pleased to inform the Council of Governors that two consultants were successfully appointed pending pre-employment checks.

Diane Wake
Chief Executive
October 2015
STRATEGIC SUB-GROUPS

1 INTRODUCTION

1.1 This report provides an update on the work and discussions of the Council of Governors’ Quality & Governance sub-group (QGSG) and Finance & Performance sub-group (FPSG) meetings held in August and September respectively, and the latest Governors’ training session.

1.2 Changes to the sub-group leadership are also reported.

2 SUB-GROUP LEADERSHIP & MEMBERSHIP

2.1 David Brannan and Jordan Ramsey are Chairs for FPSG and QGSG respectively; Trevor Smith is the Vice-Chair for both sub-groups.

2.2 Membership of the sub-groups remains informal. Governors are welcome to attend the sub-group meetings regularly or on an ad hoc basis if preferred. If any Governor wishes to raise an item through either of the sub-groups, the Chairs would be pleased to hear from you ahead of the next meeting’s agenda.

3 WORK OF THE SUB-GROUPS

3.1 One of the primary objectives of the sub-groups is to support the Governors’ role of holding the Non Executive Directors (NEDs) – and through them, the Board – to account for the Trust’s performance. As part of this, the sub-groups continue to review progress against the strategic aims and objectives underpinning the Trust’s business plan.

3.2 In addition to the Chair’s Logs received from the Board’s Finance & Performance and Quality & Governance Committees, Board reports on a range of issues of interest to Governors continue to be shared at sub-group meetings and other information can be presented on request.

3.3 The sub-group meetings also provide a valuable opportunity for Governors to share feedback from their constituencies (public, partners and staff) as well as their own experiences and observations of the hospital’s services.

3.4 Minutes from the sub-groups are shared with all Governors by email. Printed copies are available to Governors on request and key points from each meeting are reported at General Meetings (see below).
3.5 As stated previously, sub-group meetings are intended to supplement and support the work of the wider Council of Governors. Other information will also continue to be available to Governors via formal and informal updates from the Chairman and Chief Executive, Governor attendance at Board meetings held in public, the annual joint meeting of the Governors and Board, briefings received at General Meetings, private briefing sessions for Governors, and the Board’s responses to any questions raised by Governors.

4 REPORT ON SUB-GROUP MEETINGS

4.1 Quality & Governance (QGSG)

This group’s latest meeting was held on 11th October and was chaired by Jordan Ramsey. Key issues discussed are noted below.

- Informal feedback on the Care Quality Commission inspections that took place in July (formal outcomes still awaited). It was emphasised that the improvements and continued focus on quality and patient safety reflected the Trust’s continuous approach and had not been driven solely by the visit.

- An informative overview of the 2014/15 annual report on complaints, compliments and concerns was provided by Jill Pell, Head of Patient Experience. Jill highlighted the evidence based service improvements delivered in response to feedback from patients and their families/carers and learning from reported incidents throughout the year, and the improved system now in place to ensure faster (but still robust) responses to patients’ complaints. The report also flagged the increased number of queries handled through the Patient Advice & Liaison team as well as via the formal complaint system and the nearly 4000 compliments recorded throughout the year. Jill outlined key areas for further improvements too and confirmed that these had been built into the teams’ plans for 2015/16.

- The Chair’s Logs from the latest meetings of the Board’s Quality & Governance Committee were presented by Linda Christon, Non Executive Director and Committee Chair. She also presented and expanded on the quality issues within the Integrated Performance Report. The Committee’s discussions focussed on continuing work to reduce DNAs (did not attends), improvements in surgical site infections, continued improvement in mortality ratios and the spike in serious incidents (partly reflecting wider reporting systems).

- The sub-group also received the internal audit report on the Quality & Safety visits, many of which are attended by Governors. The audit was encouraging and showed that wards welcomed and responded positively to feedback from the visits. Any further points of particular interest from the report will be revisited at the next meeting. Governors’ request for more regular reporting on the outcomes from the visits (quarterly or six monthly) was noted and is being progressed.

- Governors’ input to the Trust’s first “mystery shopper” programme was reviewed: this had been useful for both Governors and the Trust and would be repeated at a later date. Other opportunities for ward visits would be welcomed by Governors too.

- Accessibility to wheelchairs for patients/visitors was raised and would be pursued by the Quality & Governance Committee Chair.

- Impact of the bed reconfiguration was also reviewed by the sub-group and would be monitored as it became more established.
4.3 Finance & Performance (FPSG)

The latest FPSG meeting was Chaired by David Brannan on 8th September and covered a diverse agenda, including:

- confirmation of the agreed date for the Governors’ Annual Development Session (ie 5.30-7.30pm on 17th November) and a repeated invitation for any items of interest to be included;

- review of the Chair’s Log from the Board’s Finance & Performance (F&P) Committee and the performance and workforce issues from the latest Integrated performance Report, presented by two Non Executive Committee members – Francis Patton (Committee Chair) and Nick Mapstone. Among issues of particular interest were the shortfall on the cost improvement programme and plans to redress this (including new initiatives valued at £600,000); the reported financial deficit against plan (partly due to phasing but with work requested by the Committee to clarify issues within individual clinical business units too); work on agency spend (although the Trust remained in a better position than many of its peers); good progress on addressing the backlog in outpatients review appointments reported previously; overall good performance against key national indicators albeit with pressures noted across several activities; a spike in sickness absence levels and actions planned to support staff and reduce unplanned absences where possible, and positive feedback from the latest survey on appraisals, which showed a much better response and wide support for the improved appraisal systems albeit with some areas for improvement, which will be addressed in the action plan being developed. The F&P Committee Chair also reported on plans to update the Trust’s strategy for Information & Communications Technology (ICT), with the latest 3-year plan drawing to an end and appointment of a new Director of ICT shortly to be announced.

- Both FPSG and QGSG commented on the ongoing work around DNAs and Governors raised a few comments which could be factored into the work - including raising staff awareness of the opportunities for inpatients to attend extant clinic appointments, more opportunity to phone into the departments direct to change appointments where needed (this seemed to work well where it was available), which might also offset the difficulties experienced by several Governors with the central appointments number.

- The Non Executive Directors (NEDs) welcomed Governors’ positive responses when asked if the information provided via the Chairs’ Logs and the Integrated Performance report was sufficient. Governors appreciated the opportunity to raise questions of the NEDs directly with their increased attendance at sub-groups.

- FPSG also received the annual report from the Audit Committee, presented by Nick Mapstone on behalf of the Committee Chair, Mrs Suzy Brain England. The report highlighted the Committee’s work throughout the year, supported by both internal and external auditors, and plans for 2015/16. Tony Dobell would be attending the September meeting of the Audit Committee, as Audit Liaison Governor, helping to develop closer links between governors and the Committee. Annual reports from the Q&G and F&P Committees would be available to Governors in October.
5 GOVERNORS’ TRAINING

5.1 The in-house training sessions re-launched at the beginning of 2015 continue to be well received and well attended.

5.2 The latest session was held on 3rd September and provided a useful insight into the complex factors that contributed to reporting of mortality ratios and an informative briefing on the pathways for medical staff – from entry as trainees/junior doctors, through to Consultants. This session was led by the Medical Director and copies of his presentation are available for Governors on request.

6 CONCLUSION & RECOMMENDATIONS

6.1 The notes above are by no means a full reflection of the meetings’ business. Governors are encouraged to come along to hear more and contribute to the sub-groups’ discussions and work.

6.2 Governors are asked to:

a) note and support this report, and

b) put forward any ideas they would like to propose for the 2015 Annual Development session.

David Brannan
Finance & Performance
SUB-GROUP CHAIRS
September 2015

Jordan Ramsey
Quality & Governance
1 MEETING PAPERS & AGENDA

1.1 The Agenda for the meeting of the Board of Directors to be held in public on 1st October 2015, is attached for information. The minutes of the previous meeting, held in September are also attached (nb: these will be subject to approval at the Board’s meeting on 1st October).

1.2 The latest performance report is enclosed too. This is in the developing format, which will be further refined over the next few months.

1.3 Progress against delivery of the strategic objectives for the 2015/16 Business Plan will continue to be monitored through the Governors’ sub-groups. Any questions or comments on the performance report would also be welcomed at the General Meeting.

1.4 Copies of the full reports from all Board meetings held in public are available on the Trust’s website (www.barnsleyhospital.nhs.uk) or on request from the Secretary to the Board (Carol Dudley, 01226 431818 or email carol.dudley@nhs.net).

2 FUTURE MEETINGS

2.1 Governors, staff and members of the public are welcome to come along to observe any meetings of the Board held in public. Meeting papers will be provided on the Trust’s website and at the meeting.

2.2 The Board of Directors’ regular meetings are usually held on the first Thursday of every month but there are exceptions and Governors are advised to check with the Governors’ Office or on the Trust’s website for further details.

2.3 The next Board of Directors’ meetings to be held in public are scheduled for 5th November (joint meeting between the Board and Governors) and 3rd December 2015, both commencing at 9am.

3. RECOMMENDATION

Governors are asked to receive and note this report.

Stephen Wragg
CHAIRMAN
October 2015
**A MEETING OF THE BOARD OF DIRECTORS**  
**WILL TAKE PLACE ON THURSDAY 01 OCTOBER 2015, 9AM**  
**IN THE EDUCATION CENTRE, BARNSTLE HOSPITAL**

### AGENDA

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Sponsor</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apologies and Welcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>To <strong>receive</strong> any declarations of interests</td>
<td>S Wragg, Chairman</td>
<td>15/10/P-03</td>
</tr>
<tr>
<td>3.</td>
<td>To <strong>approve</strong> the Minutes of the meeting of the Board of Directors held in public on 03 September 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>To <strong>approve</strong> the Action Log in relation to progress to date and <strong>review</strong> any outstanding actions</td>
<td></td>
<td>15/10/P-04</td>
</tr>
</tbody>
</table>

#### Strategic Aim 1: Patients will experience safe care

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Sponsor</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>To <strong>receive</strong> and <strong>review</strong> latest Patient’s Story</td>
<td>H McNair Dir of Nursing &amp; Quality</td>
<td>Presentation</td>
</tr>
<tr>
<td>6.</td>
<td>To <strong>receive</strong> and <strong>endorse</strong> the Chair’s Log and assurance from the Quality &amp; Governance Committee</td>
<td>L Christon Committee Chair</td>
<td>To be tabled</td>
</tr>
<tr>
<td>7.</td>
<td>To <strong>receive</strong> the quarterly report on the Trust’s Mortality Ratios</td>
<td>Dr R Jenkins, Medical Dir</td>
<td>15/10/P-07</td>
</tr>
<tr>
<td>8.</td>
<td>To <strong>review</strong> the Chair’s Log on any escalation issues from the Executive Team</td>
<td>D Wake Chief Executive</td>
<td>-</td>
</tr>
<tr>
<td>9.</td>
<td>To <strong>receive</strong> and <strong>endorse</strong> the Chair’s Log and assurance from the Audit Committee</td>
<td>S Brain England, Committee Chair</td>
<td>To be tabled</td>
</tr>
<tr>
<td>10.</td>
<td>To <strong>approve</strong> the Trust’s response to NHS England core standards for emergency preparedness, resilience and response (EPRR) 2015/16</td>
<td>K Kelly Director of Operations</td>
<td>15/10/P-10</td>
</tr>
</tbody>
</table>

#### Strategic Aim 2: Partnership will be our strength

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Sponsor</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>To <strong>note</strong> the monthly report from the Chairman</td>
<td>S Wragg, Chairman</td>
<td>15/10/P-11</td>
</tr>
<tr>
<td>12.</td>
<td>To <strong>note</strong> and <strong>endorse</strong> monthly report from Chief Executive</td>
<td>D Wake, Chief Executive</td>
<td>15/10/P-12</td>
</tr>
<tr>
<td>13.</td>
<td>To <strong>approve</strong> the annual review of the Trust’s Constitution</td>
<td>A Keeney Assoc Dir of Corp Affairs</td>
<td>15/10/P-13</td>
</tr>
</tbody>
</table>

#### Strategic Aim 3: People will be proud to work for us

#### Strategic Aim 4: Performance matters

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Sponsor</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>To <strong>receive</strong> and <strong>endorse</strong> the Chair’s Log and assurance from the Finance &amp; Performance Committee</td>
<td>F Patton Committee Chair</td>
<td>To be tabled</td>
</tr>
<tr>
<td>15.</td>
<td>To <strong>review</strong> the integrated performance report (month 5)</td>
<td>Executive Team</td>
<td>15/10/P-15</td>
</tr>
<tr>
<td>16.</td>
<td>To <strong>note</strong> intelligence reporting/horizon scanning for the Board</td>
<td>E Parkes Dir of Marketing &amp; Comms</td>
<td>15/10/P-16</td>
</tr>
</tbody>
</table>

17. In accordance with the Trust’s Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.

Date of next meeting: 05 November 2015, 9am (joint meeting with Council of Governors)

Signed: ..............................................  
Chairman

*Please see reference section at back of papers for key to business plan and glossary of terms/acronyms*
REPORT TO THE BOARD OF BARNSLEY HOSPITAL NHSFT

MINUTES OF A MEETING OF THE
BOARD OF DIRECTORS
HELD ON 03 SEPTEMBER 2015
IN THE EDUCATION CENTRE, BARNSLEY HOSPITAL NHSFT

PRESENT:
Mrs S Brain England OBE  Non Executive Director
Mrs L Christon  Non Executive Director
Dr R Jenkins  Medical Director
Ms K Kelly  Director of Operations
Mr N Mapstone  Non Executive Director
Mrs H McNair  Director of Nursing & Quality
Ms R Moore  Non Executive Director
Mr F Patton  Non Executive Director
Ms D Wake  Chief Executive
Mr S Wragg  Chairman
Mr M Wright  Acting Director of Finance

IN ATTENDANCE:
Mr J Bradley  Director of ICT
Mrs L Christopher  Associate Director of Estates & Facilities
Ms C E Dudley  Secretary to the Board
Ms D Edwards  Head of Nursing, Emergency and Trauma & Orthopaedics Services (CBU1) *
Mr J Fernandez  Associate Director of HR&OD
Mr A Jones  Lead Nurse, Paediatrics, Emergency and Trauma & Orthopaedics Services (CBU1) *
Ms A Keeney  Associate Director of Corporate Affairs
Mr R Kirton  Director of Strategy & Business Development
Ms E Parkes  Director of Marketing & Communications
Ms G Thompson  Cancer Services Manager
(* attended part of meeting, re Minute 15/154)

15/149 APOLOGIES & WELCOME

Members and attendees noted above were welcomed. Members of staff and the public were also welcomed as observers to the meeting.

Members’ apologies were noted as above. It was also noted that, as a courtesy, apologies had been received from several Clinical Directors: Miss Dass, Dr Kapur and Mr Wickham, and from Mr Diggles, External Consultant.

15/150 DECLARATION OF INTERESTS

None.

15/151 MINUTES OF LAST MEETING  (15/09/P-03)

The Minutes of the meeting of the Board of Directors held in public on 6th August 2015 were received and reviewed. It was noted that Mrs Kelly had been present at the meeting; subject to this amendment, the Minutes were approved as a true record.
The action log showing progress on matters arising from the last and previous meetings held in public was reviewed and noted.

Mrs McNair introduced Mr Jones, to present a patient’s story illustrating the benefits of the “Addaction” service. In his presentation, Mr Jones provided an overview of the Addaction service, which enabled staff working in children and young people’s emergency services to have better accountability of the wider needs of their patients. Addaction was built around a scoring tool aid, to identify risks to young attendees and refer them for support from Addaction, which operated a weekly clinic in the Emergency Department (ED). Addaction was able to provide advice and more direct support for any form of substance abuse; it had developed good links with schools and social services in the community to ensure all referrals were followed up. 16 patients had been referred to Addaction since March, three of whom had already been discharged after receiving support. Mr Jones outlined the story of one young person who had been referred to and helped by Addaction. Initially the young person had not attended any of the appointments made with Addaction but the team had followed this up to get them engaged and treated in the community, resulting in a good outcome.

In response to questions from the Board, Mr Jones affirmed Addaction had a long term benefit too: as part of the process, children were being challenged about their actions in a positive way (not just reported to their parents or carers), with offers of help, giving them cause to think about their own actions and he believed this had resulted in fewer re-attendances from substance abuse. He assured the Board that awareness of the Addaction pathway had been shared with other staff, to ensure that it was utilised at all times, even when paediatric ED staff were not available; it had been welcomed by staff – empowering them to help young patients more. He confirmed that the pathway sheets were incorporated into the patients’ notes and would be joined up with other issues, such as safeguarding, where necessary. He agreed, however, that to develop the service further it would be useful to look at adding feedback from the Addaction teams into the records too.

Before leaving the meeting, Mr Jones and Ms Edwards were thanked for attending and for providing a comprehensive overview of the Addaction service.

The thematic review of SIs in the six months January-June 2015 was received and considered. Dr Jenkins highlighted the increase in harm from falls over this period and reminded the Board of the work now being led by Mrs McNair to address this. Mrs McNair outlined some of the key workstreams recently introduced, including a consultant leading more frequent ward rounds across the Trust, with the falls team, which it was anticipated would have a significant impact, and introduction of a new multifactorial assessment tool on Lorenzo. Dr Jenkins also highlighted the cluster of incidents reports in theatres and the actions taken to address same, including Human Factors training. The Chairman advised Members that this training would be undertaken by the Board shortly too. The three never events in the report were also highlighted, one of which had since been assigned to another Trust.

Mrs Brain England appreciated the good record keeping and transparent reporting on SIs and never events and the work being undertaken to prevent...
recurrences. She had noted that many of the consequent actions referred to training and shared learning - and questioned if this was sufficient and queried how this was taken forward. Dr Jenkins and Mrs McNair emphasised the multifactorial approach, which included the work outlined in the report to drive a further reduction in falls, ongoing work with the teams in theatres, actions progressed through Listening into Action (LiA) and working through recommendations from the Improvement Academy, including the recent roll out of safety huddles. Mrs Christopher reported on a series of actions regularly undertaken by the Estates team too to ensure a safer environment for patients. From the investigations carried out on each incident, the Trust knew where focus was needed to deliver greater safety. The impact of the various workstreams outlined would be reviewed in 3-4 months. Training, however, remained essential – reinforcing the basics and ensuring assessments were carried out effectively to ensure the right support was put in place for patients throughout their stay. Mrs Christon, as Chair of the Quality & Governance (Q&G) Committee, assured the Board that the issues were closely monitored through Q&G. Recent discussions had focus on specific times and issues affecting frail elderly patients and work to offset those risks and Mrs McNair also referred to work shortly to be taken forward with support from an external specialist company to develop a more interactive approach with this patient group, rather than simply expanding the current specialising approach.

Ms Moore appreciated the Trust’s commitment not to be complacent around outliers despite demands on beds but did enquire about the outcomes of previous work around outliers, any correlation between falls patients with dementia or cognisance impairment (and related work to develop more dementia friendly environments) and whether or not it might be useful to seek an external review of the Trust’s work to gain a fresh perspective on work to date and areas for further development. Mrs McNair and Ms Wake advised that vulnerable patients were cared for on core wards and rarely as outliers despite current high demands and escalation needs, so this had not been identified as an issue for the Trust. In terms of the environment, the Chairman highlighted the work already carried out extensively on Ward 19 specifically to create more dementia friendly areas and Ms Wake affirmed that the Dementia Lead Nurse was involved with any refurbishment works across the Trust to ensure that environmental needs were taken into account more widely as every opportunity arose. It was agreed that ‘fresh eyes’ were always useful but it was further agreed that the wide range of ongoing work and initiatives being introduced from Mrs McNair’s links with the Improvement Academy should be progressed and assessed through Q&G as a first step, with options for further external review to be considered later.

The range of actions being progressed was welcomed, as were the Board’s extensive discussions, both giving further evidence to the seriousness of the issues around patient safety and the Trust’s commitment to continuing improvements. The Chairman reiterated Mrs Brain England’s comments around training and shared learning and it was agreed that the Board needed more assurance and that these factors should be referred to Q&G for further discussion.

15/155 **EXECUTIVE TEAM (ET) CHAIR’S LOG**

Ms Wake presented and expanded on the ET Log, which highlighted the Trust’s response to the letter received from Monitor requesting further review of financial plans. Monitor, NHS England and the Trust Development Agency had written to all trusts across England and Wales, seeking further savings through a number of proposed interventions.
Ms Wake advised that prior to submission of the Trust’s response, the ET had spoken with the Relationship team at Monitor, who had acknowledged the Trust’s already challenging plan and thus the probability that little leeway would be available from BHNFT. Nevertheless the Executives had considered each proposal within the letter, 90% of which the Trust was already enacting and some of which could not be actioned at the time (eg agency spend, pending the national guidance issued subsequently).

Mrs Brain England suggested it could be useful if the Trust was able to look still further ahead, to get itself better placed in readiness on the assumption that NHS finances nationally would be increasingly tight and central funding might be expected to reduce significantly in future years. Ms Wake assured the Board that the executives were constantly doing this, looking internally at where more savings and efficiencies could be delivered and looking outwards to take advantage of learning from good practice in other organisations. Work had already begun on the 2016/17 efficiency plans, with the clear aim of being ready to start from 1st April 2016 rather than depending on delivery in the second half of the year. The Chairman also reminded the Board of the likely need to revisit and reinforce its agreed strategy of quality over finance at all times, which was becoming increasingly contrary to national directives. He believed the Trust needed to revisit its service improvement and efficiency decisions continuously to ensure that any unintended adverse consequences were identified quickly and addressed. Ms Wake believed that the latter risk had reduced with more robust quality assessments now inherent within the preparation work for all efficiency plans but it was still an important consideration for past actions. She cited the example of phlebotomy support, which previously had been removed from wards as a cost saving but with the unforeseen impact of delaying some clinical assessments and discharges. It was intended for ward services to be reintroduced as part of the winter planning for 2015/16.

15/156 ANNUAL REVIEW OF GOVERNANCE STRUCTURE (15/09/P-08)

Ms Keeney presented an overview of the changes made to the governance structure in September 2014, and progress to date. It was noted that overall the changes had been quite effective, as reflected in both Ms Keeney’s and external reviews. She flagged that there was more work to progress on the review in the short term, including a refresh of the terms of reference (ToR) for each of the Governance Committees; further alignment of the Q&G Committee’s remit with the Trust’s agreed Quality Strategy and revisions of the reporting groups feeding into Q&G; proposed inclusion of the Board Assurance Framework (BAF) as a standing item on Chair’s Logs (to add useful further assurance for the Board and the Audit Committee), and a protocol to be developed for writing Board papers, supporting Mr Patton’s work on the review of the front covers for reports to the Board. Most of these issues would be addressed at the next meeting(s) of the Committees.

From the Board’s discussions a number of items for consideration in the next stage of the review were noted:

- Mr Mapstone pointed out that there was not currently an identified Deputy Chair for Q&G; this was queried and would be addressed in the refresh of the Committee’s ToR.
- Mr Mapstone also believed that the Audit Committee’s ToR should be tightened up to reflect that the auditors were required at every meeting.
- Mr Patton suggested that the presented report was pre-emptive as not all of the Committees had yet completed their annual reports.
- The Chairman queried the need for the BAF to become a standing item on the Chair’s Logs. It had been agreed that the Logs were intended to identify issues for escalation; the Minutes of each Committee were available to the Board for further assurance and the BAF was a standing item therein. Mrs Christon agreed and clarified that specific issues of significant change to the BAF should continue to be reported through the Chair’s Logs.

15/157 CHAIRMAN’S REPORT (15/09/P-09)

The Chairman’s report was received and noted, providing an overview on a number of activities undertaken by the Chairman since the last Board meeting and items of interest, including feedback from national and local events and the continuing work of the Council of Governors and Barnsley Hospital Charity. Points expanded in discussion included:

- the annual elections to the Council of Governors, due to start on 24th September. Every effort would be made to ensure all seats were filled, supported by a series of information sessions;

- promotional work planned by Ms Parkes, to widen awareness of the Charity Lottery and proposals to expand invitations for people to join the Lottery (currently restricted to staff and members only), although this would be subject to further discussions with the Charity’s Board of Trustees;

- the volunteers evening, held on 1st September; it was a valued opportunity to meet and chat to the volunteers albeit fewer had attended than in previous years. The Board took the opportunity to formally record its thanks to the volunteers for their support throughout the year. Mindful of the lower attendance, the Chairman commented that it was important for the Board to help the team find the right format for this special annual event in future.

Reports were invited from other members of the Non Executive team. Ms Moore reported on her recent meetings with the Dementia Lead Nurse and a day spent with the Trust’s spiritual care team, both of which had been very useful. She had been particularly impressed with the vibrant spiritual care culture offered across the Trust for all denominations. Mrs Kelly added to this with information on the spiritual team’s recent purchase of electric candles for the Chapel and news of one of the Trust’s volunteers who had now managed to secure a post within the hospital, which was great for both the person involved and the Trust. The Chairman reported a similar situation where an individual from overseas had secured voluntary work within the Trust’s labs and now been able to obtain permanent work in another organisation. The Board agreed that it was good to be able to support people using voluntary work as a way into employment.

15/158 CHIEF EXECUTIVE’S REPORT (15/09/P-09)

The Chief Executive’s report was received and noted, providing information on a number of internal, regional and national matters. Ms Wake highlighted the feature on the health checks available to staff throughout September, reinforcing the Trust’s intent to support staff health and wellbeing and also a timely link to recent national messages on sickness levels in the NHS.

Mrs Brain England reported on opportunities for working with Barnsley College for other factor that staff might appreciate (eg nail painting), which Mr Fernandez undertook to follow up. She would also like to see arrangements for walking groups and fitness classes set up in house, to encourage and support staff’s with health and social activities. Ms Wake also
suggested that the Trust could help encourage participation in events such as the charity walks and with fitness-related prizes offered for in-house competitions where appropriate. In wider discussion of support and facilities for staff, the restaurant’s opening hours were queried and several Board members reported on staff and their own experiences of it being closed earlier than expected. Mrs Christopher advised that the restaurant should be open and be offering healthy meal options until 8pm each day; she would look into the reports to get more information on opening hours.

15/159 COUNCIL OF GOVERNORS

The latest agenda and approved Minutes for the Council of Governors’ General Meetings held in August and June respectively were received and noted.

15/160 FINANCE & PERFORMANCE COMMITTEE (F&P)

Mr Patton, Chair of F&P, expanded on the Chair’s Log presented from the Committee’s meeting held in August. Key issues escalated by the Committee included:

- the £1 million deficit adverse to plan for month 4, which had caused considerable consternation. Core factors had included spend, costs and phasing (not done correctly – but lessons learned for future planning). To obtain more assurance on future delivery the Committee had requested a review of agency spend vs recruitment; work to be presented from the Clinical Business Units (CBUs) to demonstrate their position against plan and actions to address any identified gaps; and an outturn forecast to be presented in October – the mid year review meeting – with worst case scenarios factored in
- the latest position on the Cost Improvement Programme (CIP), which had worsened month on month – £440,000 behind plan. A full review of all plans had been requested for the next F&P meeting and, separately, it had been agreed that one of the Non Executive Directors should take up the previous invitation to attend a CIP meeting, to get further assurance on the work in hand to redress the shortfall
- the second iteration of the service line report (SLR), which now provided too little information for the Committee. This was being redressed to achieve the right balance for the next report, before being shared with the Board
- an update on the Outpatients review list, which had shown good progress, with 2486 patients validated as requiring appointments, which were now being booked in. The Committee expected a full plan to be presented shortly, showing longer term plans for outpatients to improve flow through and prevent a recurrence of the current position;
- actions to address the increase in workforce sickness absence reported in July, possibly impacted by the summer holidays. Work would include home visits for staff on long term sick and those identified as taking higher levels of sick leave in holiday times, to see if support could be provided for them. Also looking to explore options for in-house child care
- good outcomes from the much improved re-run appraisals survey (non-medical staff), and some areas for further development
- an update on the Trust’s 3 year ICT strategy: this was now approaching its end and had put the Trust in a good position to refresh the programme for the next 3-5 years. This would fit well with the change of IT lead imminent,
with the new Director of ICT to be appointed shortly.

Mrs Christon reinforced the feedback from the Committee and its focus on gaining further evidenced assurance on the actions outlined to redress the current areas of concern. The error around phasing could not be accepted as the reason for the shortfall (and it was emphasised at the Board meeting that this had not been the intention) and it was imperative that more movement on mitigating CIPs and cost recovery was progressed. Mr Wright highlighted other key pressures which had contributed to the position, including penalties (c£400,000 year to date), unfunded escalation costs and agency spend. Ms Wake emphasised the ET’s discussions regarding preparation for 2016/17, taking lessons from this year’s CIP, to ensure that plans were enacted from 1st April rather than later in the year and with appropriate consultation started soon enough to support this. To give further assurance on the CIP, Ms Wake reminded the Board that all plans remained subject to robust quality assessment as well as evaluation of financial efficiencies. Additionally the Trust would review clinic management over the summer period to take account of leave, which would impact on wider aspects of the outpatient review too, including a revised clinical template for outpatients based on 46 rather than 52 weeks per annum. Mr Kirton also highlighted the need to maintain a balance on risks; income continued to show a favourable position which had made the unplanned adverse position against deficit plan all the more unexpected. He would be working with colleagues to develop a clear set of actions to take the Trust forward towards year end targets.

Mr Mapstone reiterated concerns about the bed reconfiguration CIP and the underpinning system changes needed to enable delivery. Mrs Kelly agreed that this was a critical plan for the Trust; implementation had been delayed due to a variety of factors, including the recent Care Quality Commission visit and need for further consultation with staff. The ET remained committed to its delivery, supported by high quality services and different practices in nursing and clinical care. Other developments would also be dependent on schemes within the wider health economy to ensure robust support after discharge and the scheduled reduction in ED admissions not yet evidenced.

Ms Moore enquired if any further short terms gains could be achieved in year using LEAN principles. It was affirmed that these had all been identified and actioned previously. For the benefit of the newer Directors in post, the Chairman highlighted the Trust’s involvement in the “Productive” series launched in theatres and on several wards, which had largely encompassed the same principles. It was agreed that it might be useful to revisit these programmes at some point.

Mrs Brain England referred to coding and sought assurance on plans to drive real improvements, supported by effective IT systems. Mr Bradley assured the Board that good progress had been made; that the Trust would meet its deadlines for coding, and that work was continuing to ensure further improvements in future. He emphasised that not all of the issues related to “coding” – recording of data and other elements of the activities from clinic to payment were also important. A dedicated working group was working on every aspect to look at how processes could be changed, with IT solutions where practicable. Ms Wake advised that coding had also been identified as an area for focus in the 2016/17 efficiencies.

Discussions of these key issues had been wide ranging and intensive; it was reinforced that the Board, as a unitary board, remained committed to continued efficiencies and high quality services within the Trust. The frank and challenging debate underpinned this approach and had been welcomed.

Mr Patton reiterated the plans going forward for further reporting to the F&P
Committee in September and October as outlined. He also reminded members that the October meeting would also serve as the mid year review and was open to all Directors.

Two final points were highlighted from the F&P Chair’s Log:
- the new Mediation and Appeals procedure for disputes related to job planning policy. This had been approved by the Committee and was endorsed by the Board, and
- the proposed new-style cover report drafted by Mr Patton and Mr Diggles, to promote more use of executive summaries and clearer reporting. The Board accepted the new style, for trial by the Board and other governance Committees as well as F&P.

INTEGRATED PERFORMANCE REPORT (IPR) (15/09/P-13)

The latest iteration of the IPR for month 4 was distributed. Mrs Kelly pointed out key changes in the new format and some further work required, to expand benchmarking and reporting on all cancer tumours as part of the 8 key priorities identified by the national Cancer Waiting Times Taskforce. Whilst several points from the report had been rehearsed in earlier discussions, lead Directors expanded on the key points from the executive summary for quality, performance and workforce.

Quality
Mrs McNair highlighted the continued good performance against complaints, the increased level of harm from falls and the reported SIs (discussed earlier), and three grade 3 pressure ulcers. Of the three pressure ulcer cases, one had reinforced the need for improvements in assessment on admission and the other two highlighted a potential correlation between staffing fill rates on wards dealing with patients vulnerable to skin breakdowns. Ms Wake advised that the staffing challenges was one of the key drivers for the bed reconfiguration plan and would be relieved with the movement of stroke services into the same area as wards 19/20, although some work would be required to protect staff engagement in this difficult area in the longer term.

Referring to the report on staffing levels, a number of errors were pointed out by Dr Jenkins, including reference to cardio thoracic staffing (not carried out at BHNFT) and reported overstaffing of non-qualified staff at night on ward 23. Mrs McNair would review and correct the report for next month. Mr Mapstone requested more information on this chart but it was reiterated that it was compiled in line with national parameters and was not of itself a useful report to the Trust as, whilst it had shown the shortfall on wards 19/20, it did not take account of key factors such as patient numbers or acuity mix.

Workforce
Mr Fernandez referred to discussions reported earlier around work on sickness absences. Work was continuing to ensure the supporting processes were more robust. He also highlighted the continuing increase in mandatory training.

Performance
Mrs Kelly pointed out the continuing pressures in cancer targets, particularly in terms of pathways shared with other trusts. This pressure was common to other trusts too and a working group had been established to address this and improve pathways, which was imperative to avoid full allocation of breaches being returned to the originating trusts.

Pressures continued too around the A&E targets, particularly so with higher
than expected admissions of frail elderly patients over the recent bank holiday. Although performance had been non-compliant against target in July, it had been achieved in August and was still in line to deliver for the quarter – with micro management in place throughout September to support this. It was reiterated that wider improvements needed community input too (eg reduction in attendances) and could not be delivered by the hospital alone. Mrs Kelly assured the Board that this point was made clearly and frequently to help gain wider understanding of the Trust’s position, with teams keen to work with community colleagues on any schemes where they could give support. The Trust needed to be ready to bid against penalty funding available through the Systems Resilience Group (SRG) to support further internal improvements too.

No breaches were identified against diagnostic testing in July but 12 cases had been reported previously against the year end target of zero.

Average length of stay had been good for elective patients but less so on the non-elective side, with patients with complex conditions staying longer. This reflected the growing need to gain more access to better support services within the community, to ensure the right people had the right treatment in the right place.

The position on referrals to treatment had improved. Work around the Choose & Book programme was now linked into the outpatients review, which would support improvements in future.

In terms of theatres, and in response to observations from Mr Mapstone and Mrs Christon, Mrs Kelly affirmed that a working group was focused on delivering further improvements in this area. The current monitoring system was being used effectively to measure times for each theatre session against each case but work was being progressed with the clinical teams to extend theatres to 4 hours (rather than 3½), taking account of impact on job plans and schedules too. In addition a business case had been developed for a minor operations room to support day case activity, moving patients into that dedicated area and freeing more time in main theatres – making a better journey for patients as well as delivering efficiencies in the service. The minor operations room might also be useful for some Obstetrics & Gynaecology patients.

Finance
Mr Wright reiterated the key points highlighted in earlier discussions under F&P (above). Clinical income was still £660,000 ahead of plan, cash too was ahead of plan and capital slightly behind but further external funding was likely to be needed within the next 4-6 weeks. Ms Wake also reported on the outcome of recent discussions with the Clinical Commissioning Group (CCG), who had allocated a further £225,000 for winter pressures – this would support the opening of an additional ward for one month (planned for January 2016).

The run rate for agency spend had increased, particularly in areas such as CBU1 (emergency medicine and trauma & orthopaedic services) and CBU3 (general and specialist medicine). As mentioned earlier, more information on this would be presented at the next F&P Committee meeting. Ms Wake advised that related business cases were also being reviewed to assess benefits realisation, including the appointment of two additional consultants in the ED.

The Chairman thanked the ET for the revised report. The information provided was much improved, giving better overview on performance and a lot of food for thought but with, as mentioned by Mrs Kelly some areas for further improvement (he specifically referred to some of the graphs, which needed
more clarity). This was endorsed by the full Board and Mrs Kelly added her thanks to the ICT team who had led much of the work.

15/162 HORIZON SCANNING AND INTELLIGENCE (15/09/P-14)

The latest report on national and regional developments and issues of note was received and noted. Ms Parkes drew attention to the most recent comment on the NHS Choices website; this had been more negative than previous submissions. As usual, an invitation had been extended for the author to meet with the PALS team to discuss their concerns. The Safe Staffing Advisory Group was also flagged: Mrs McNair had registered an interest in joining the group.

Members also discussed:

- the report from the HSJ that most trusts would be likely to breach agency spending guidance to ensure staff staffing. Mrs McNair advised that the guidance for nursing had been issued recently; it included a wide range of exceptions (to protect quality) which might make the cap difficult to manage. Guidance on doctor spend was awaited, and

- the vanguard issue reported, which did not have any direct lessons for Barnsley but would be interesting to monitor.

Ms Parkes also reported that the Trust had submitted a nomination for this year’s HSJ Awards. The Board would be kept informed of progress.

15/163 ANY OTHER BUSINESS & DATE OF NEXT MEETING

Public Comments

a) Mr Millington, as observer and Deputy Chair of the CCG’s Governing Body, echoed the comments made by several Board members, emphasising the need for collective action across community partners to achieve progress in key areas. He would like to see the Boards from BHNFT and the CCG meeting within the next two weeks, to talk about long term planning. This was appreciated by the Chairman, who confirmed that the Trust was working with NHS England to reinstate Chair/CEO and Board-to-Board meetings between the two organisations, to support discussions on future ways of working together for the benefit of the Barnsley health economy. Members were conscious of the roles of other partners too, such as the SRG and the Health & WellBeing Board

b) Mrs Micallef, a member of staff, had no comments on the Board’s discussions but did observe that, compared to previous Board meetings she had observed, the discussions had been much more open and transparent. As a departmental manager, she had found this very reassuring and would share her observations with colleagues.

c) Date of Next meeting

The next meeting of the Board of Directors was scheduled for 1st October 2015 commencing at 9am. The Trust’s Annual General & Public Members Meting would be held beforehand on 24th September.

In accordance with the Trust’s Constitution and Standing Orders, it was resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.
Integrated Performance Report

August 2015

Created by: Management Information Services
Title of report: Integrated Performance Report
Executive Lead: Karen Kelly
Contents

Executive Summary........................................... 3
Summary.................................................................. 7
Patients will experience Safe Care........... 9
Partnerships will be our Strength.......... 21
People will be proud to work for us...... 22
Performance Matters................................. 25
  a) Key Performance Indicators............... 26
  b) Financial Overview............................. 36
# Executive Summary by Exception

## Key Messages

<table>
<thead>
<tr>
<th>YTD</th>
<th>Patients will experience safe care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Quality &amp; Patient Experience:</td>
</tr>
<tr>
<td></td>
<td>Friends &amp; Family Test - ED</td>
</tr>
<tr>
<td></td>
<td>The Friends &amp; Family Test positivity rate has improved in August achieving 85.4% for the month and 81.0% for the year to date.</td>
</tr>
</tbody>
</table>

### Complaints

During August the Trust received 17 new formal complaints bringing the year to date total to 99, of which 40 are currently under investigation. Performance in closing complaints has improved during August to 79% and the average number of working days taken to investigate a complaint has also fallen to 38 days. Work is progressing on the integration of the PALS and Complaints Teams and new training resources for CBU's will be developed to improve the quality of complaint responses.

Performance in closing complaints within the agreed target has slightly reduced during July to 76%. Work is on-going with regards to how the Trust can achieve and maintain this performance target.

The Trust continues to receive an average number of 20 complaints per month however in July this was slightly higher with CBU’s 1, 3 & 6 receiving the majority. There has been an increase in the number of PALS enquiries received during July. This has been due to an increase in enquiries relating to the outpatient validation letters and a number of enquiries relating to access issues regarding outpatient appointments.

### Falls

Total numbers of falls incidents in August have decreased slightly from the number seen in July. This number is significantly higher than the Trust’s target of 43 per month and higher than the Trust’s seasonal average i.e. we are seeing more falls incidents reported this summer than last. In terms of patterns it is notable that clinical areas that have previously had very few clinical incidents reported are now demonstrating small increases and overall this is significantly increasing the total numbers.

We believe there are two main reasons for this:

1. The case mix of patients in all our wards has changed with more frail elderly patients being cared for in non-specialist wards
2. Clinical teams have significantly improved in terms of incident reporting

In addition to the small increases in incidents seen across our wards the two elderly care wards continue to have a significant proportion of the Trust ‘fallers’.

The Trust has now launched a number of new initiatives: Multifactorial Falls Assessments, Patient/Relative Information, Post Fall Medical Assessments, New Bed Rail assessments, Falls Monitoring, Root Cause Analysis for all moderate and above harm and it is hoped and anticipated that this will impact positively on reducing the number of falls incidents.

All falls were rated as low or no harm. This means there were no harms occurring in the month which resulted on moderate, severe or death of the patients.

### Pressure Ulcers

#### Grade 3 Avoidable

In August 2015, there was 1 confirmed avoidable Grade 3 pressure ulcers. This was attributed to Ward 33 and on the elbow.

There is one additional Grade 3 which is still awaiting completion of the RCA. The outcome of this will be reported in Septembers IPR narrative.

#### Hospital Acquired Grade 2

In August there are four confirmed Hospital Acquired Grade 2 Pressure Ulcers of which two have been confirmed as avoidable. These were on Ward 32 (Sacrum) and Ward 19 (Penis). There is one additional Hospital Acquired Grade 2 of the heel which is still awaiting completion of the RCA. The outcome of this will be reported in Septembers IPR narrative.
### Hospital Acquired Clostridium Difficile

- Ward 19 - one case preliminary unavoidable due to antibiotics required to treat a severe sepsis secondary to a urinary tract infection.
- Ward 33 - two cases both different Ribotypes but more in depth infection control audit completed. Both were unavoidable, one due to antibiotics required for a chest infection and one due to antibiotics required for an unidentified infection.
- Ward SHDU - one case unavoidable due to antibiotics required to treat Pancreatitis.

Whilst none identified any lapses in care the learning points include:
- Completion of stools charts in a correct and timely manner
- Pharmacy and doctors to more accurately review antibiotics changing or discontinuing when necessary
- Mandatory training needs to be up to date
- Equipment needs to be kept clean especially commodes
- Following each Clostridium difficile toxin infection, a thorough review of each case is undertaken by Route Cause Analysis and multidisciplinary team review. Any lessons learnt are disseminated via the Infection Prevention and Control Group and individual ward actions are fed back to the clinical areas. Each case is then presented at a District-wide RCA overview group for peer review.

### Patient Safety:-

#### Medication Errors

Patient prescribed and administered x10 the dose of morphine during intubation on ward 15 (Neonatal). Patient closely monitored throughout intubation and no adverse effects noted; parents informed at time of incident.

#### Never Events

No cases to report in August. Year to date position has been reduced to 2 as one of the cases reported in April has been reallocated to Sheffield.

### Serious Incidents

- **2015/26559** – sub-optimal care of deteriorating patient; the incident occurred in October 2014 and concerns were identified following an inquest.
- **2015/26565** – grade 3 pressure ulcer; the incident occurred in July 2015.
- **2015/26194** – hospital acquired VTE; the incident occurred in April 2015.
- **2015/26351** – patient fall resulting in a cerebral bleed; patient subsequently died. The incident occurred in July 2015.
- **2015/25946** – level 2 confidentiality breach; patient handover sheet found in the hospital shop. The incident occurred in July 2015.

### Serious Incidents Resulting in Death

Patient died on ITU due to sepsis and multi organ failure; this was not identified in a timely fashion following admission (Declared an SI in September 2015/29321)

### Mortality:-

#### Hospital Standardised Mortality Rate (HSMR)

The 12 month rolling HSMR to May 2015 is 102.7. This is above the target of 100 for 2015/15, however, based on the trajectory for achievement of target by the end of March 2016 the estimated trajectory is 103.3 which indicates that we are achieving trajectory.
### Executive Summary by Exception cont.

#### RAG Key Messages

<table>
<thead>
<tr>
<th>YTD</th>
<th>People will be proud to work for us</th>
<th>Committee: F&amp;P</th>
<th>Page: 21-23</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Mandatory Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 CBUs have now achieved the 90% compliance target.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sickness Absence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sickness has fallen sharply from 4.35% last month to 3.96%. This brings the underlying trend back into line with previous months and July figures are something of an anomaly. The revised figures for July published in September are also now below 4% which indicates that further investigations into processing of SAN forms needs to be undertaken to ensure such fluctuations do not occur again and reflect negatively on performance. This month has seen the introduction of an Occupational Health Tracker to monitor referrals under Fast Track Scheme from CBU’s and the performance on OHD in time taken to see referrals to ensure timely and appropriate intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>a) Key Performance Indicators</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostic Waits Over 6 Weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Challenges to the delivery of diagnostic target wait time are evident in cardiology for Angiography, Echocardiography and Ambulatory ECG. The CBU team are in the process of developing a business case for the expansion of capacity in in Echocardiography and Ambulatory ECG to address capacity shortfalls against demand, whilst delivering the additional activity in a cost effective manner. In order to address protracted waits in diagnostic angiography, a 4th weekly Angiography list has been established. This commenced in September and will deliver reductions in wait times across September to December 2015.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancer - 2 Week Breast Symptomatic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The breast symptomatic target for August remains non-compliant at 92% although this is a marked improvement from the previous month. September performance to date is good, suggesting compliance against the quarter is still achievable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>62 Day - GP Referral to Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The August position showed compliance at 88.8%, with further final validation work still in progress. Trajectory for the quarter indicates a strong September position will be needed to achieve the full quarter. Robust pathway monitoring and escalation processes are in place to sustain focus on individual pathways.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>62 Day - Consultant Upgrade to Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The small number of Consultant Upgrades are significantly impacted by any breaches incurred - more consistently rendering us non compliant against this locally agreed target. As part of the CWT 8 Key Priorities work - a revised Consultant Upgrade process will be presented in the Operational Policy (under development) for consideration. This would potentially increase the volume of Consultant Upgrades and therefore accountable treatments to offset the impact of breaches.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Key Messages

#### ED 4 Hour Waits

The A&E 4 hour wait target was met in August with an achievement of 95.4%. However, the quarter to date position remains below target at 94.3%.

#### Average Length of Stay - Elective

The average length of stay for elective patients has decreased again from 2.40 days in July to 2.35 days in August and remains within target. The average year to date position remains above target at 2.68 days.

#### Average Length of Stay - Non Elective

The average length of stay for non-elective patients has decreased slightly from 3.63 days in July to 3.61 days in August but remains slightly above target. The average year to date position is also slightly above target at 3.49 days.

#### Cancelled Operations - Breaches of the 28 day rule

There have been no further breaches of the 28 day rule. The year to date position remains at 1.

#### Outpatient DNA Rates

The largest percentage of DNAs are in Oral Surgery (19.2%), Physiotherapy (14.4%) and Trauma & Orthopaedics (13.4%)

### Financial overview

The Trust has a year to date deficit position of £7,468k that is £1,776k adverse to the plan. This is driven by several key factors:- penalties incurred of £225k, unfunded escalation costs and a £614k adverse position to date on 2015/16 CIP achievement. There is also some non-recurrently unmet CIP from 2014/15. In addition there is significant pressure on pay costs driven by agency spend. Urgent action is being taken to reduce adverse variances and identify new CIPs. The cash position is £4,076k favourable to plan which is driven by lower capital spend, working capital management and the advanced receipt of working capital funding. Liquidity has reduced slightly to -17.6 days, and the Trust has reverted to a Continuity of Service rating of 1 for the month.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients will experience safe care</td>
<td>FFT Positivity Rates - ED</td>
<td>BHNFT</td>
<td>G &gt;85%, A &gt;=80%, R &lt;80%</td>
<td>81.0%</td>
<td>94.5%</td>
<td>96.7%</td>
<td>94.7%</td>
<td>80.6%</td>
<td>88.7%</td>
<td>92.7%</td>
<td>90.3%</td>
<td>89.0%</td>
<td>78.3%</td>
<td>70.6%</td>
<td>81.4%</td>
<td>85.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFT Positivity Rates - IP</td>
<td>BHNFT</td>
<td>G &gt;85%, A &gt;=80%, R &lt;80%</td>
<td>97.3%</td>
<td>96.9%</td>
<td>96.6%</td>
<td>95.3%</td>
<td>95.6%</td>
<td>97.9%</td>
<td>93.7%</td>
<td>97.0%</td>
<td>96.7%</td>
<td>97.8%</td>
<td>96.5%</td>
<td>97.5%</td>
<td>98.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFT Positivity Rates - OP</td>
<td>BHNFT</td>
<td>G &gt;85%, A &gt;=80%, R &lt;80%</td>
<td>92.6%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>98.5%</td>
<td>90.0%</td>
<td>91.5%</td>
<td>90.7%</td>
<td>95.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFT Positivity Rates - MAT</td>
<td>BHNFT</td>
<td>G &gt;85%, A &gt;=80%, R &lt;80%</td>
<td>97.5%</td>
<td>98.0%</td>
<td>98.2%</td>
<td>97.5%</td>
<td>98.1%</td>
<td>98.1%</td>
<td>97.3%</td>
<td>97.1%</td>
<td>99.0%</td>
<td>96.5%</td>
<td>98.7%</td>
<td>96.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complaints closed within target</td>
<td>BHNFT</td>
<td>G &gt;90%, A &gt;=70%, R &lt;70%</td>
<td>72.7%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>91.3%</td>
<td>97.5%</td>
<td>95.0%</td>
<td>94.3%</td>
<td>94.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dementia - Find/Assess</td>
<td>National</td>
<td>90%</td>
<td>94.7%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>91.3%</td>
<td>97.5%</td>
<td>95.0%</td>
<td>94.3%</td>
<td>94.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dementia - Investigate</td>
<td>National</td>
<td>90%</td>
<td>100%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Falls</td>
<td>BHNFT</td>
<td>515</td>
<td>76</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>11</td>
<td>21</td>
<td>19</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>18</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multi Falls</td>
<td>BHNFT</td>
<td>128</td>
<td>8</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Falls resulting in moderate harm or above</td>
<td>BHNFT</td>
<td>20</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hand washing</td>
<td>National</td>
<td>95%</td>
<td>98.4%</td>
<td>99.3%</td>
<td>100.0%</td>
<td>99.4%</td>
<td>98.4%</td>
<td>99.4%</td>
<td>100.0%</td>
<td>99.6%</td>
<td>99.6%</td>
<td>98.2%</td>
<td>96.3%</td>
<td>98.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grade 3 &amp; 4</td>
<td>BHNFT</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grade 2</td>
<td>BHNFT</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single Sex Breaches</td>
<td>National</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Acquired Clostridium Difficile</td>
<td>NHSE</td>
<td>13</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MRSA</td>
<td>NHSE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VTE Screening Compliance</td>
<td>NHSE</td>
<td>95%</td>
<td>95.6%</td>
<td>97.1%</td>
<td>96.1%</td>
<td>95.1%</td>
<td>95.5%</td>
<td>95.6%</td>
<td>95.8%</td>
<td>95.1%</td>
<td>93.5%</td>
<td>93.5%</td>
<td>96.1%</td>
<td>95.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incidence of Medication Errors - All</td>
<td>National</td>
<td>440</td>
<td>163</td>
<td>103</td>
<td>121</td>
<td>51</td>
<td>49</td>
<td>32</td>
<td>34</td>
<td>38</td>
<td>34</td>
<td>28</td>
<td>28</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incidence of Medication Errors - No adverse outcome</td>
<td>National</td>
<td>241</td>
<td>59</td>
<td>91</td>
<td>28</td>
<td>40</td>
<td>22</td>
<td>18</td>
<td>22</td>
<td>23</td>
<td>18</td>
<td>19</td>
<td>21</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incidence of Medication Errors - Near misses</td>
<td>National</td>
<td>63</td>
<td>44</td>
<td>29</td>
<td>22</td>
<td>9</td>
<td>9</td>
<td>13</td>
<td>15</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>14</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incidence of Medication Errors - Causing harm</td>
<td>National</td>
<td>10</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never Events</td>
<td>NHSE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serious Incidents</td>
<td>NHSE</td>
<td>66</td>
<td>36</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td>11</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>National</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>National</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of Incidents Causing Harm</td>
<td>BHNFT</td>
<td>&lt;28%</td>
<td>7.3%</td>
<td>7.2%</td>
<td>6.9%</td>
<td>7.4%</td>
<td>7.6%</td>
<td>7.0%</td>
<td>10.6%</td>
<td>6.3%</td>
<td>7.8%</td>
<td>6.1%</td>
<td>8.4%</td>
<td>8.1%</td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total (All)</td>
<td>National</td>
<td>7400</td>
<td>3445</td>
<td>640</td>
<td>707</td>
<td>707</td>
<td>641</td>
<td>591</td>
<td>612</td>
<td>613</td>
<td>672</td>
<td>659</td>
<td>693</td>
<td>769</td>
<td>652</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HSMR</td>
<td>National</td>
<td>100</td>
<td>102.7</td>
<td>102.8</td>
<td>102.6</td>
<td>101.7</td>
<td>101.1</td>
<td>102.7</td>
<td>103.6</td>
<td>103.4</td>
<td>102.3</td>
<td>102.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SHMI</td>
<td>National</td>
<td>105</td>
<td>103.2</td>
<td>103.2</td>
<td>102.5</td>
<td>103.2</td>
<td>103.2</td>
<td>103.2</td>
<td>103.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention of future death report - Notifications received</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------</td>
<td>-------------------------</td>
<td>--------</td>
<td>--------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td><strong>Staff Turnover (Rolling 12 months)</strong></td>
<td>G &lt;=10%, A &gt;10% - 12%, R &gt; 12%</td>
<td>BHNFT</td>
<td>9.81%</td>
<td>7.15%</td>
<td>7.51%</td>
<td>8.09%</td>
<td>7.85%</td>
<td>7.94%</td>
<td>7.93%</td>
<td>8.88%</td>
<td>9.09%</td>
<td>9.66%</td>
<td>9.85%</td>
<td>9.63%</td>
<td>9.81%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appraisals (Rolling 12 months)</strong></td>
<td>G &lt;= 10%, A &gt; 10% - 12%, R &gt; 12%</td>
<td>BHNFT</td>
<td>90.02%</td>
<td>92.55%</td>
<td>93.93%</td>
<td>91.93%</td>
<td>92.59%</td>
<td>92.26%</td>
<td>91.29%</td>
<td>91.47%</td>
<td>87.40%</td>
<td>81.02%</td>
<td>87.16%</td>
<td>88.69%</td>
<td>90.02%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mandatory Training (Rolling 12 months)</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>86.90%</td>
<td>85.98%</td>
<td>86.38%</td>
<td>84.95%</td>
<td>84.24%</td>
<td>82.83%</td>
<td>82.24%</td>
<td>84.30%</td>
<td>86.48%</td>
<td>86.80%</td>
<td>86.90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sickness Absence (Rolling 12 months)</strong></td>
<td>G &lt;=3.5%, A &gt;3.5% - 4%, R &gt; 4%</td>
<td>BHNFT</td>
<td>4.22%</td>
<td>4.17%</td>
<td>4.46%</td>
<td>4.69%</td>
<td>5.06%</td>
<td>4.81%</td>
<td>4.62%</td>
<td>3.94%</td>
<td>4.30%</td>
<td>3.99%</td>
<td>3.79%</td>
<td>4.35%</td>
<td>3.98%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RTT Admitted</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RTT Non-Admitted</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RTT Incomplete Pathways</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>93.1%</td>
<td>92.3%</td>
<td>92.8%</td>
<td>93.4%</td>
<td>93.0%</td>
<td>92.8%</td>
<td>92.2%</td>
<td>91.3%</td>
<td>91.2%</td>
<td>91.5%</td>
<td>91.3%</td>
<td>91.3%</td>
<td>91.5%</td>
<td>91.2%</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic patients waiting more than 6 weeks</strong></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td>24</td>
<td>69</td>
<td>20</td>
<td>18</td>
<td>60</td>
<td>84</td>
<td>3</td>
<td>16</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Symptomatic Breast 2 Week Waits</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>96.6%</td>
<td>93.2%</td>
<td>94.2%</td>
<td>97.0%</td>
<td>95.8%</td>
<td>98.1%</td>
<td>94.3%</td>
<td>98.8%</td>
<td>95.7%</td>
<td>96.3%</td>
<td>91.2%</td>
<td>91.5%</td>
<td>91.5%</td>
<td>90.3%</td>
<td></td>
</tr>
<tr>
<td><strong>31 Day - 1st Definitive Treatment</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>96.2%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.7%</td>
<td>98.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td><strong>31 Day - Subsequent Treatment [Surgery]</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>94.6%</td>
<td>99.2%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td><strong>31 Day - Subsequent Treatment [Chemotherapy]</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>96.2%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td><strong>62 Day - GP Referral to Treatment</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>85.4%</td>
<td>63.4%</td>
<td>83.5%</td>
<td>91.7%</td>
<td>94.4%</td>
<td>81.4%</td>
<td>82.5%</td>
<td>89.9%</td>
<td>88.0%</td>
<td>84.1%</td>
<td>83.2%</td>
<td>77.2%</td>
<td>88.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>62 Day - Screening Referral to Treatment</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>90.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td><strong>62 Day - Consultant Upgrade to Treatment</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>92.4%</td>
<td>89.8%</td>
<td>92.3%</td>
<td>95.0%</td>
<td>93.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>81.8%</td>
<td>88.9%</td>
<td>88.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>% Patients Waiting &lt;4 Hours</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>95.3%</td>
<td>91.3%</td>
<td>97.1%</td>
<td>97.6%</td>
<td>97.7%</td>
<td>98.5%</td>
<td>97.7%</td>
<td>98.6%</td>
<td>97.4%</td>
<td>97.8%</td>
<td>89.4%</td>
<td>95.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Operational Efficiency</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>3.49%</td>
<td>3.46%</td>
<td>3.52%</td>
<td>3.57%</td>
<td>3.95%</td>
<td>3.67%</td>
<td>3.53%</td>
<td>3.60%</td>
<td>3.10%</td>
<td>3.62%</td>
<td>3.50%</td>
<td>3.63%</td>
<td>3.61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DNA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient DNA Rates</strong></td>
<td>G &gt;90%, A &lt;=85% - 90%, R &lt; 85%</td>
<td>BHNFT</td>
<td>11.2%</td>
<td>9.9%</td>
<td>9.9%</td>
<td>12.3%</td>
<td>12.4%</td>
<td>12.1%</td>
<td>10.9%</td>
<td>10.9%</td>
<td>11.2%</td>
<td>11.4%</td>
<td>11.3%</td>
<td>11.0%</td>
<td>11.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RAG Description**
- **RED**: Failed Target
- **AMBER**: Failed by <5% (This tolerance does not apply to Cancer & A&E targets which will be RED if the target is not achieved)
- **GREEN**: Achieved Target

**NOTE:**
- National Indicators such as Cancer, RTT, Cancelled Ops, etc. are considered as being either Achieved or Failed. These are therefore RAG rated as Green or Red.
- All other indicators are classed as Achieved or Failed with the exception of all Workforce KPIs, Average Length of Stay & DNA rates which detail the tolerances applied in the Target column.
### Patients will experience safe care - "At a glance"

#### Patients will experience safe care - Quality & Experience

<table>
<thead>
<tr>
<th></th>
<th>Target 15/16</th>
<th>Target YTD</th>
<th>Aug-15</th>
<th>Actual YTD</th>
<th>Trend</th>
<th>YTD Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Friends &amp; Family Test (Quality Strategy Goal 1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - ED</td>
<td>85%</td>
<td>85%</td>
<td>85.4%</td>
<td>81.0%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - Inpatients</td>
<td>85%</td>
<td>85%</td>
<td>98.2%</td>
<td>97.3%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - Maternity</td>
<td>85%</td>
<td>85%</td>
<td>96.0%</td>
<td>97.5%</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Family Test - Outpatients</td>
<td>85%</td>
<td>85%</td>
<td>95.3%</td>
<td>92.6%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>Complaints (Quality Strategy Goal 1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total no. of complaints</td>
<td>N/A</td>
<td>N/A</td>
<td>17</td>
<td>99</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Complaints closed within target</td>
<td>90%</td>
<td>90%</td>
<td>78.9%</td>
<td>72.7%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Complaints re-opened</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>7</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td><strong>Dementia (Quality Strategy Goal 1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Find/Assess</td>
<td>90%</td>
<td>90%</td>
<td>94.3%</td>
<td>94.7%</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>Investigate</td>
<td>90%</td>
<td>90%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td>Refer</td>
<td>90%</td>
<td>90%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td><strong>Falls (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Falls</td>
<td>515</td>
<td>215</td>
<td>76</td>
<td>364</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>No. of Multiple Falls</td>
<td>128</td>
<td>53</td>
<td>16</td>
<td>76</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Falls resulting in moderate harm or above</td>
<td>20</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>Hand washing (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand washing</td>
<td>95%</td>
<td>95%</td>
<td>98.6%</td>
<td>98.4%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>Pressure Ulcers (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grades 3 &amp; 4</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Grade 2 Post</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>26</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td><strong>Infections (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Clostridium Difficile</td>
<td>13</td>
<td>N/A</td>
<td>4</td>
<td>7</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>MSSA</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td>Ecoli - Total hospital</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
<td>9</td>
<td>↑</td>
<td></td>
</tr>
</tbody>
</table>

#### Patients will experience safe care - Patient Safety

<table>
<thead>
<tr>
<th></th>
<th>Target 15/16</th>
<th>Target YTD</th>
<th>Aug-15</th>
<th>Actual YTD</th>
<th>Trend</th>
<th>YTD Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality (Quality Strategy Goal 3)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSMR (Latest data May 15)</td>
<td>100</td>
<td>103.3</td>
<td>102.7</td>
<td>102.7</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>SHMI (Latest data Dec 14)</strong></td>
<td>105</td>
<td>105</td>
<td>0</td>
<td>102.5</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>Prevention of Future Death Report - Notifications Rec'd</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td><strong>VTE Screening Compliance (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>95%</td>
<td>95%</td>
<td>95.5%</td>
<td>95.6%</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td><strong>Medication Incidents (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence of medication errors - All</td>
<td>400</td>
<td>167</td>
<td>35</td>
<td>163</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Incidence of medication errors - No adverse outcome</td>
<td>241</td>
<td>100</td>
<td>26</td>
<td>107</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>Incidence of medication errors - Near misses</td>
<td>63</td>
<td>26</td>
<td>8</td>
<td>47</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Incidence of medication errors - Causing harm</td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>Serious Incidents (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td>Serious Incidents</td>
<td>66</td>
<td>11</td>
<td>5</td>
<td>36</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>Incident Grading (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>↔</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
<td>40</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>N/A</td>
<td>N/A</td>
<td>34</td>
<td>198</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>No Harm</td>
<td>N/A</td>
<td>N/A</td>
<td>612</td>
<td>3187</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Percentage of incidents causing harm</td>
<td>&lt;28%</td>
<td>28%</td>
<td>6.1%</td>
<td>7.3%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Safety (Quality Strategy Goal 2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (All)</td>
<td>7400</td>
<td>3083</td>
<td>652</td>
<td>3445</td>
<td>↑</td>
<td></td>
</tr>
</tbody>
</table>
Patients will experience safe care (Quality & Experience)

Friends & Family Test (Quality Strategy - Goal 1: Delivering Patient Centred Care)

Friends & Family Test Positivity Rates

- Percentage Positivity
- ED Actual
- IP Actual
- OP Actual
- MAT Actual
- Target

Friends & Family Test - Inpatient Benchmarking

Friends & Family Test - Maternity Benchmarking
Patients will experience safe care (Quality & Experience)

Complaints (Quality Strategy - Goal 1: Delivering Patient Centred Care)

Comments:

17 New Complaints were received in August which is slightly below the average of approximately 20 complaints a month. Of these 17 complaints the majority relate to CBUs 1, 3 and 6. Ten complaints were assessed as moderate risk and 7 as high risk. We currently have 1 complaint under investigation by the PHSO and 1 complaint has been referred for review. The PALS team handled 122 concerns/enquiries during the month of August.

The Trust continues to receive an average number of 20 complaints per month however in July this was slightly higher with CBU’s 1, 3 & 6 receiving the majority.

The main themes continue to be patient care, access and communication.

There has been an increase in the number of PALS enquiries received during July. This has been due to an increase in enquiries relating to the outpatient validation letters and a number of enquiries relating to access issues regarding outpatient appointments.
Patients will experience safe care (Quality & Experience)

Dementia (Quality Strategy - Goal 1: Delivering Patient Centred Care)

Comments:
All targets achieved.

Percentage of Cases Identified
(Latest NHS England published data June 2015)

Percentage of Cases with Diagnostic Assessment
(Latest NHS England Published data June 2015)

No data published for Hull, Leeds & Mid Yorkshire

Peer Group
Target
Patients will experience safe care (Quality & Experience)

Falls (Quality Strategy - Goal 2: Delivering Consistently Safe Care)

**Comments:**

Total numbers of falls incidents in August have decreased slightly from the number seen in July. This number is significantly higher than the Trust’s target of 43 per month and higher than the Trust’s seasonal average i.e. we are seeing more falls incidents reported this summer than last. In terms of patterns it is notable that clinical areas that have previously had very few clinical incidents reported are now demonstrating small increases and overall this is significantly increasing the total numbers.
Patients will experience safe care (Quality & Experience)

Pressure Ulcers (Quality Strategy - Goal 2: Delivering Consistently Safe Care)

In August there are four confirmed Hospital Acquired Grade 2 Pressure Ulcers of which two have been confirmed as avoidable. These were on Ward 32 (Sacrum) and Ward 19 (Penis). There is one additional Hospital Acquired Grade 2 of the heel which is still awaiting completion of the RCA. The outcome of this will be reported in September's IPR narrative.

In August 2015, there was 1 confirmed avoidable Grade 3 pressure ulcers. This was attributed to Ward 33 and on the elbow. There is one additional Grade 3 which is still awaiting completion of the RCA. The outcome of this will be reported in September's IPR narrative.
Patients will experience safe care (Quality & Experience)

Infections (Quality Strategy - Goal 2: Delivering Consistently Safe Care)

Comments:
Following each Clostridium difficile toxin infection, a thorough review of each case is undertaken by Route Cause Analysis and multidisciplinary team review. Any lessons learnt are disseminated via the Infection Prevention and Control Group and individual ward actions are fed back to the clinical areas. Each case is then presented at a District-wide RCA overview group for peer review.
Patients will experience safe care (Quality & Experience)

Nursing Staffing Fill Rate (Quality Strategy - Goal 4: Building on Capacity and Capability)

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Specialty</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Ave fill rate</td>
<td>Ave fill rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Registered</td>
<td>Care staff (%)</td>
</tr>
<tr>
<td>14</td>
<td>502 - Gynaecology</td>
<td>95.7%</td>
<td>81.7%</td>
</tr>
<tr>
<td>17</td>
<td>320 - Cardiology</td>
<td>86.0%</td>
<td>88.3%</td>
</tr>
<tr>
<td>18</td>
<td>340 - Respiratory Medicine</td>
<td>83.3%</td>
<td>95.8%</td>
</tr>
<tr>
<td>19</td>
<td>430 - Geriatric Medicine</td>
<td>86.1%</td>
<td>90.6%</td>
</tr>
<tr>
<td>20</td>
<td>430 - Geriatric Medicine</td>
<td>68.8%</td>
<td>103.5%</td>
</tr>
<tr>
<td>AMU</td>
<td>300 - General Medicine</td>
<td>77.1%</td>
<td>97.9%</td>
</tr>
<tr>
<td>23</td>
<td>300 - General Medicine</td>
<td>90.2%</td>
<td>91.9%</td>
</tr>
<tr>
<td>24</td>
<td>370 - Medical Oncology</td>
<td>97.1%</td>
<td>104.2%</td>
</tr>
<tr>
<td>28</td>
<td>301 - Gastroenterology</td>
<td>85.6%</td>
<td>86.0%</td>
</tr>
<tr>
<td>31</td>
<td>100 - General Surgery</td>
<td>71.6%</td>
<td>118.6%</td>
</tr>
<tr>
<td>32</td>
<td>100 - General Surgery</td>
<td>90.9%</td>
<td>110.9%</td>
</tr>
<tr>
<td>34</td>
<td>110 - Trauma &amp; Orthopaedics</td>
<td>77.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>ITU</td>
<td>192 - Critical Care Medicine</td>
<td>81.6%</td>
<td>49.0%</td>
</tr>
<tr>
<td>SHDU</td>
<td>192 - Critical Care Medicine</td>
<td>104.5%</td>
<td>69.2%</td>
</tr>
<tr>
<td>CCU</td>
<td>320 - Cardiology</td>
<td>94.3%</td>
<td>74.3%</td>
</tr>
<tr>
<td>AN/PN</td>
<td>501 - Obstetrics</td>
<td>101.7%</td>
<td>102.3%</td>
</tr>
<tr>
<td>Birthing Centre</td>
<td>501 - Obstetrics</td>
<td>94.2%</td>
<td>77.1%</td>
</tr>
<tr>
<td>37</td>
<td>420 - Paediatrics</td>
<td>87.7%</td>
<td>72.8%</td>
</tr>
<tr>
<td>15</td>
<td>422 - Neonatology</td>
<td>94.7%</td>
<td>73.0%</td>
</tr>
</tbody>
</table>

**Comments:**

BHNFT is committed to ensuring that levels of nursing staff, match the acuity and dependency needs of patients in order to provide safe and effective care. Nurse staffing includes:

- Registered Nurses
- Registered Midwives
- Unregistered health care/midwifery care assistants
- Unregistered nursing/midwifery auxiliaries

The Trust uses an e-rostering system with duty rosters created eight weeks in advance to ensure the levels and skill mix of the nursing staff on duty are appropriate for providing safe and effective care.

This allows for contingency plans to be made where the roster identifies that the planned staffing falls short of the minimum requirement, for example where there are vacant nursing posts or staff appointed have not started in post. These contingency plans can include: moving staff from a shift which is above the minimum required level, moving staff from another ward/area which is above the minimum required level, or the use of flexible/temporary staffing from the Trust’s internal bank or via an external nursing agency.

The areas that currently have the most vacancies in nursing are in CBU 1 including wards 20, wards 34 and the emergency department and the. Following a recruitment campaign we have 27 newly qualified staff nurses commencing in September 2015 who will be following a robust preceptorship programme and will improve staffing levels in a number of areas. Specific recruitment is on-going in the emergency department.

There are rates of over 100% staffing of care staff in some areas on nights this is explained due to the dependency of patients in some of the medical wards and the requirement for 1-1 nursing.
Patients will experience safe care (Safety)

Mortality  (Quality Strategy - Goal 3: Delivering Consistently Effective Care)
Patients will experience safe care (Safety)

Incidents (Quality Strategy - Goal 2: Delivering Consistently Safe Care)

See narrative provided with Heatmap data

See narrative provided with Heatmap data

See narrative provided with Heatmap data

See narrative provided with Heatmap data
### Heatmap

**Reporting Month:** August-2015  
**Executive lead:** Heather McNair

Trend Arrow: Latest Month v Previous Month  
↑ = Got Better  
↓ = Got Worse

<table>
<thead>
<tr>
<th>Trust</th>
<th>CDU</th>
<th>MRSA</th>
<th>C-Dff</th>
<th>Incidents - Deaths</th>
<th>Incidents - Moderate</th>
<th>Incidents - Severe</th>
<th>Never events</th>
<th>Medication Incidents - Causing harm</th>
<th>Falls - Adverse Outcome</th>
<th>Multiple Falls - Adverse Outcome</th>
<th>Pressure Ulcers 2</th>
<th>Pressure Ulcers 3</th>
<th>Pressure Ulcers 4</th>
<th>Single Sex Breaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency, Ortho &amp; Care Services</td>
<td>CDU</td>
<td></td>
<td></td>
<td>4 ↓</td>
<td>1 →</td>
<td>5 ↑</td>
<td></td>
<td></td>
<td>1 ↑</td>
<td>17 ↑</td>
<td>3 ↑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 19</td>
<td></td>
<td></td>
<td>1 ↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 ↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 20</td>
<td></td>
<td></td>
<td></td>
<td>1 ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 ↓</td>
<td></td>
<td>1 ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 34</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 33</td>
<td></td>
<td></td>
<td>2 ↓</td>
<td>1 →</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatres, Anaesth &amp; Critical care</td>
<td>ICU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SHDU</td>
<td></td>
<td></td>
<td>1 ↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ITU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Theatres</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General &amp; Spec Med</td>
<td>AMU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 17</td>
<td></td>
<td></td>
<td>1 ↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 ↓</td>
<td>2 ↓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chemotherapy Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General &amp; Spec Surg</td>
<td>Urology Investigation Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SHDU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SDA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 31</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Clinical Support</td>
<td>Medical Imaging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Womens, Children &amp; GUM</td>
<td>Ward 14 (Gynae)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward 15 (Neonatal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paediatric OPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Heatmap

**Reporting Month:** Aug-15  
**Executive lead:** Heather McNair

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidents resulting in Death</td>
<td>Patient died on ITU due to sepsis and multi organ failure; this was not identified in a timely fashion following admission (Declared an SI in September 2015/29321)</td>
</tr>
</tbody>
</table>
| Incidents resulting in moderate harm | 1 failure to diagnose - patient sent home with a large pneumothorax (medical imaging)  
1 delay to undertake tests - patient suffered a STEMI and was transferred to CCU (ward 33)  
3 hospital acquired grade 3 pressure ulcers (AMU, ward 18 and ward 20) |
| Medication incidents resulting in harm | Patient prescribed and administered x10 the dose of morphine during intubation on ward 15                                               |
| Pressure Ulcers                       | Grade 3 Avoidable - In August 2015, there was 1 confirmed avoidable Grade 3 pressure ulcer. This was attributed to ward 33 and on the elbow. There is one additional Grade 3 which is still awaiting completion of the RCA. The outcome of this will be reported in September’s IPR narrative.  
Hospital Acquired Grade 2 - In August there are four confirmed Hospital Acquired Grade 2 Pressure Ulcers of which 2 have been confirmed as avoidable. These were on Ward 32 (Sacrum) and Ward 19 (Penis). There is one additional Hospital Acquired Grade 2 of the heel which is still awaiting completion of the RCA. The outcome of this will be reported in September’s IPR narrative. |
| Falls - adverse outcome               | A total of 76 inpatient falls were reported in August; 17 of which resulted in adverse outcome (22%). The 17 incidents resulting in adverse outcome were all low harm; this includes where the patient has sustained laceration |
## Partnerships will be our strength - "At a glance"

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Target 15/16</th>
<th>Target YTD</th>
<th>Aug-15</th>
<th>Actual YTD</th>
<th>Trend</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Care Fund - Emergency Admissions</td>
<td>7704</td>
<td>22302</td>
<td>8149</td>
<td>8149</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>(Latest data Q1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Barnsley Hospital Quality in Care)
People - "At a glance"

<table>
<thead>
<tr>
<th>Workforce (Quality Strategy - Goal 4: Building on Capacity and Capability)</th>
<th>Target 15/16</th>
<th>Target YTD</th>
<th>Aug-15 YTD</th>
<th>Actual YTD</th>
<th>Trend</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness Absence Rate</td>
<td>3.50%</td>
<td>3.50%</td>
<td>3.96%</td>
<td>4.22%</td>
<td>↑</td>
<td>Red</td>
</tr>
<tr>
<td>Staff Turnover</td>
<td>10.00%</td>
<td>10%</td>
<td>9.81%</td>
<td>9.81%</td>
<td>↓</td>
<td>Green</td>
</tr>
<tr>
<td>Mandatory Training</td>
<td>90.00%</td>
<td>90%</td>
<td>86.90%</td>
<td>86.90%</td>
<td>↑</td>
<td>Yellow</td>
</tr>
<tr>
<td>Appraisal Rates - Medical</td>
<td>90%</td>
<td>90%</td>
<td>97.92%</td>
<td>97.92%</td>
<td>↑</td>
<td>Green</td>
</tr>
<tr>
<td>Appraisal Rates - Non Medical</td>
<td>90%</td>
<td>90%</td>
<td>89.55%</td>
<td>89.55%</td>
<td>↑</td>
<td>Yellow</td>
</tr>
<tr>
<td>Appraisal Rates - Total</td>
<td>90%</td>
<td>90%</td>
<td>90.02%</td>
<td>90.02%</td>
<td>↑</td>
<td>Yellow</td>
</tr>
<tr>
<td>Recruitment - Medical</td>
<td>90%</td>
<td>90%</td>
<td>N/A</td>
<td>67.00%</td>
<td>↑</td>
<td>Green</td>
</tr>
<tr>
<td>Recruitment - Non-Medical</td>
<td>90%</td>
<td>90%</td>
<td>88.00%</td>
<td>75.00%</td>
<td>↑</td>
<td>Green</td>
</tr>
</tbody>
</table>
People will be proud to work for us

Workforce (Quality Strategy - Goal 4: Building on Capacity and Capability)

Staff Turnover

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-15</td>
<td>9.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td>May-15</td>
<td>9.0%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Jun-15</td>
<td>8.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Jul-15</td>
<td>8.0%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Aug-15</td>
<td>7.5%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Sep-15</td>
<td>7.0%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Oct-15</td>
<td>6.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Nov-15</td>
<td>6.0%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Dec-15</td>
<td>5.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Jan-16</td>
<td>5.0%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Feb-16</td>
<td>4.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Mar-16</td>
<td>4.0%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Vacancy Levels

<table>
<thead>
<tr>
<th>CBU</th>
<th>FTE Budget</th>
<th>FTE Contracted</th>
<th>Variance</th>
<th>Maternity Count</th>
<th>Sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>2705.95</td>
<td>2567.65</td>
<td>5.11%</td>
<td>78</td>
<td>3.96%</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>100.93</td>
<td>89.06</td>
<td>11.29%</td>
<td>1</td>
<td>1.68%</td>
</tr>
<tr>
<td>Diagnostic &amp; Clinical Support Services CBU</td>
<td>490.22</td>
<td>433.57</td>
<td>11.56%</td>
<td>11</td>
<td>4.13%</td>
</tr>
</tbody>
</table>

Estates – Vacancy factor remains high because of organisational restructure within Estates which is underway.

CBU 5 – Vacancy factor remains high because of recruitment difficulties for Healthcare Scientists within the Labs and in Radiology where there are particular issues with recruiting radiographers. These are both national issues. Recruitment is on-going to attract staff.

Recruitment - Medical

The non-medical recruitment timeline compliance has improved from 75% last month to 88%, so returns to amber. Each recruiting manager who has breached the timeline is followed up to advise on how to improve future management of recruitment.

Recruitment - Non medical

25 campaigns were completed for August 2015, 3 were outside the timeline standard, giving a figure of 88%, due to manager delay in two instances and references delay in one case, despite chasing. Each manager who has breached timeline is followed up by telephone to advise on breach and how to improve future management of recruitment.

There were no campaigns that completed for August 2015.
People will be proud to work for us

Workforce (Quality Strategy - Goal 4: Building on Capacity and Capability)

Mandatory Training

Overall compliance as of the 31st August: 86.9%
Estates and facilities, Theatres and anaesthetics and women’s and children’s CBU’s have all achieved compliance.

Appraisals

CBU1 = 100%  CBU2 = 95.5%  CBU3 = 97.00%
CBU4 = 100%  CBU5 = 92.90%  CBU6 = 100%

Overall compliance as of the 30th August is 97.9%. Estates and facilities, General and specialist medicine and women’s and children’s CBU’s have all achieved compliance.

Sickness Absence

Sickness has fallen from 4.35% last month to 3.96%, so returns to amber.
Sickness absence continues a downward trend since January. A new Occupational Health dashboard has been introduced this month to monitor referrals and use of the fast track scheme.
## Performance - "At a glance"

### Performance - Key Performance Indicators

<table>
<thead>
<tr>
<th>Cancer Reporting</th>
<th>Target 15/16</th>
<th>Target YTD</th>
<th>Aug-15</th>
<th>Trend</th>
<th>Current</th>
<th>Qtr Status</th>
<th>YTD Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cancer 2 week waits</td>
<td>93%</td>
<td>93%</td>
<td>95.4%</td>
<td>↓</td>
<td>96.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 week wait - Breast Symptomatic</td>
<td>93%</td>
<td>93%</td>
<td>92.0%</td>
<td>↑</td>
<td>90.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 day diagnostic to 1st treatment</td>
<td>96%</td>
<td>96%</td>
<td>100.0%</td>
<td>↑</td>
<td>99.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 day subsequent treatment - Surgery</td>
<td>94%</td>
<td>94%</td>
<td>100.0%</td>
<td>⇔</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 day subsequent treatment - Drugs</td>
<td>94%</td>
<td>94%</td>
<td>100.0%</td>
<td>⇔</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62 day urgent GP referral to treatment</td>
<td>85%</td>
<td>85%</td>
<td>88.8%</td>
<td>↑</td>
<td>83.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62 day screening programme</td>
<td>90%</td>
<td>90%</td>
<td>100.0%</td>
<td>⇔</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62 day consultant upgrades</td>
<td>85%</td>
<td>85%</td>
<td>50.0%</td>
<td>↓</td>
<td>79.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Breast Screening

| Screening to offer of 1st assessment <=3 weeks | 90% | 90% | ↑ |
| Screening to 1st assessment                   | 90% | 90% | ↑ |
| Screening to issue of normal results <=2 weeks | 90% | 90% | ↑ |

### Referral to Treatment

| RTT Admitted - % treatment within 18 weeks | 90% | 90% | 97.6% | ↓ | 97.9% |
| RTT Non Admitted - % treatment within 18 weeks | 95% | 95% | 98.2% | ↑ | 98.2% |
| RTT Incomplete Pathways - % still waiting   | 92% | 92% | 94.5% | ↓ | 95.1% |

### Diagnostics

| No. of diagnostic tests waiting over 6 weeks | 0 | 0 | 12 | ↓ |
| % of diagnostic tests waiting over 6 weeks  | 0% | 0% | 0.5% | ↓ |

### ED

| Percentage of patients treated in less than 4 hours | 95% | 95% | 95.4% | ↑ | 94.3% |
| Emergency Department Attendances                  | 6506 | ↓ | 13391 |
| 12 Hours Trolley Waits                            | 0 | 0 | n/a | ↔ | 0 |

### Ambulance to ED Handover Time

| % under 15 mins                              | 73.9% | ↑ | 63.5% |
| % between 15 and 30 mins                     | 17.4% | ↑ | 15.7% |
| % between 30 and 60 mins                     | 1.7%  | ↓ | 1.8%  |
| % between 60 and 120 mins                    | 0.4%  | ↑ | 0.2%  |
| Over 120 mins (SI)                           | 0.0%  | ↔ | 0.0%  |
| % Not Recorded                               | 6.6%  | ↓ | 18.8% |
| Total Ambulance Handovers                    | 1695  | ↓ | 8873  |

### Performance - Key Performance Indicators cont.

<table>
<thead>
<tr>
<th>Cancelled Operations</th>
<th>Target 15/16</th>
<th>Target YTD</th>
<th>Aug-15</th>
<th>Trend</th>
<th>Actual YTD</th>
<th>Trend</th>
<th>YTD Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Cancelled Operations</td>
<td>1%</td>
<td>1%</td>
<td>1.1%</td>
<td>↑</td>
<td>0.9%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Urgent operations - cancelled twice</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td>0</td>
<td>↔</td>
</tr>
<tr>
<td>Cancelled operations - breaches of 28 day rule</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>↔</td>
<td>0</td>
<td>↔</td>
</tr>
</tbody>
</table>

### Theatre Utilisation

| Theatre Utilisation - Day       | 80.1% | 82.1% | ↑ | 82.1% |
| Theatre Utilisation - Main      | 96.5% | 94.5% | ↑ | 94.5% |
| Theatre Utilisation - Trauma    | 80.8% | 90.0% | ↓ | 90.0% |

### GP Referrals

| GP Written Referrals - made      | 3814 | 19948 | ↓ | 19948 |
| GP Written Referrals - seen      | 3484 | 18728 | ↓ | 18728 |
| Other Referrals - Made           | 1356 | 7517  | ↓ | 7517  |

### DNA Rates

| New outpatient appointment DNA rate | 10% | 10% | 11.3% | 11.5% | ↓ |
| Follow-up outpatient appointment DNA rate | 10% | 10% | 10.8% | 11.0% | ↑ |
| Total outpatient appointment DNA rate | 10% | 10% | 11.0% | 11.2% | ↑ |

### Appointment Slot Issues

| No. of appointment slot issues | 0 | 0 | n/a | 2617 | ↔ |
| % of appointment slot issues  | 4.0% | 4.0% | n/a | 30.7% | ↔ |

### Average Length of stay (Quality Strategy Goal 3)

| Average Length of Stay - Elective | 2.42 | 2.42 | 2.35 | 2.68 | ↑ |
| Average Length of Stay - Non-Elective | 3.44 | 3.44 | 3.61 | 3.49 | ↑ |
Due to issues encountered as a result of the migration from Choose & Book to the new eReferral system, HSCIC have advised that reports will not be available until September.
The largest percentage of DNAs are in Oral Surgery (19.2%), Physiotherapy (14.4%) and Trauma & Orthopaedics (13.4%).
Challenges to the delivery of diagnostic target wait time are evident in cardiology for Angiography, Echocardiography and Ambulatory ECG. The CBU team are in the process of developing a business case for the expansion of capacity in Echocardiography and Ambulatory ECG to address capacity shortfalls against demand, whilst delivering the additional activity in a cost effective manner. In order to address protracted waits in diagnostic angiography, a 4th weekly Angiography list has been established. This commenced in September and will deliver reductions in wait times across September to December 2015.
Performance Matters (KPIs)

Regulatory Performance - ED

A&E 4 Hour Wait

No. Ambulance Handover Times (pre-validated YAS)

### Performance Matters (KPIs)

#### Regulatory Performance - 18 Week Referral to Treatment

<table>
<thead>
<tr>
<th>Specialty</th>
<th>&lt;18</th>
<th>&gt;18</th>
<th>Total</th>
<th>%</th>
<th>&lt;18</th>
<th>&gt;18</th>
<th>Total</th>
<th>%</th>
<th>&lt;18</th>
<th>&gt;18</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>114</td>
<td>7</td>
<td>121</td>
<td>94.2%</td>
<td>307</td>
<td>12</td>
<td>319</td>
<td>96.2%</td>
<td>1613</td>
<td>122</td>
<td>1735</td>
<td>93.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>21</td>
<td>0</td>
<td>21</td>
<td>100.0%</td>
<td>76</td>
<td>1</td>
<td>77</td>
<td>98.7%</td>
<td>506</td>
<td>27</td>
<td>533</td>
<td>94.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>142</td>
<td>2</td>
<td>144</td>
<td>98.6%</td>
<td>116</td>
<td>2</td>
<td>118</td>
<td>98.3%</td>
<td>961</td>
<td>74</td>
<td>1035</td>
<td>92.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>52</td>
<td>4</td>
<td>56</td>
<td>92.9%</td>
<td>326</td>
<td>0</td>
<td>326</td>
<td>100.0%</td>
<td>638</td>
<td>32</td>
<td>670</td>
<td>95.2%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>27</td>
<td>0</td>
<td>27</td>
<td>100.0%</td>
<td>204</td>
<td>3</td>
<td>207</td>
<td>98.6%</td>
<td>901</td>
<td>55</td>
<td>956</td>
<td>94.2%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>33</td>
<td>0</td>
<td>33</td>
<td>100.0%</td>
<td>12</td>
<td>0</td>
<td>12</td>
<td>100.0%</td>
<td>231</td>
<td>5</td>
<td>236</td>
<td>97.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>16</td>
<td>0</td>
<td>16</td>
<td>100.0%</td>
<td>121</td>
<td>1</td>
<td>122</td>
<td>99.2%</td>
<td>674</td>
<td>25</td>
<td>699</td>
<td>96.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>100.0%</td>
<td>110</td>
<td>0</td>
<td>110</td>
<td>100.0%</td>
<td>322</td>
<td>12</td>
<td>334</td>
<td>96.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>127</td>
<td>2</td>
<td>129</td>
<td>98.4%</td>
<td>141</td>
<td>4</td>
<td>145</td>
<td>97.2%</td>
<td>762</td>
<td>26</td>
<td>788</td>
<td>96.7%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>100.0%</td>
<td>104</td>
<td>1</td>
<td>105</td>
<td>99.0%</td>
<td>194</td>
<td>7</td>
<td>201</td>
<td>96.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>100.0%</td>
<td>81</td>
<td>7</td>
<td>88</td>
<td>92.0%</td>
<td>159</td>
<td>17</td>
<td>176</td>
<td>90.3%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>43</td>
<td>0</td>
<td>43</td>
<td>100.0%</td>
<td>166</td>
<td>1</td>
<td>167</td>
<td>99.4%</td>
<td>434</td>
<td>31</td>
<td>465</td>
<td>93.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>31</td>
<td>0</td>
<td>31</td>
<td>100.0%</td>
<td>228</td>
<td>6</td>
<td>234</td>
<td>97.4%</td>
<td>876</td>
<td>60</td>
<td>936</td>
<td>93.6%</td>
</tr>
<tr>
<td>Other</td>
<td>612</td>
<td>15</td>
<td>627</td>
<td>97.6%</td>
<td>2045</td>
<td>38</td>
<td>2083</td>
<td>98.2%</td>
<td>8411</td>
<td>493</td>
<td>8904</td>
<td>94.5%</td>
</tr>
</tbody>
</table>

### Consultant 18 Week Referral to Treatment

- **Admitted Pathways**
  - April 15 to March 16
  - Percentage Positivity

- **Non-Admitted Pathways**
  - April 15 to March 16
  - Percentage Positivity

- **Incomplete Pathways**
  - April 15 to March 16
  - Percentage Positivity

**Final Position**

- **Admitted - Target 90%**
  - <18
  - >18
  - Total
  - %

- **Non-Admitted - Target 95%**
  - <18
  - >18
  - Total
  - %

- **Incomplete - Target 92%**
  - <18
  - >18
  - Total
  - %

**Target Values**

- Incompletes - Target 92%
- Admitted - Target 90%
- Non-Admitted - Target 95%
The breast symptomatic target for August remains non-compliant at 92% although this is a marked improvement from the previous month. September performance to date is good, suggesting compliance against the quarter is still achievable.
The August position showed compliance at 88.8%, with further final validation work still in progress. Trajectory for the quarter indicates a strong September position will be needed to achieve the full quarter. Robust pathway monitoring and escalation processes are in place to sustain focus on individual pathways.

The small number of Consultant Upgrades are significantly impacted by any breaches incurred - more consistently rendering us non compliant against this locally agreed target. As part of the CWT 8 Key Priorities work - a revised Consultant Upgrade process will be presented in the Operational Policy (under development) for consideration. This would potentially increase the volume of Consultant Upgrades and therefore accountable treatments to offset the impact of breaches.
Performance Matters (KPIs)

Regulatory Performance - Breast Cancer Screening

Screening to offer of 1st assessment ≤3 weeks

Screening to issue of normal results ≤2 weeks

The target has been missed due to patient choice.

Comments:
Breast screening information is reported a month in arrears.
### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>14/15 Actual</th>
<th>15/16 Plan</th>
<th>15/16 Actual</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Day cases</td>
<td>9260</td>
<td>9730</td>
<td>9712</td>
<td>-18</td>
<td>0%</td>
</tr>
<tr>
<td>Elective Inpatients</td>
<td>1557</td>
<td>1606</td>
<td>1726</td>
<td>120</td>
<td>7%</td>
</tr>
<tr>
<td>Elective Total</td>
<td>10817</td>
<td>11336</td>
<td>11438</td>
<td>102</td>
<td>1%</td>
</tr>
<tr>
<td>Non Elective</td>
<td>14809</td>
<td>14367</td>
<td>14921</td>
<td>554</td>
<td>4%</td>
</tr>
<tr>
<td>Maternity Pathway</td>
<td>2500</td>
<td>2585</td>
<td>2489</td>
<td>-96</td>
<td>-4%</td>
</tr>
<tr>
<td>A&amp;E Attendances</td>
<td>33883</td>
<td>34030</td>
<td>33678</td>
<td>-352</td>
<td>-1%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>101836</td>
<td>104675</td>
<td>96551</td>
<td>-8125</td>
<td>-8%</td>
</tr>
</tbody>
</table>

* Please note excess bed days are not included in these figures. Obstetric outpatient attendances are excluded as they are covered by the Maternity Pathways.

---

**Day Cases**

<table>
<thead>
<tr>
<th>Month</th>
<th>2014/15 Outturn</th>
<th>2015/16 Activity Plan</th>
<th>2015/16 Activity Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Elective Inpatients**

<table>
<thead>
<tr>
<th>Month</th>
<th>2014/15 Outturn</th>
<th>2015/16 Activity Plan</th>
<th>2015/16 Activity Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Non-Elective Inpatients**

<table>
<thead>
<tr>
<th>Month</th>
<th>2014/15 Outturn</th>
<th>2015/16 Activity Plan</th>
<th>2015/16 Activity Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Main areas of overperformance are Elective and NEL Inpatients, new outpatients are 937 over achieved but overall outpatients are under performing. Electives: highest over performances against plans are Urology (47, 91%), Gastro (42.31%) and Paediatrics (64, 42%). For non-electives the mains areas of over performance are in Cardiology, Respiratory and Geriatric Medicine.

Outpatients: There is a general underperformance against follow-up plans across most specialties with the highest variances (against aggregated attendances and procedure plans) in Endocrinology - 617, Dermatology - 574, Diabetes - 770, Retinal Screening - 730, Rheumatology - 739 and Gynaecology -590.
### Performance - Financial Overview

<table>
<thead>
<tr>
<th>ACTIVITY LEVELS</th>
<th>Month Plan</th>
<th>Month Actual</th>
<th>Variance</th>
<th>Plan YTD</th>
<th>Actual YTD</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective inpatients</td>
<td>361</td>
<td>362</td>
<td>0.28%</td>
<td>1</td>
<td>1,876</td>
<td>2,096</td>
<td>11.73%</td>
</tr>
<tr>
<td>Day Cases</td>
<td>1,871</td>
<td>1,811</td>
<td>-3.21%</td>
<td>-60</td>
<td>9,730</td>
<td>9,712</td>
<td>-0.18%</td>
</tr>
<tr>
<td>Non-elective inpatients</td>
<td>3,246</td>
<td>3,098</td>
<td>-4.56%</td>
<td>-148</td>
<td>16,704</td>
<td>17,773</td>
<td>6.40%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>22,536</td>
<td>18,265</td>
<td>-18.95%</td>
<td>-4,271</td>
<td>117,870</td>
<td>101,547</td>
<td>13.85%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>6,619</td>
<td>6,506</td>
<td>-1.71%</td>
<td>-113</td>
<td>34,030</td>
<td>33,678</td>
<td>-1.03%</td>
</tr>
</tbody>
</table>

| Clinical Activity | | | | | | | |
|-------------------| | | | | | | |
| Other (excludes direct access tests) | 10,491 | 8,607 | -17.96% | -1,884 | 54,239 | 47,263 | 12.86% | -6,976 |

**Total activity**

<table>
<thead>
<tr>
<th>Month Plan</th>
<th>Month Actual</th>
<th>Variance</th>
<th>Plan YTD</th>
<th>Actual YTD</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>45,124</td>
<td>38,649</td>
<td>-14.35%</td>
<td>-6,475</td>
<td>234,449</td>
<td>212,069</td>
<td>-9.55%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIP</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>206</td>
<td>117</td>
<td>-43.20%</td>
<td>-89</td>
<td>831</td>
<td>692</td>
</tr>
<tr>
<td>Pay</td>
<td>212</td>
<td>87</td>
<td>-58.96%</td>
<td>-125</td>
<td>824</td>
<td>398</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>162</td>
<td>202</td>
<td>24.69%</td>
<td>40</td>
<td>707</td>
<td>658</td>
</tr>
</tbody>
</table>

**Total CIP**

<table>
<thead>
<tr>
<th>Month Plan</th>
<th>Month Actual</th>
<th>Variance</th>
<th>Plan YTD</th>
<th>Actual YTD</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>580</td>
<td>406</td>
<td>-30.00%</td>
<td>-174</td>
<td>2,362</td>
<td>1,748</td>
<td>-25.99%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INCOME</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical (Activity)</td>
<td>8,638</td>
<td>8,495</td>
<td>-1.66%</td>
<td>-143</td>
<td>44,553</td>
<td>45,347</td>
</tr>
<tr>
<td>Other Clinical</td>
<td>2,980</td>
<td>2,987</td>
<td>0.23%</td>
<td>7</td>
<td>15,000</td>
<td>14,605</td>
</tr>
<tr>
<td>CQUINS</td>
<td>274</td>
<td>274</td>
<td>0.00%</td>
<td>0</td>
<td>1,370</td>
<td>1,370</td>
</tr>
<tr>
<td>Risks &amp; Penalties</td>
<td>0</td>
<td>42</td>
<td>-100.00%</td>
<td>42</td>
<td>0</td>
<td>-225</td>
</tr>
<tr>
<td>Business Cases</td>
<td>144</td>
<td>34</td>
<td>-76.99%</td>
<td>-110</td>
<td>720</td>
<td>1,245</td>
</tr>
<tr>
<td>Other</td>
<td>1,704</td>
<td>1,385</td>
<td>-18.72%</td>
<td>-319</td>
<td>8,141</td>
<td>7,458</td>
</tr>
</tbody>
</table>

**Total income**

<table>
<thead>
<tr>
<th>Month Plan</th>
<th>Month Actual</th>
<th>Variance</th>
<th>Plan YTD</th>
<th>Actual YTD</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,740</td>
<td>13,217</td>
<td>-3.81%</td>
<td>-523</td>
<td>69,784</td>
<td>69,800</td>
<td>-0.02%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPERATING COSTS</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>-9,720</td>
<td>-10,060</td>
<td>-3.50%</td>
<td>-340</td>
<td>48,676</td>
<td>50,493</td>
</tr>
<tr>
<td>Drugs</td>
<td>-1,081</td>
<td>-1,021</td>
<td>5.55%</td>
<td>60</td>
<td>-5,406</td>
<td>-5,270</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>-3,695</td>
<td>-3,652</td>
<td>1.16%</td>
<td>43</td>
<td>18,062</td>
<td>18,401</td>
</tr>
</tbody>
</table>

**Total Costs**

<table>
<thead>
<tr>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>-14,496</td>
<td>-14,733</td>
<td>-1.63%</td>
<td>-237</td>
<td>-72,144</td>
<td>-74,164</td>
</tr>
</tbody>
</table>
## Summary Performance:

**Commentary**

Key to RAG rating

- The RAG rating applied to Variance % is based on the following criteria:
  - Green equating to 0% or greater
  - Amber behind plan by up to 5%
  - Red greater than 5% behind plan

The key points derived from this table are as follows:

- Total activity is behind plan year to date excluding Direct Access. The main driver is a shortfall on Outpatient activity and impacts across all relevant CBU's. Activity levels are favourable to plan for Elective and Non-elective Inpatients. Direct Access tests were excluded from the other category because large variances in these figures skew the overall activity variance.

- CIP achievement has been validated in month. The overall adverse variance is due to a slower start of delivery from a number of schemes. CIP delivery is expected to remain adverse to plan for the next few months as schemes are driven through to delivery and new initiatives are identified. £0.4m of the adverse position is due to the bed utilisation scheme.

- Clinical activity based income is £0.8m favourable to plan. The main variances are non-elective income is £1.4m favourable to plan, outpatient income is £1.0m adverse to plan.

- Business case income is £0.5m favourable to plan partially due to receipt of resilience funding not included within the plan. There is however a significant adverse cost variance as not all resilience requirements are funded.

- Other income is £0.7m adverse to plan.

- Operating costs are adverse to plan. Pay is £1.8m adverse to plan which is driven by resilience spend, which is not fully funded, and increased activity. In addition there are agency costs covering vacant posts and CIPs are behind plan by £0.4m on pay.

- Non-pay costs total are £0.3m adverse to plan, which links to activity.

- EBITDA is adverse to plan by £2.0m.

- Depreciation, restructuring and finance costs are all slightly favourable to plan.

- The overall deficit is £1.8m adverse to plan.

- Capital expenditure is £0.5m underspent to plan.

- Inventory is £0.2m lower than plan, £0.3m is due to differences to the opening position assumed in the plan.

- Total receivables incl. prepayments are £0.1m favourable to plan.

- Total payables incl. accruals are favourable to plan by £1.5m, this is due to differences to the opening position assumed in the plan and continued payments management.

- Deferred income is £0.2m adverse to plan and is due to differences to the opening position and release against the maternity pathway.

- Cash is £4.1m favourable to plan and results from additional loan drawdown, and improvements to working capital (inventory, receivables and payables).

- Debtor days are 16.3 year to date, which is 0.2 days favourable to plan.

- Payable days 104.7 year to date which is 7.8 days better than plan.

- The Continuity of service rating has reverted to a 1 at month 5 due to an adverse movement in liquidity days.
Performance Matters (Financial Overview)

Comments:
- Clinical income per day: This is adverse to plan for August 2015.
- Pay as a % of clinical income: This is adverse to plan for August 2015 and reflects the additional costs incurred due to escalation and covering vacancies.

Actual Income Analysis
- This graph analyses the split of income on a monthly basis and demonstrates the variability of clinical income.

Clinical Income Per Day
- This graph shows the actual income per day compared to the plan over the months.

Pay as a % of Income
- This graph shows the percentage of income paid as a variable cost over the months.
Performance Matters (Financial Overview)

Comments:

Agency monthly spend - this graph indicates that the agency costs have been increasing month on month. Agency expenditure is now being reviewed in depth.

Deficit trend analysis - this graph highlights the gap between plan and actual at month 4 and suggests that the profiled deficit for the month was optimistic.

CIP is adverse to plan with the key driver being the bed utilisation scheme.