Barnsley Hospital NHS Foundation Trust

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Annual Report and Accounts

2012/13

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.

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Contents

About Barnsley Hospital

Barnsley Hospital NHS Foundation Trust was founded on 1 January 2005 under the Health and Social Care (Community Health and Standards) Act 2003, as re-enacted in the National Health Service Act 2006 (the 2006 Act).

We were one of the first hospitals in the country to become a Foundation Trust. Since becoming a Foundation Trust in 2005 Barnsley Hospital NHS Foundation Trust has sought to utilise the foundation trust regime that this brings to benefit our patients.

We provide a range of acute hospital services. These include emergency and intensive care, medical and surgical services, elderly care, paediatric and maternity services and diagnostic and clinical support services. We also provide a number of specialised services, including cancer and surgical services, in partnership with Sheffield Teaching Hospitals NHS Foundation Trust.

The hospital was built in the 1970s and covers a site of 8.2 hectares. It has c500 beds and employs 3168 staff (at 31 March 2013). We serve a population of approximately 231,900 across an area which matches the same geographical boundaries as Barnsley Metropolitan Borough Council and our main commissioner, NHS Barnsley.

We work closely with a wide range of partners, including NHS Barnsley, the local authority and other private and public sector partners.

Chairman and Chief Executive Overview

As we began this year it was clear that the continuing pace of change in the NHS, our savings expectations, a third consecutive year with no inflationary uplift in our annual budget and exacting performance and quality targets, would mean that 2012/13 would be another stretching year for the Trust.

Our biggest challenge is not only to improve the efficiency of our services but also to develop a different approach to how we work and last year we started a three year Transformation Programme to achieve this. Year one of the programme (2012) was focused on the planning of the workstreams, identifying the resource requirements and agreeing achievable and measurable measures of success.

Year two of the Transformation Programme (2013/14) will focus on delivery and benefits realisation with the absolute requirement to ensure that each transformation workstream is owned by the appropriate Clinical Service Unit (CSU) and that there is clarity around accountability for achievement of key quality indicators and financial milestones.

The Transformation Board holds to account and encourages clinical teams to be more ambitious in their aspirations, compared to surrounding providers and to challenge traditional ways of working and staffing models to be much more creative in where services are delivered and by whom in the future.

The publication of the Francis Report reminded us that the safety and quality of care of our patients is our top priority. The Trust's Board of Directors, Clinical Directors and Senior Managers have all attended a number of workshops and focus groups to discuss the recommendations. The Trust's Human Resources and Organisational Development department has been working to ensure that the actions from these events, plus actions already taken such as developing and rolling out a set of Values and Board meetings being held in public, are reflected in our work over the coming year.

The Trust's flexibility and responsiveness was tested as we saw a continued rise in unplanned admissions, due to factors outside our control. This placed enormous pressure on our teams and services and to address this we have begun building work to expand the physical space in our emergency department which will result in a new 10 bed observation area in the emergency department and a significant expansion of the Acute Medical Unit (AMU) from 22 beds to 45 beds. In addition to this we are implementing an action plan which takes a whole hospital approach and takes into account the nature and complexities of patients presenting at the emergency department.

The Care Quality Commission made an unannounced full inspection in January and we were found to be fully compliant in all areas. This was greatly appreciated by all and an important recognition of the hard work and effort staff have made.

We have made progress against the plans we set ourselves, despite increasing pressures and are particularly struck by the skill, commitment and enthusiasm of our staff.

Our performance

Meeting our target to see and treat 95% of all patients within four hours proved extremely difficult this year. Faced with the continued high levels of attendances to the Emergency Department, we failed to meet the target in the last half of the year. Working with the wider health community, we have a whole hospital approach plan in place to try to meet this target in 2013/14.

We continued to manage the increase in unplanned patient numbers by opening more beds in addition to the extra winter ward. While this helps us to cope with the peaks in demand, it means that our patients do not get an established ward team looking after them. This is not ideal and our plans for greater continuity of care and improving urgent care services in the first quarter of the year ahead will help us tackle this.

It is a tribute to their professionalism and dedication to patients that our staff succeeded in continuing to deliver high standards of care under such pressure. The Board, our Governors and the people of Barnsley and surrounding areas, are indebted to them.

Vigorous infection control standards mean that we were able to report that cases of Clostridium Difficile (C Diff) were at an all-time low 29% below target. We are also pleased to report that we had no cases of MRSA bacteraemia.

Quality

The Trust received a number of unannounced inspections from the Care Quality Commission (CQC) during 2012/13 and was visited on the 21 March 2012 as part of the CQC's national targeted programme assessing arrangements for termination of pregnancy across care providers. The Trust received an initial draft report in April 2012 and a final report at the end of May 2012. The final report highlighted a minor concern with regards to record keeping which the Trust immediately actioned.

The CQC revisited the Trust on the 4 October 2012 to re-assess record keeping compliance and found the Trust to be fully compliant. This was formally reported at the end of October 2012.

The Trust was visited on the 1 May 2012 to assess the Trust's compliance with the Ionising Radiation Regulations; the CQC outlined a number of changes that they would like to see within the Trust's imaging departmental procedures. These changes were all made and submitted to the CQC and the Trust was declared compliant in December 2012.

The Trust was also visited on the 28 January 2013 and was assessed across four outcomes in four clinical ward areas - gynaecology, cardiology, the stroke unit and orthopaedics. The inspection focused in particular on the respect, involvement, care and welfare of patients, the hospital's work to safeguard patients from abuse and its support for its workers. In addition to observing the patient care and treatment being

given, the inspectors spoke to 18 members of staff, 17 patients and four visiting relatives, as well as examining patient notes.

The Trust was found to be fully compliant against all outcomes in all clinical areas the final report was published at the end of February 2013.

Transformation

At the beginning of last year we began an ambitious three year transformation programme that aims to improve efficiencies of our services, save cost and transform the way we work. We have made significant progress. We appointed 14 Clinical Directors from within our existing clinical teams – who have been at the centre of our transformation plans during the year.

You can read more about these developments in the business review on page 18.

Looking ahead

We are determined and dedicated to meeting our patients' needs and if we are to put quality and safety first, if we are to flourish in the new NHS, we need to work harder to ensure the Transformation Programme we have embarked upon really delivers.

In recognition of the benefits of working with our partners across the region, the Chairs and Chief Executives of acute providers in South Yorkshire, Mid Yorkshire and North Derbyshire have agreed to work together to meet future financial challenges and clinical quality standards. Our Board has endorsed this approach and agreed a Memorandum of Understanding under which this work can be progressed within a 'Working Together' programme.

The Health and Social Care Act reforms aim to improve patient outcomes, drive up quality and increase clinical leadership. On April 2013 GPs became the Trust's lead commissioners and competition for providing some NHS services will open up. In addition, the reforms will strengthen local accountability with increased powers for our Governors. The Trust has worked closely with Barnsley Clinical Commissioning Group (CCG) through the development phase of their formal authorisation to develop a collaborative approach in understanding and meeting the needs of the local population.

The CCG Commissioning Plan 2013/14 clearly sets out their intention to work closely with the Trust. The plan builds on the collaborative approach undertaken with all partners across health and social care to encourage the introduction of new and innovative ways of working to improve the overall health of the local population; reduce the health inequalities that exist across Barnsley and improve productivity and efficiency of the services delivered.

The findings from the Mid Staffordshire NHS Foundation Trust public inquiry were published in February 2013 and the recommendations made by Robert Francis QC will permeate throughout the NHS. Over the coming year we will include consideration to the Francis Report in all that we do while we ensure we are providing high-quality, safe and effective care.

In August 2012, ahead of the requirements of the Health and Social Care Act and the publication of the Francis Report and reflecting its ethos of transparency and openness, the Board changed its programme to ensure meetings were held in public each month. A limited amount of business continues to be held in private session where required, the agenda and minutes from which are shared with our Governors.

To continue providing safe, high quality care and treatment for our patients while continuing to make savings, we need total dedication, personal excellence and partnership working.

To have the best chance of success, we decided to put greater clinical leadership at the heart of the way we deliver our services. We have established 14 clinical service units (CSUs), each with a Clinical Director at the helm. The units will ensure that patients are always at the centre of our decision-making.

To ensure the decisions being made are in the best interests of patients, we have dedicated plans to develop our Clinical Directors, Governors and Board Directors so that they are equipped to take on their enhanced roles.

In the development of all our plans, we involved our staff, governors, partners, patients and unions. These are their ideas, shaped through discussion, exploration and fine-tuning. They have been developed to help us meet the enormous challenges ahead which include: delivering the challenging cost improvement programme (CIP) which is predominantly being achieved through the Trust's quality, innovation productivity and prevention plans (QIPP) delivered through the Transformation Programme; channelling staff engagement to deliver the significant service changes required to deliver both the Trust's business plan and the wider NHS reform agenda and managing the impact that changes to the commissioning landscape will have on provider organisations.

We face immense challenges in the year ahead and our risk assessment process is designed to identify, manage and mitigate business risks. There are examples of risks associated with achieving our business plan and what we did and are doing to manage them, on page 52. Additional risks not currently known to the management team and Board, or deemed to be less material, may also have an adverse effect on the business of the hospital.

We are confident we have prepared as well as we can and that the hospital is in the best possible position to succeed and prosper.

The Board of Directors

A strong Board is fundamental to the success of the hospital. It is made up of Executive Directors and Non-Executive Directors who develop and monitor the Trust's strategic aims. Together, they receive, accept and challenge reports to enable assurance of their responsibilities and to be able to assure the Council of Governors.

On behalf of the Board of Directors, I would like to record our thanks to our Chief Executive, Paul O'Connor who will be leaving us in May to take up a new challenge at Sherwood Forest Hospitals NHS Foundation Trust. Paul has made an immense

contribution to the Trust over the past three years, in particular his focus on improving quality, safety and patient care and the delivery of sound financial and organisational performance. He leaves Barnsley Hospital in a strong and stable position and the Board will ensure that we build on his legacy. We all wish Paul every success with the next stage of his NHS career.

Chairman - Stephen Wragg

Non-Executive Directors
Anne Arnold (until 31 August 2012)
Suzy Brain England OBE
Linda Christon
Stephen Houghton CBE
Francis Patton
Paul Spinks (from 1 September 2012)

Chief Executive - Paul O'Connor

Executive Directors
Medical Director - Dr Jugnu Mahajan
Director of Finance and Information - Dawn Hanwell, (until July 2012)
Janet Ashby (from 1 August 2012)
Chief Nurse - Heather Mcnair
Chief Operating Officer - David Peverelle

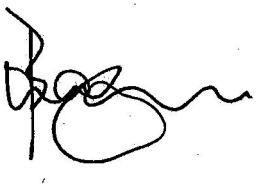
The Management Team
The hospital's management team is made up of Executive Directors from the Board and other Directors who support the day to day running of the hospital.

Paul O'Connor, Chief Executive
Hilary Brearley, Director of Human Resources and Organisational Development
Dawn Hanwell, Director of Finance and Information (until July 2012)
Janet Ashby (from August 2012)
Elaine Jeffers, Director of Transformation
Liz Libiszewski, Director of Quality and Performance
Dr Jugnu Mahajan, Medical Director
Heather Mcnair, Chief Nurse
David Peverelle, Chief Operating Officer
Helen Stevens, Associate Director of Communications and Marketing (until February 2013) Caroline Shaw (interim from February 2013)

Going Concern Statement
After making enquiries, the Directors have a reasonable expectation that Barnsley Hospital NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts**.**

Stephen Wragg
Chairman

Date: 28th May 2013



Paul O'Connor
Chief Executive

Date: 28th May 2013

Performance

Performance overview

In 2012/13 we cared for 62,972 patients in the hospital (1,779 more than the previous year), saw 275,787 in clinic appointments (7,762 more) and treated 79,953 in our Emergency Department (1,736 more). The extended winter, more very sick elderly and frail patients and the unpredictable volumes and variation in times that patients attend the hospital have all contributed to our ability to manage the extra demand.

As a result of the continuing increase in patients attending the Emergency Department, there was a corresponding increase in the number of unplanned admissions. These patients came mostly from Barnsley but also continued to come from health communities on our borders and continued the trend from last year. Our staff have risen to this challenge and proved that they always go the extra mile to ensure our patients are seen, treated and cared for to high standards, despite the incredible pressure they are under at times. I am, as ever, immensely proud to work at this hospital with such dedicated teams.

Managing the increased demand on our services has been testing and this may have had an impact on the levels of service we would expect to provide. We cope by opening and closing escalation wards. Staff who work on them do their absolute best to ensure high quality patient care at all times and while this is safe and the standards are high, we know it is not ideal for our patients or our staff. In response we have expanded our Acute Medical Unit (AMU) and are building a new observation area in our Emergency Department. Developed by our clinicians, these initiatives will improve the conditions for patients and staff and help us to manage demand in a more planned and sustainable way. We have also commissioned extended reviews of all our internal emergency care pathways to streamline and enhance the service we offer.

We have worked on developing our services beyond the routine Monday to Friday, nine to five pattern. Patients who are admitted outside of these times have a right to continuity of care and to ensure that they do our diagnostics teams will provide an extended cover and I am particularly indebted to our radiology team who will be implementing this new working pattern. Consultant medical staff are also reviewing their working patterns to achieve the same levels of service over seven days.

The Trust's overall performance against national and local standards fell short of our expectations. In the winter months we missed the target to see and treat 95% (93.81% for the year) of all patients within four hours in our Emergency Department.

Although we have had an excellent track record in delivering across the full range of cancer targets, we narrowly failed to deliver the two week wait 93% targets for breast symptomatic cancers in quarter three (92.8%) and 'all cancers' in quarter four (92.97%) as a result of patients declining appointments.

I am indebted to the teams who work so hard to provide the best healthcare for all and I would like to thank each and every member of staff who continues to make Barnsley Hospital the success story it is.

You can read more about the national and local quality standards we work with in the quality account.

Workforce

Workforce numbers: the Trust maintained a stable workforce (3008 in 2011/12 and 3168 in 2012/13), with last year's investment in nursing posts remaining a priority. This year, we have undertaken a detailed review of our nursing, medical, Allied Health Professional (AHP) and administration workforce, to ensure that we have the right numbers and skills in the Trust to provide the high quality care we are so proud of.

Our Clinical Directors, appointed last year to ensure that we plan, run and monitor the performance of our services by practising clinicians, are now established in their posts. We have invested time in their leadership development and supporting them in their new roles.

Our Together We Will Make It: Better programme has continued through the year. This is a key vehicle for making sure our staff are fully involved in working out how we can improve the things we know need to be better. Our staff survey results for the year tell us that we have made improvements in many of our priority areas and compare well with other trusts across the country. Our staff are keen to continue with this programme and will be working with us again in the coming year to build on the progress we have made so far.

This year, we have been building on our much improved appraisal and training rates, turning our attention to how we develop our staff so that they can lead and deliver excellent care. We have designed a development and engagement plan (our Organisation Development Framework) around our Values, to ensure that everything we do is about:

- Treating people how we would like to be treated ourselves
- Working together to provide the best quality care we can
- Focusing on individual and diverse needs

During the year we started to revise and improve our services for patients, you can read about examples in the sections on providing high quality and services and designing healthcare around our patients needs on pages 21-24.

Looking ahead

The impact of the Health and Social Care Act 2012 and the findings of a public inquiry into Mid Staffordshire NHS Foundation Trust will have a profound effect on us. There is no doubt that as a District General Hospital we face immense challenges but we are already doing much to mitigate the risks and our work in the last year, coupled with our plans for the coming year and beyond, give us a strong foundation on which to face them.

Continuing to meet the growing demand for our services at a time of massive change in the NHS, combined with the need to continuously improve the quality of our services and reduce costs, means we need to accelerate a number of Transformation Programmes and fast-track the re-shaping of our services. To have the best chance of success, we need to work with our clinicians and health care partners. Our programmes for the year ahead and beyond firmly put them and our patients at the centre.

By David Peverelle

David Peverelle
Chief Operating Officer

Date 28th May 2013

Performance against our plans

Key performance indicators

National targets

We met most of our national targets

- ✖ 95% patients to be seen within four hours in the Emergency Department.
  We achieved 93.81%
- ✓ 90% patients treated within 18 weeks of referral for admitted patients.
  We achieved 96.0%
- ✓ 95% patients treated within 18 weeks of referral for non-admitted patients.
  We achieved 98.2%
- ✓ 95% patients to have a maximum waiting time of 31 days from diagnosis to treatment.
  We achieved 100%
- ✓ 85% of all patients to have a maximum waiting time of 62 days from urgent referral to treatment of all cancers.
  We achieved 92.7%
- ✓ 100% patients to be seen within a maximum two week wait standard for rapid access chest pain clinics.
  We achieved 100%
- ✓ 100% patients to have access to a genito-urinary medicine clinic within 48 hours of contacting the service.
  We achieved 100%
- ✓ All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
  Our target was less than 5% and we achieved 0%
- ✓ 0% patients to have delayed transfer of care.
  We achieved 0.2% which is within the target of less than 1%
- ✓ 93% of symptomatic breast patients - two week wait (non cancer referrals)*
  We achieved 93.9%
- ✓ 93% of all cancer patients waited no more than two weeks for referral**
  We achieved 94.1%

- Due to patient choice, only 92.8% was achieved for the third quarter

** Due to patient choice, only 92.97% was achieved for the fourth quarter

Infection control

- ✓ There were no cases of MRSA Bacteraemia in the year
- ✓ There were 22 cases of C Diff against a target of 31
  Last year there were 28 cases of C Diff (against a target of 31)

Handling complaints

The Trust received 245 formal complaints during 2012/13. This represents a reduction of 27 from the previous year. All complaints were acknowledged within the three working day standard.

The Parliamentary and Health Service Ombudsman (Ombudsman) undertakes independent reviews of complaints under stage two of the complaints procedure. The Trust was notified of five requests for information to support the stage two review by the Ombudsman in the past year, the outcome being that two have been assessed by the Ombudsman with a decision not to conduct an investigation and take no further action. One was resolved by the Ombudsman requesting the Trust complete further actions and two have been accepted for an investigation and the Trust is awaiting notification of those investigations.

We assess and monitor the improvements we action from every single complaint and carry out quarterly analysis and reviews of our complaints in order to learn and improve from the feedback and experiences of our service users. Here are some of the improvements we have made in 2012/13:

- 'Intentional rounding' has been introduced across all in-patient wards. These are hourly checks completed to ensure that each patient is observed by ward staff for comfort, safety and wellbeing
- Password Protected Communication (PPC) reviewed. PPC involves setting up a password so relatives of patients who may not be able to visit the patient can phone in and ask for updated information that would not normally be given over the phone. This system aids communication with relatives whilst protecting patient confidentiality
- Process mapping and review of General Office standards for completion of death certificates and procedure following death; procedures developed and rolled out Trust-wide
- Revise Endoscopic Retrograde Cholangiopancreatography Procedure (ERCP) care plan includes a section when medications have been stopped
- Development of a checklist for use by Bereavement Support Midwives to ensure all relevant agencies and GP are informed
- Drop in sessions have been facilitated for women who have chosen a planned home birth to provide support and advice.

Business Review

Our local health and social community

The community of Barnsley faces many health challenges. These are largely due to socioeconomic deprivation, a growing ageing population and increasing morbidity as a result of lifestyle choices. While local life expectancy is improving, the gap between Barnsley and the rest of country is widening. There is also an above average number of people receiving disability and other benefits, impacting on the already heavy reliance of people on Barnsley's health and social care provision. Although we cannot predict the impact, major changes to the benefit system and the phased introduction of Universal Credit is likely to have an effect on the local population in the year ahead.

The major health issues facing Barnsley people include:

- Life expectancy is improving but the gap between Barnsley and the rest of the country is not narrowing
- Cancer is the major cause of premature death
- Major causes of chronic ill health include
    - Stroke
    - High blood pressure
    - Diabetes
    - Dementia
    - Chronic obstructive pulmonary diseases (COPD)
- The population of Barnsley is growing and is expected to increase by 16% by 2031 and the percentage of older people will grow by 67% in the same period
- The high number of people receiving disability and other benefits means that a large number of the people will continue to rely on the health and social care provision in the area
- The percentage of minority ethnic groups is also growing and has more than doubled from 1.9% in 2001 to 4.8% in 2012.

Transformation Programme

It was identified during the 2012-15 business planning process that for Barnsley Hospital NHS Foundation Trust, this equates to a minimum of £20m savings in the next three years. In order to do this we will need to transform our services and work differently as an organisation.

The NHS is operating in a very different environment now and if we, Barnsley Hospital, want to remain as a leading, viable health provider of really good, high quality health care, we have to think more creatively and differently about the type of services we provide and where we deliver those services.

Continuing to transform the way the hospital and its staff operate will not only draw on new ways of working and will look to innovations and technology to deliver a Barnsley Hospital that is leaner and smarter in everything that it does.

At the same time, expectations among our patients are very different to how they used to be. The population is also changing, more people are living longer and there is a notable increase in the number of people with long-term conditions.

We have to look closely at what clinical services we provide, our non-clinical support and even how we use the hospital estate and buildings. This is about providing the best care possible in the best place at value for money.

The principal activity of Barnsley Hospital Support Services Limited during the period was to provide support services to Barnsley Hospital NHS Foundation Trust.

Barnsley Hospital Support Services Limited (BHSS) is a wholly owned subsidiary of Barnsley Hospital NHSFT (BHNFT), established on the 16 April 2012 as a commercial, independent corporate entity, initially to provide a range of pharmacy services. The company's set up has been progressed and an internal project/steering group was also established to facilitate the company's set up and ensure the right transfer of services and support to BHSS.

As authorised by the Board of Directors of BHNFT, the Board of BHSS comprises of one Non-Executive Director (appointed as Chair of BHSS), the Director of Finance and Information and the Director of Quality and Performance.

Essential Agreements between BHNFT and BHSS have been developed and reviewed by the Board of BHSS. The Agreements are intended to ensure that arrangements between the two organisations are appropriate, robust and transparent, enabling BHSS to operate as a legal entity in its own right but also acknowledging its role as a subsidiary of BHNFT and adhering to the Board's values.

BHSS has been supported by a transfer of £500,000 from BHNFT. This is start up capital and will enable BHSS to progress as a commercial company. This will be accounted for, emphasising the respective Boards' commitment to good governance, best value and transparency for both BHSS and BHNFT.

As a company in its first year of trading, BHSS is able to extend its first reporting period and the BHSS Board has agreed that full accounts at the end of March 2013 will not be required for submission to Companies House and first accounts will be submitted at December 2013. The Board of BHSS will receive a year-end report and robust accounts will be prepared to meet the parent company's needs for its consolidated accounts for 2012/13. This approach has also been advised to and supported by the Trust's external auditors.

All staff need to be empowered and supported to challenge the status quo, to look at and try new ways of working and to put forward new schemes to be included within the Transformation Programme and the Business Plan for the coming years.

The Transformation Programme is now well established within the organisation with a robust governance structure that monitors progress and reports directly to the Board of Directors. Two of the original programmes have amalgamated resulting in seven internal Transformation Programmes as set out below:

1. **Strategic Service Review** – Assess and determine the current and future configuration of the Trust's Clinical Services identifying key strategic issues and proposing solutions and transformational plans to ensure planned and responsive transition securing the viability of local services
2. **Urgent Care** – Develop Urgent Care Pathways that span health and social care boundaries
3. **Elective Care** – Ensure the most efficient use of the elective care capacity to improve patient experience, improve access times, reduce costs and maximise income
4. **Outpatients** – Review the patient's journey for outpatients ensuring right care in the right setting at the right time, reducing attendances where not needed
5. **Consistency in Care** – Improve clinical outcomes through consistency of care
6. **Workforce** – Ensure that the current and future workforce is productive and matches organisational need
7. **Information Management and Technology/Estates/Non-clinical** – Transform how we work through improved use of space, reducing overheads and maximising the benefits of information management and technology. Maximise the efficiency and effectiveness of the non-clinical support structures that support the business.

During the first year of transformation many of the workstreams identified were already priority areas of action for the Trust. External stakeholders, our staff and patients have confirmed that these have been the right things on which to focus our attention but we need to ensure that as we move into year two of transformation challenging historical practice and seeking to continuously improve not only the services we currently deliver but those services that our patients need becomes the 'norm' for our clinical and managerial teams.

To succeed, we need as many staff as possible to get involved in the Transformation Programme and create a culture of continuous improvement where we all challenge what we can do that bit better to maintain Barnsley as a leading health care provider.

Principal risks and uncertainties

Our risk assessment process is designed to identify, manage and mitigate business risks. Examples of risks facing the Trust include: failure to achieve the A&E four hour national target which impacts on our financial and operational performance and our reputation; delivering the 24 hour imaging target for stroke patients; managing the Winter bed capacity and our ability to manage surges in patient flow; meeting healthcare acquired infection standards which impacts on patient safety and delivering our cost improvement programme which impacts on the Trust's financial stability. You can read more about risks to the Trust and our plans about what we did and are doing to manage them on pages 48, 52 and in the Quality Account on pages 55-141.

Providing high quality and safe services

As a Foundation Trust, Barnsley Hospital is committed to providing high quality care using evidence based pathways and clinical standards that help to achieve the best outcomes for our patients, promote their safety and give them the best experience of care while upholding their dignity and respect.

To achieve this we work in partnership with our primary and community care providers to make the most of local knowledge and expertise for the benefit of patients.

Improving birthing environments

Following a successful funding bid we were awarded £748,482 from the Department of Health review panel for the Improving Birthing Environments Capital Fund Awards. As a result of the success of this bid we anticipate being able to modernise facilities as follows:

- seven delivery rooms, all with en-suite facilities and three with plumbed-in pools for labour and birth
- a dedicated triage with three bed spaces to assess if women are in labour
- a dedicated fit for purpose bereavement suite
- a dedicated area for partners to stay overnight following difficult births, or when babies are admitted to the Special Care Baby Unit

New child abuse alert system for hospitals

Hospitals will have new systems to help doctors and nurses identify children suffering from abuse and neglect. Known as the 'Child Protection – Information Systems' it will enable medical staff in emergency departments or urgent care centres to see if the children they treat are subject to a child protection plan, or are being looked after by the local authority, or have frequently attended their units.

Clinicians will be able to use this information as part of their overall clinical assessment along with data about where and when children have previously been receiving urgent treatment. This will help them build up a better picture of what is happening in a child's life so that they can alert Social Services if they think something might be wrong. Work on the system began in early 2013 and it will start to be introduced to NHS hospitals in 2015.

Baby Friendly Initiative Stage 3 Accreditation

The Trust was identified as fully compliant with the UNICEF Standards for full Baby Friendly Initiative Stage 3 Accreditation, following an assessment carried out in October 2012. The assessment team concluded that in many areas pregnant women and new mothers received an extremely high standard of care.

Stroke service external peer review

The Stroke Service achieved Level 2, hyper-acute care (including acute and rehabilitation) in January 2012. Highlighted in particular was the vast improvement in Thrombolysis rates (now compliant with International Stroke Trial 3 criteria), the clarity with regard to medical staff on rotas, improved nurse staffing levels, seven

day working for therapy staff, improved staff training and better engagement with A&E staff.

Patient Safety First Week

The hospital committed to the National Safety First Campaign when it was introduced in 2010 and continues to perform well to improve patient safety. The hospital has taken part in the Annual Patient Safety First themed patient safety week each year and committing to other high-profile patient safety initiatives across the year.

Patient safety is led by the Board of Directors through a full schedule of patient safety visits to clinical areas across the hospital each year, supporting staff to improve environments and procure equipment to continually improve all our services and reduce patient safety incidents.

Designing healthcare around the needs of our patients

We endeavour to work together with our patients and partners to design our services and pathways around the needs of patients. We also aim to make our services personal and specific to each patient.

Working with patients in this way means the care and treatment they receive is seamless and as convenient as possible.

£600,000 bequest funds new CT scanner

Hundreds of patients will benefit from the purchase of a second CT scanner for the hospital's imaging department thanks to a £600,000 bequest left to Barnsley Hospital by a local couple, Ted and Mary Tasker. The additional scanner will enable us to see and treat patients much sooner than has been previously possible and will make a real difference to our imaging department.

Working Together Programme

Barnsley Hospital has been working with the Chairs and Chief Executives of seven acute providers in South Yorkshire, Mid Yorkshire and North Derbyshire who have agreed to collaborate to meet to review future services and financial challenges and clinical quality standards. A Memorandum of Understanding has been agreed under which this work can be taken forward. A programme of work reviewing key clinical and non-clinical services delivered by South Yorkshire Providers will be undertaken over a three year period.

The Working Together programme's stated aims are: to establish a clear and agreed framework, mechanism and process to enable acute providers to work together in a structured, systematic and collaborate way to enable them to achieve benefits that they would not achieve by working on their own; to support the delivery of high quality and sustainable services to people in the most appropriate care setting(s) as local and as close to their home(s) as possible; to support the achievement of financial viability and sustainability for each participating organisation; to ensure that strong acute providers are working collaboratively with strong commissioners to meet commissioners' intentions, improve the health and wellbeing of the people we serve and do so in the most economic, efficient and effective way.

Productive Operating Theatre Programme

The Trust has commissioned an external review to examine how operating theatres can be improved. This will complement the existing Productive Operating Theatre programme that has already made a number of improvements to increase operating theatre throughput and create more time our staff have to care for patients, improving staff satisfaction and ultimately, the patient experience.

Patients have their say on A&E experience

The findings from the Accident and Emergency Department Survey 2012 for Barnsley Hospital were published earlier this year.

The survey asked adults who had been recently treated in the department what they thought about the care and treatment they experienced during their visit.

The hospital scored ‘about the same’ as 65 other Trusts featured in the survey on nearly all questions relating to arriving at the department, care and treatment, staff involved in care and treatment and leaving the hospital.

Areas where the department rated significantly better than average were:

- Waiting times and overall time of stay in the department
- Doctors and nurses taking the time to discuss medical problems with patients, talking to them, not about them
- Doctors and nurses explaining test results to patients
- The cleanliness of the department

More details and the results of the inpatient survey are available on the CQC website http://www.cqc.org.uk/surveys/accidentemergency

Patients have their say on inpatient experience

The 2012/13 inpatient survey indicates that the hospital scored 'about the same' as other acute Trusts on 69 out of the 70 questions in the survey.

On the question of whether hand gels were available for patients and visitors to use, the hospital scored extremely highly, with a score of 9.9 out 10 - amongst the best performance in the country.

Other high scores were seen on issues such as not feeling threatened by other patients or visitors, with a score of 9.6, and not sharing a sleeping area with a member of the opposite sex, with a score of 9.4, although these scores still showed no major differences from most other Trusts in the country.

There were areas where room for improvement was identified and include being given information on how to complain about the care a patient has received, which scored only 1.4 out of 10 and patients being asked to give their views on the quality of care they received, which scored 0.9 out of 10.

The hospital saw significant improvements on last year's scores in five areas, all within the area of 'leaving hospital'. These included patients being given written information about what they should or should not do after leaving hospital, members of staff explaining the purpose of medicines to be taken home and members of staff telling patients who to contact if they were worried about their condition or treatment after they left hospital.

The hospital did not see a significant decline on any questions since 2011 and the response rate was 46%, 1% higher than in 2011 but 5% lower than the national average.

NHS Constitution

We continually review our legal obligations to the NHS Constitution in relation to the rights and pledges of patients, public and staff. Our reviews show that we were compliant and updates on how we are doing are now regularly taken to the Board.

Investing in our workforce

Barnsley Hospital's biggest and best asset is its staff, who are often referred to as "friendly and caring" by our patients. With a workforce of over 3000, it is essential that we act as a responsible employer, providing training and career development as well as family friendly policies to achieve a healthy work life balance.

The Trust's workforce

At 31 March 2013, the Trust employed 3168 employees. A breakdown of the Trust's workforce is shown below.

Employee profile table (age profile by staff group)

	Staff	%
Ethnic Origin		
White British	2909	92%
White - Other	44	1%
Mixed	30	1%
Asian and Asian British	109	3%
Black and Black British	37	1%
Other Ethnic	21	1%
Not Stated	18	1%
Gender		
Male	567	18%
Female	2,601	82%
Age		
16-20	117	4%
21-30	709	22%
31-40	743	23%
41-50	880	29%
51-60	611	19%
61+	108	3%
Sexual Orientation		
Heterosexual	2563	81%
Bisexual	4	0%
Lesbian	9	0%
I do not wish to disclose my sexual orientation	574	18%
Gay	18	1%
Religious Belief		
Atheism	264	8%
Buddhism	6	0%
Christianity	1933	61%
Hinduism	36	1%
I do not wish to disclose my religion/belief	628	20%
Islam	50	2%
Judaism	Less than 5	0%
Other	246	8%

Sikhism	Less than 5	0%
Disability		
Yes	124	4%
No	2880	91%
Not Stated/Unknown	164	5%

Gender profile table

Gender	Female	Male
Add Prof Scientific and Technical	89	32
Additional Clinical Services	709	66
Administrative and Clerical	521	127
Allied Health Professionals	117	24
Estates and Ancillary	31	53
Healthcare Scientists	62	34
Medical and Dental	92	153
Nursing and Midwifery Registered	976	78
Students	4	
	2,601	**567**

Staff survey 2012-13

The results of this year's staff survey overall are very positive. Our response rate was among the best in the country at 67.1%, the third highest of all acute trusts. We have improved on 15 measured elements and report better than average on 25 elements. These include improvements in some of the areas we had identified as priorities from the previous year's surveys, for example numbers having an up to date appraisal, improved line management engagement and the perception of the priority of patients to the Trust. It has also helped us to identify what our priorities should be this coming year, which will include ensuring that our staff understand how to raise concerns in the organisation and feel comfortable doing so, reducing levels of stress in the organisation and improving the quality of our appraisals.

These themes fit well with our Trust-wide Organisation Development Framework and will help us to achieve our ambition to gain Bronze Standard Investor in People accreditation in 2014. As in previous years, we will be working with 'Agents for Change' across the workforce, to deliver these improvements.

Staff survey 2011/2012 – 2012/13: key comparisons

	2011/12	2011/12	2012/13	2012/13	Trust improvement/ deterioration
	Trust	**Nat Av**	**Trust**	**Nat Av**	
Survey response rate	43%	55%	67.1%	45.6%	
Top four ranking scores (2012)					
Staff receiving health and safety training in the last 12 months	95%	81%	93%	74%	**2% deterioration**
Staff experiencing physical violence from staff in the last 12 months	0%	1%	1%	3%	**1% deterioration**
Staff having equality and diversity training in the last 12 months	82%	48%	75%	55%	**7% deterioration**
Staff believing the trusts provides equal opportunities for career progression or promotion	94%	90%	93%	88%	**1% deterioration**
Bottom four ranking scores (2012)					
Staff suffering work-related stress in last 12 months	34%	29%	42%	37%	**8% deterioration**
Staff motivation at work	3.72	3.82	3.73	3.84	**0.1 improvement**
Percentage of staff agreeing that their role makes a difference to patients	90%	90%	87%	89%	**3% deterioration**
Staff experiencing physical violence from patients, relatives or the public in the last 12 months	0%	1%	16%	15%	**16% deterioration**

Future priorities and targets

The key priority areas arising from the 2012 staff survey are:

- Stress
- Presenteeism
- Violence and Aggression towards staff from patients/visitors
- Fraud/Malpractice/Raising Concerns
- Motivation/Satisfaction/Engagement

The following action plan represents a new approach, incorporating both 2012 staff survey and IiP continuous improvement action plan (2011) themes.

THEME/ ACTION	WORKSTREAMS	MONITORING	MEASURES OF SUCCESS
1. STRESS **Reduce levels of workplace stress**	**OCCUPATIONAL HEALTH** Stress Action Group Healthy Workplace Group Counselling services Occupational Health aftercare packages Training for staff/managers Advice to line-managers/staff Health & Wellbeing Strategy	 On-going On-going On-going On-going On-going On-going On-going	**OCCUPATIONAL HEALTH:** BHNFT HSE Stress Survey 2014 BHNFT Stress Action Plan Departmental Stress Action Plans Datix data

	LEARNING & DEVELOPMENT:		**LEARNING & DEVELOPMENT:**
	Team-building interventions	Dec 13	BHNFT Staff Survey 2013
	Platform to Transform Programme - Change Management + Engagement topics	Jan 13 onwards	Investors in People Assessment
	SLM Programme – Change Management + Engagement topics	May 13 onwards	'Join the Conversation' data
	Management Master classes – various	Dec 13	
	LEO Programme		Together We Will Make It: Better data
	Integration of Values + Behaviours into HR policies		
	Staff Engagement Strategy (with Comms Team)	Aug 13	
	Pilot 'Communication Cells' in Endoscopy Dept	July 13	
	'Join the Conversation' Roadshows (+ Comms Team)	April 13 onwards	
	Team Coaching	April 13 onwards	
	LF 360 Appraisal	May 13 onwards	
	Training Needs Analysis	Jan 13 onwards	
	HUMAN RESOURCES:		**HUMAN RESOURCES:**
	Sickness Absence Policy	On-going	Sickness Absence Levels
	Organisational Change Policy development	Aug onwards	Sickness Absence Notifications
			ESR/e-roster
	Advice to line-managers/staff	On-going	
	Change Management Group/Forum	Aug onwards	Back to Work Interviews
	Managing Sickness Absence Master class	On-going	
	Performance Management Master class	On-going	
	Sickness Absence Policy Briefings	On-going	
	Sickness Absence CSU data via HR Officers	On-going	
	Flexible Working/Family Friendly Policies	On-going	
	ORGANISATIONAL:		**ORGANISATIONAL:**
	Line Managers to manage sickness absence in line with Sickness Absence Policy	On-going	Patient Echo
			Friends & Family Test
	Line Managers to refer staff to Occupational Health	On-going	Complaints/PALS data

THEME / ACTION	ACTIVITIES	MONITORING	MEASURES
2.PRESENTEEISM **To understand why staff attend work when unwell**	**OCCUPATIONAL HEALTH:** Stress Action Group Healthy Workplace Group Counselling services Occupational Health aftercare packages Training for staff/managers Advice to line-managers/staff Health & Wellbeing Strategy	 On-going On-going On-going On-going On-going On-going On-going	**OCCUPATIONAL HEALTH:** BHNFT HSE Stress Survey 2014 BHNFT Stress Action Plan Departmental Stress Action Plans
	LEARNING & DEVELOPMENT: 'Join the Conversation' Roadshows (+ Comms Team)	April 13 onwards	**LEARNING & DEVELOPMENT**: BHNFT Staff Survey 2013 Investors in People Assessment 'Join the Conversation' data Together We Will Make It: Better data
	HUMAN RESOURCES: Sickness Absence Policy Sickness Absence Policy Briefings Sickness Absence CSU data via HR Officers Flexible Working/Family Friendly Policies Managing Sickness Absence Master class	 On-going On-going On-going On-going On-going	**HUMAN RESOURCES:** Sickness Absence Levels Sickness Absence Notifications ESR/e-roster
THEME/ ACTION	**WORKSTREAMS**	**MONITORING**	**MEASURES**
3. VIOLENCE + AGGRESSION (by Patients/Visitors) To reduce the incidence of violence and aggression towards staff by patients and visitors	**RESILIENCE + SECURITY:** Target CSU hot-spots Mandatory Training Security Policies CRT Risk Assessments	 June onwards On-going On-going On-going	**RESILIENCE + SECURITY:** Datix data
	LEARNING & DEVELOPMENT: Conflict Resolution Training Customer Care Training CRT Risk Assessments	 On-going April 12 – May 13 As required	**LEARNING & DEVELOPMENT:** BHNFT Staff Survey 2013 Investors in People Assessment 'Join the Conversation' data CRT compliance data Customer Care Training compliance data
THEME/ ACTION	**WORKSTREAMS**	**MONITORING**	**MEASURES**

4. FRAUD/ MALPRACTICE/ RAISING CONCERNS: To increase awareness amongst staff on how to raise concerns and report any fraud and malpractice	RESILIENCE + SECURITY: Counter Fraud Policies Mandatory Training + e-Learning Intranet Microsite/comms	 On-going On-going On-going	RESILIENCE + SECURITY: Counter Fraud data Datix data
	LEARNING & DEVELOPMENT: 'Join the Conversation' Roadshows	April 13 onwards	**LEARNING & DEVELOPMENT:** BHNFT Staff Survey 2013 Investors in People Assessment 'Join the Conversation' data
	HUMAN RESOURCES: Whistleblowing Policy Raising Concerns Policy	 On-going By Sept 2013	**HUMAN RESOURCES:** Disciplinary data
THEME ACTION	**WORKSTREAMS**	**MONITORING**	**MEASURES**
5. MOTIVATION/ SATISFACTION/ ENGAGEMENT To increase levels of staff motivation, job satisfaction and engagement to enable delivery of high quality and safe patient care	**OCCUPATIONAL HEALTH:** Capture themes from Occupational Health activities and share with CSU leads to develop an understanding of these issues and provide advice		**OCCUPATIONAL HEALTH:** BHNFT HSE Stress Survey 2014 BHNFT Stress Action Plan Departmental Stress Action Plans Healthy Workplace Group
	LEARNING & DEVELOPMENT: Deliver programme of engagement activities, including, 'Join the conversation workshops, 1 year club and world café event Together We Will Make It: Better programme Review of Trust appraisal process Support Trust to achieve 90% compliance for appraisal and mandatory training Together We Will Make It: better programme group topic	By Dec 13 March 14 March 14 March 14 March 14	**LEARNING & DEVELOPMENT:** BHNFT Staff Survey 2013 Investors in People Assessment 'Join the Conversation' data Organisational Development Framework Appraisal compliance data Together We Will Make It: Better data Mandatory Training compliance data
	HUMAN RESOURCES: Capture themes from HR policy compliance rates and share with CSU leads to develop an understanding of these issues and provide advice	On-going	**HUMAN RESOURCES:** Sickness Absence Compliance Staff turnover rates Exit interview data Performance Management/PRF Disciplinary & Grievance data
	ORGANISATIONAL:		**ORGANISATIONAL:** Complaints/PALS data Friends + Family Test Patient Echo CQC Inspection visits Datix data

THEME/ ACTION	WORKSTREAMS	WHEN	MEASURES
6. VALUE OF KSF APPRAISALS To increase the quality of appraisals	**LEARNING AND DEVELOPMENT:** Monitor where appraisals and team meetings do not appear to have happened and ensure that manages are communicating effectively with their staff, offer support or further training in the first instance Continuation and extension of the current Together We Will Make It: Better group to further develop solutions to address this theme in 2013/14 Appraisal monitoring on-going to ensure target compliance and quality of appraisals Explore developing formal procedures for team meetings Implement training and good practice tools and techniques for line managers in delivering effective meetings	Appraisals on-going Meetings by Nov 13 By March 14 On-going Dec 14 Sept 14	2013 staff survey IiP assessment - 2014 Feedback from staff via formal and informal methods Themes summarised and issues addressed via ideas implementation groups Agreed suggestions implemented and incorporated into organisational processes Measurable improvement in 2013 staff survey IiP assessment 2014
7. LEADERSHIP AND MANAGEMENT COMPETENCE To develop leadership and management competence	**LEARNING AND DEVELOPMENT;** Review the expectations of leaders and managers, re-publish and remind staff about what to expect from their managers in leading, managing and developing them Develop leadership and management training provision/toolkits in line with Trust strategy Develop line-management capability Deliver Platform to Transform Programme Deliver SLM Leadership Development Programme Develop nurse leaders, particularly band 7	Sept 13 March 14 March 14 March 14 January 14 March 14	2013 staff survey Outputs from investment in leadership programmes IiP assessment
THEME / ACTION	**WORKSTREAMS**	**WHEN**	**MEASURES**
8. REWARD AND RECOGNITION To encourage managers and staff to recognise and reward success	**ORGANISTIONAL;** Encourage more people to nominate colleagues for staff awards, publicise the awards process throughout the Trust	Dec 13	Staff feeling of value increase whey they or their team are nominated for or receive awards, this often leads to an increase in motivation and performance
THEME / ACTION	**WORKSTREAMS**	**WHEN**	**MEASURES**
9. REVIEW AND EVALUATION OF	**LEARNING AND DEVELOPMENT;** Further develop evaluation to	Dec 13	To identify training that has impacts

TRAINING To ensure all training and development delivers defined objectives and is cost effective	include more specific focus on return on investment for education, learning and development Further develop and implement ROI methodology across Learning and Development and Trust Educate trainers in effective evaluation methodologies	 Dec 13 Sept 13	on Trust performance and that which does not to make cost effective decisions on where best to spend resource IiP Assessment

Consulting and communicating with our staff

Throughout the year we used all our regular channels of communication with staff, including the intranet, email, newsletters, weekly bulletins, Team Brief cascade, focus groups, development sessions and appraisals, staff roadshows, Non-Executive Directors' monthly meetings with staff on wards and departments, Chief Executive all-staff emails and an open request from the Chief Executive to visit wards and departments, to keep our staff informed about issues relevant to them. We also encourage staff to use these channels, as well as routine meetings with their managers, to raise issues and put forward ideas.

These methods of communication are also used to ensure staff are made aware of the financial and economic factors affecting the Trust and at service level, encouraged to be involved in the Trust's performance, in particular via Team Brief and other routine staff meetings. Our social media presence and increased use of these channels continues to grow and demonstrate greater engagement with our audiences. We launched an extensive series of roadshows called 'Join the Conversation' which encourages staff to think about the recommendations from the Francis Report, what they mean for Barnsley Hospital and how we can all learn the lessons from what happened at Mid Staffordshire NHS Foundation Trust. Monthly reports feedback common themes and concerns that staff raise and an action plan will be drawn up to address important issues raised that will help us change our culture where necessary.

In addition to the embedded methods of consultation, engagement and awareness, we have continued the work we started on the Together We Will Make It: Better programme, a 'bottom up' approach to making improvements to areas identified in the staff survey. Staff were also involved in developing the Values and Behaviours for the hospital in a similar engagement exercise.

Staff side representatives are involved in regular meetings with managers to discuss issues that affect staff and to ensure their views are taken into account in decision making.

Investors in People

We have been recognised as an Investor in People (IiP) organisation since 1996. The Trust is committed to continuous improvement and to using the IiP standard to drive cultural change and good practice. We have a detailed Action Plan (see pages 27-32) to help us achieve our ambition to attain Bronze status when we are re-assessed in 2014.

Healthy Workers Scheme awarded Gold

The Trust was awarded "Gold" for its achievements in promoting health at work in the lead up to the 2012 Olympic Games. The prestigious NHS 2012 Challenge Gold Award was presented to the hospital by Sir David Nicholson, Chief Executive of NHS England and received on behalf of the Trust by Dr Rajiv Gupta, Chair of the Trust's Healthy Workplace Project.

BRILLIANT staff awards

We continue paying tribute to our staff with the monthly BRILLIANT staff awards. Two awards are handed out each month – one celebrates a 'top team' in the hospital and the second honours an individual member of staff. All individual winners receive automatic entry into the annual staff HEART awards.

HEART awards

In addition to our monthly BRILLIANT staff award scheme, the Trust runs its annual HEART Awards, giving us an opportunity to recognise the hard work and dedication of our staff and volunteers and the valuable contribution they make to shaping our services and improving patient care. Award categories range from Patient Safety, Healthy Workplace to Innovation, Outstanding Achievement and Partnership Working awards which celebrate individuals and teams who inspire, lead or take the initiative to change the way a service, or care, is delivered to improve the overall experience for our patients.

Our Values

The 'Your Values are Our Values' programme last year involved more than ten per cent of all hospital staff who had the opportunity to feedback their thoughts about what the Trust's values should include.

Our *Values and Behaviours Statement* is underpinned by a set of agreed behaviours*:*

1. **Value: We treat people how we would like to be treated ourselves**
   Behaviours: We will:-
   Show you respect, courtesy and professionalism
   Treat you with kindness, compassion and dignity
   Communicate with you in a clear, honest and responsible manner

2. **Value: We work together to provide the best quality care we can**
   Behaviours: We will:-
   Share the same goals: finding answers together
   Recognise your contribution by treating you fairly and equally
   Constantly learn from you, so we share and develop together

3. **Value: We focus on your individual and diverse needs**
   Behaviours: We will:-
   Personalise the care we give to you
   Keep you informed and involve you in decisions
   Take the time to listen to you

Employees congratulated for their dedication and achievement

Eighty staff were congratulated for more than 1,985 years combined service to the hospital in the annual long service awards.

The employees were awarded certificates, presented to them by the Chairman, for their dedication to the hospital for 20 years, 25 years, 30 years or 35 years service. Two staff were awarded for 40 years service. Employees receiving awards included Healthcare Assistants, Nurses, Community Midwives, Radiographers, Maintenance Technicians and Estates Managers.

Midwives recognised for excellent services

Barnsley Hospital midwives were shortlisted for a prestigious Royal Collage of Midwifes Award in the category of 'Maternity Services of the Year'.
Midwifery services in Barnsley have a higher than average normal delivery rate thanks to the range of innovative services offered to women thinking about having a baby, during pregnancy and while in labour.

These include drop in active birth sessions, out of hour's clinics for working women, offering flu vaccines in antenatal clinics, an exercise referral scheme to Barnsley Premier Leisure and a Hypnobirthing service.

Sickness absence data

The table below shows the sickness absence rates for 2012/13. Overall performance over the last three years shows a trend of continual improvement, so this years slight decline was disappointing, from 4.65 % in 2009/10 to 4.46% in 2010/11 to 4.26% in 2011/12 and to 4.39% in 2012/13, further improvement will be a key focus for the Trust.

Annual sickness data

	Apr-12 % Abs Rate	May-12 % Abs Rate	Jun-12 % Abs Rate	Jul-12 % Abs Rate	Aug-12 % Abs Rate	Sep-12 % Abs Rate	Oct-12 % Abs Rate	Nov-12 % Abs Rate	Dec-12 % Abs Rate	Jan-13 % Abs Rate	Feb-13 % Abs Rate	Mar-13 % Abs Rate	Cumulative % Abs Rate (FTE)
Barnsley Hospital NHS Foundation Trust	**3.45**	**4.10**	**3.74**	**3.84**	**3.88**	**4.51**	**4.71**	**4.45**	**5.12**	**5.55**	**4.59**	**4.64**	**4.39**
Clinical Support Services	2.93	4.35	2.88	3.56	4.31	5.51	6.12	6.15	7.32	8.06	5.76	6.98	5.35
Corporate Services	3.08	3.74	3.94	3.01	3.46	3.53	3.71	2.69	3.59	4.30	2.38	2.05	3.28
Estates & Facilities Directorate	5.58	4.66	4.88	3.50	6.20	6.16	5.47	4.56	3.53	5.33	4.20	7.16	5.11
Cardio-Respiratory Medicine CSU	2.16	1.51	4.38	5.66	4.60	5.75	6.18	3.47	1.85	2.16	3.20	4.29	3.78
Care of the Elderly CSU	3.95	3.47	3.05	4.92	6.88	7.73	6.96	6.36	5.03	6.49	6.69	5.98	5.50
Emergency Medicine CSU	1.85	3.58	4.47	3.34	2.55	2.20	3.41	4.08	5.93	6.48	5.59	5.97	4.21
General Medicine CSU	2.98	4.73	3.44	5.23	4.79	5.90	7.42	6.81	5.71	6.32	6.83	6.23	5.44
Specialty Medicine CSU	7.15	7.31	6.49	4.26	3.05	1.68	4.28	5.52	7.91	11.63	8.85	9.90	6.46
Critical Care CSU	2.47	5.50	1.87	1.96	2.38	3.56	4.35	4.57	6.73	4.96	5.03	3.71	3.93
General Surgery CSU	3.35	5.25	5.11	5.70	5.06	5.00	4.03	3.88	3.36	4.87	2.81	2.54	4.25
Head and Neck CSU	4.03	3.68	4.93	1.99	5.69	2.67	3.66	3.88	4.35	7.02	6.41	3.04	4.27
Trauma & Orthopaedic Surgery CSU	4.79	3.56	4.09	3.98	2.31	4.30	2.28	2.69	1.66	4.17	5.26	3.18	3.51
Children's Services CSU	1.77	2.95	2.92	2.48	1.79	3.74	5.87	7.58	10.09	8.33	6.81	5.39	4.91
Diagnostic Imaging & Nuclear Medicine CSU	6.14	3.35	4.16	5.33	4.18	3.08	3.12	2.77	4.96	5.95	2.91	3.34	4.13
Pathology CSU	2.41	3.43	3.04	3.53	3.94	5.65	5.82	5.09	6.34	7.40	5.63	6.33	4.90
Therapy Services CSU	3.09	3.50	2.47	0.82	0.80	3.80	2.22	2.49	4.60	1.43	3.36	3.37	2.66
Women's Services CSU	4.88	5.30	4.25	4.96	4.28	4.60	3.75	3.31	3.84	2.58	2.60	2.97	3.92

Learning and Development

Mandatory Training and Appraisal
The Learning and Development Team have worked closely with Trust Clinical Service Units (CSU) and Departments to support high levels of compliance against mandatory training and appraisal. A variety of support has been provided, including the issue of individual letters to each member of staff outlining their individual training status and support to develop action plans to achieve compliance targets. A simplified Knowledge Skills Framework (KSF) has continued to be embedded in Trust policy and practice during 2012/13 and managers and staff have benefited from a review of the appraisal process and paperwork.

Together We Will Make It: Better Programme
The Together We Will Make It: Better organisational development programme was launched in June 2011 and the Board agreed to continue the programme for a second year. The programme continued to address areas of improvement highlighted in the 2011 staff survey. The success and experiences of the first year were further developed and staff members working as agents for change worked with Trust Directors to address issues identified in the survey. The following four topic areas formed the basis of the 2012/13 '**Together We Will Make It: Better**' programme:-

- Improve Staff Perception of the Priority of Patients to the Trust
- Improve Line Management Engagement with Staff
- Increase the Quality of KSF Appraisals
- Decrease Levels of Work-Related Stress

Library and Resource Centre
Following a service review and re-launch, the Trust's Library and Resource Centre (LRC) has continued to develop its services to support staff learning and development. A number of new services and events have taken place to encourage use of the service, these include:

- Introduction of literature search service to support patient care, service developments, or in support of evidenced-based healthcare
- Working in partnership with Barnsley Public Library saw the start of a popular Readers Group that meets monthly. Staff and younger patients have benefitted from the small collection of fiction books which are housed in the LRC and children's wards
- A Library user group was further developed and have assisted the Library staff to achieve and maintain a high quality library service
- A painting competition was run by LRC staff in conjunction with staff from the children's wards to design a new logo

- A number of initiatives designed to promote and raise awareness of our service and new facilities, including themed quizzes and innovative fun events
- 10 sets of personal DVD players with headsets have been purchased and are available for loan
- The availability of the LRC computers to support e-learning and the LRC staff being trained to assist users in the use of the National Management Learning System

Organisational Development Framework
The Trust's Organisational Development Framework has been developed and agreed by the Board. This provides an agreed framework to create a culture where compassion, care and safety for our patients are at the centre of everything we do. A key aspect of the culture change is embedding the agreed Trust values and behaviours, our Values are:

- We treat people how we would like to be treated ourselves
- We work together to provide the best quality care we can
- We focus on your individual and diverse needs

The aim is to ensure that leaders at every level have the skills and capacity to create transformational change in line with the Trusts strategic vision and that our Clinical Service Units are supported to deliver clinical services to patients that are patient centred, high quality, efficient and safe.

The Organisational Development Framework is supported by a 12 month work programme which focuses on developing high performing teams, developing coaching, team and individual, developing leadership and change competence and developing behaviours that support Trust values.

Barnsley Management Development Alliance (BMDA)
The Trust has worked alongside colleagues from Barnsley Council and South West Yorkshire Partnership NHS Trust to support the development of managers and leaders at all levels in the Trust. Programme participants have developed their leadership and management skills and at the same time completed accredited qualifications accredited by the Chartered Management Institute (CMI). Attaining these qualifications has involved participants in completing work based assignments and projects, being supported by their line managers and programme tutors. The programme and learning achieved has been valuable and the Trust is planning to build on this partnership approach to developing managers and leaders in 2013.

Partnership Working with Barnsley College
During 2012 the Trust continued to develop the partnership working arrangements that exist with Barnsley College. The partnership continues to allow the Trust to deliver apprenticeships and ensure staff can access a variety of vocational training opportunities.

The Trust apprenticeship programme has continued to grow, particularly the Business Administration Programme where new placements in a variety of Trust

departments have emerged. In addition, the Trust has committed to ten health apprenticeships to support the development of the nursing support staff workforce.

Equality and Diversity

We are committed to promoting equality, diversity and Human Rights in our day-to-day treatment to all staff, patients and visitors regardless of race, ethnic origin, gender, gender identity, marital status, mental or physical disability, religion or belief, sexual orientation, age or social class.

We hold the disability 'two ticks' symbol, confirming that we positively manage the recruitment and employment of disabled employees. Our policy on recruitment and retention of employees with a disability sets out our commitment and intent to support staff who have become disabled in the course of their employment, through training, redeployment, flexible working and continued support.

Equality Delivery System (EDS)

The Trust is committed to ensuring full compliance with its public sector equality duties with regards to delivery of its services. Equality and diversity considerations are integral to the Trust's business planning and development of its services to support the diverse needs of its patients, stakeholders and staff.

The Trust's three year Single Equality scheme has now migrated to the new NHS Equality Delivery system (EDS). This new system was presented to the Executive Team by the Strategic Equality lead and the Trust's Equality and Diversity Advisor in 2012 and was approved by the Board to implement from April 2012. The EDS is reported through existing governance structures in the same way as the Single Equality Scheme. The EDS is a tool to measure the Trust's compliance with the Equality Act 2010 and its progress towards improved equality outcomes. The EDS covers all aspects of equality and diversity, including patient and workforce, under the one system. The four EDS objectives are:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well supported staff
4. Inclusive leadership at all levels

The first draft of an EDS compliance schedule has been produced. This tracks the actions required against each EDS objective and outcome, with a named responsible lead, expected completion date, the evidence required to provide positive assurance and how this will be monitored. Also provision to link any gaps in assurance (where there is no/insufficient evidence that systems are in place) to a detailed action plan.

It was presented at the Equality and Diversity Steering Group in April 2013 and will be presented at the Patient Experience Group in May 2013 with a view to set up a separate working group to take this forward.

The document will be used to help embed equality and diversity work throughout the Trust and track our progress against the patient and workforce equality objectives and outcomes.

Hate Crime Initiative
The Trust is a member of the local Hate Crime Group and has been involved in the formulation of a three year strategic action plan of work. This action plan contains a key objective for all members to provide a presentational update throughout the year to the group on how their organisation has demonstrated their commitment to Hate Crime awareness raising. In 2012/13 seven reported security incidents were considered to be racially motivated with six of these being dealt with by the local police and no offender being identified in the other incident. Increase in reporting is as a result of the Hate Crime awareness training and clearer reporting instructions.

It has been recognised that since the introduction of the Hate Crime initiative within the Trust in 2011 there is a need to embed it further within the organisation. To support this, the Trust, in partnership with South Yorkshire Police, will be delivering two Hate Crime awareness sessions for Trust staff, volunteers and Governors later in the year.

Domestic abuse
The Trust recognises that domestic abuse is prevalent in the local community. In 2012 the Trust has developed a domestic abuse policy and has established domestic abuse champions.

Diversity champions
The work of the Diversity Champions project has steadily developed over this last 12 months. A 12 month schedule of learning has been developed and approved through the Equality and Diversity Steering Group. The 12 month schedule contains various workshops at the request of the Diversity Champions developmental needs. The schedule of work has used the four key equality objectives as a framework for development. The content includes aspects of patient access and experience and workforce inclusive leadership and empowering staff. The Equality and Diversity Advisor has also developed a Diversity Champion reporting tool. On a quarterly basis, all the Diversity Champions provide an overall update on any Diversity Champion initiatives, or how evidence of how over the last quarter they have demonstrated Equality and Diversity leadership. All the reports are merged into one overarching Diversity Champion report and presented to the Equality and Diversity Steering Group for assurance of equality delivery. The overall Diversity Champion updates are also utilised as a shared learning tool with all the Diversity Champions at each quarterly workshop where they are able to view what other champions have done and share good practice.

On a weekly basis the Equality and Diversity Advisor has developed an E-Zine newsletter which is circulated to all Diversity Champions, providing timely updates on local or national Equality and Diversity information. Key outcomes and highlights in their learning for this period have been:

Transgender awareness -
The focus of Part two of our transgender awareness training was based on service delivery, patient experience and the understanding of the wider transgender community. The workshop was opened up to all Trust staff. A wide range of staff attended, including non-clinical and clinical staff. The training was

delivered by a specialist Transgender Facilitator. An evaluation of the learning outcomes highlighted:

- Improved awareness relating to understanding the diversity and specific needs of a transgender patient
- Greater awareness of what is appropriate terminology in addressing a transgender patient or staff member
- Requests were made for further bite size training in two clinical areas to help support a clinical pathway

Having assessed a need for more awareness and as a result of a request made by the Deputy Chief Nurse at the time a Gender Identity Guidance booklet was developed in conjunction with other E&D health practitioners in the region. The Gender guidance was consulted on widely through the Patient Experience Group and E&D Steering Group. Since the development of this guidance booklet, the British Medical Association and NHS Employers have been in touch with the Trust with a request to share good practice.

Future Diversity Champion schedule of training -

- Empowered and well supported staff – Bullying and Harassment awareness
- Improving patient access and experience – Hate Crime awareness
- Health inequalities and patient experience – Lesbian Gay, Bisexual issues
- Inclusive leadership at all levels – Black Minority and Ethnic staff issues

Making the best use of resources

We serve an ageing and growing population whose health and social care needs are increasing at the same time as funding is reducing. We work with our partners to share and use resources wherever possible, to achieve maximum efficiencies. We treat more patients with better outcomes without a significant increase in our income.

Working in partnership

We recognise that we cannot provide services in isolation. We work together with other organisations to provide services locally and where complex care is needed. We are also part of strategic partnerships working across the public and private sectors, which aims to ensure we are maximising benefits for our patients.

The Rotherham NHS Foundation Trust
We hold a long-standing concordat of agreement for partnership working with the Rotherham NHS Foundation Trust, which provides the basis for our trusts to work together on the formal partnership of our pathology services. The services have gone from strength to strength and work is underway to develop them further still.

Sheffield Children's Hospital NHS Foundation Trust
Sheffield Children's Hospital continues to provide a number of surgical services on an outreach basis, ensuring access for younger patients and their families is convenient and local.

Sheffield Teaching Hospitals NHS Foundation Trust
We also work with our main tertiary services provider, Sheffield Teaching Hospitals NHS Foundation Trust and a number of regional clinical networks to ensure the smooth provision of specialist services for Barnsley people. With support from the networks, we try to bring back more services to the town, reducing travel and inconvenience for patients.

Local Medical Committee (LMC)
The Local Medical Committee enables primary care medical practitioners to formally and informally interact with the Trust's clinicians and highlight issues of clinical and patient management, which through joint work could improve patient experience and outcomes.

A senior Consultant from the Hospital attends the committee and reports back regularly to the Trust's own Medical Staff Committee where issues can be dealt with by the senior medical cohort, Medical Director and Chief Executive.

Sheffield University
Barnsley Hospital has a long standing arrangement with the University for the training of medical students and is recognised as an Associate Teaching Hospital. Our research and development programme has been headed by a Professor from the University of Sheffield's Department for the Elderly.

Local Authority services
The Trust works closely with its local authority colleagues at Barnsley Metropolitan Borough Council (BMBC), especially in relation to safeguarding of adults and children's services.

In 2012/13, the hospital continued to work closely with NHS Barnsley (the local Primary Care Trust) and BMBC to provide an integrated emergency and business continuity service team to ensure effective co-ordination and response across the whole health community in the event of a major incident or emergency. We have been working with our local lead commissioners to understand their new commissioning landscape and will continue to do so as Clinical Commissioning Groups (CCG) mature and develop.

Our Chief Executive also attended BMBC's Overview and Scrutiny Committee (OSC), on request, to discuss services, issues and proposed developments in the health community and, along with the Chairman of the Trust, participates in the local strategic partnership, One Barnsley. Linked to this, we also work with BMBC and other partners on community-wide groups to enable improvements in sustainability and communications.

Both our Chief Nurse and Chief Executive are members of the (formerly shadow) Health and Wellbeing Board and have continued to regularly attend meetings.

There were no formal consultations completed in the year and there are none planned for the coming year.

One Barnsley vision
The vision for Barnsley Hospital is linked to the delivery of priorities agreed by the One Barnsley local strategic partnership, of which the Trust is a key partner. This has a number of inter-agency priorities to ensure that together all lead organisations jointly benefit local people.

Research and development

Barnsley Hospital has developed a reputation for healthcare research and innovation. Our research and development programmes help us to continually improve the care we provide to our patients.

Nationally and internationally we play a much bigger role than our size would suggest. We are far smaller than the very large city hospitals with specialist services across the country, but we still manage to attract around £1 million of research activity a year.

There are 166 research projects, including 55 clinical trials underway. All the research is co-ordinated and managed by the research and development department, a team of 20 staff led by Director of Research and Development, Professor Stuart Parker whose expertise is in ageing and care of older people.

A study within the hospital, looking at how the built or physical environment impacts on older people receiving acute care is close to completion. The scope of the project

includes Mount Vernon Hospital and residential care settings where researchers have undertake an architectural evaluation of the environment.

A team working within the Trust, which consisted of researchers, AHPs and lay representatives developed and validated the 'Educational Needs Assessment Tool' (ENAT) that can be used to assess the perceived educational needs of Rheumatoid Arthritis patients. The ENAT has currently been translated into six European languages. Our randomised controlled study of this tool, funded by the National Institute for Health Research (NIHR), is in its final stages and will report its findings in October of this year. The outcome from the study will strengthen the evidence base on patient care and could lead to recommendations as to how patient education is delivered within NHS Rheumatology Clinics.

A formal evaluation of the Advanced Nurse Practitioner (ANP) role within the Trust has been completed and will be presented to the Trust at the end of May 2013. This evaluation is as a result of collaboration between the Trust, Sheffield Hallam University and the NIHR Collaboration for Leadership in Applied Health Research and Care for South Yorkshire. It asked senior team members and clinicians what a successful ANP role would look like and then gathered formal evidence from routine data, reports, staff and patients.

The Trust is one of 12 Trusts participating in a King's Fund Programme, the Patient and Family Centred Care Programme, which seeks to improve the experience of hospital care for patients and their families and the working lives of staff. Our chosen piece of work is to redesign the care pathway for frail elderly patients. It is a collaboration between the Care of the Elderly team, the Emergency Department and PALS and externally with Yorkshire Ambulance Trust, BMBC and SWYPFT. It reports to the Urgent Care Transformation Board.

We are committed to improving the quality of care we offer and making our contribution to wider health improvement through our research and you can read more about our work in this area in the Quality Account.

Eliquis
A five-year national study involving 30 patients who were treated at Barnsley Hospital (the highest for any Trust in the UK) saw some of them being given a new drug, Eliquis (Axixaban) and others taking warfarin to thin their blood. The trial showed that the risk of stroke could be reduced by up to 75 per cent by taking Eliquis.

As a result it has now been licensed for use by the European Medicines Agency and the results will be sent to the National Institute for Health and Clinical Excellence and drug regulatory authorities, which will approve the drug allowing hospitals to prescribe it.

Improving care for stroke patients in South Yorkshire
A unique project conducted by researchers from the University of Sheffield, Sheffield Teaching Hospitals and the Collaboration for Leadership in Applied Health Research and Care for South Yorkshire (CLAHRC SY) investigated ways to improve care for

stroke patients across South Yorkshire. Stroke survivors, relatives, carers and hospital staff from Barnsley Hospital were interviewed as part of the project.

Findings from the Improving Stroke Unit Quality Project highlighted the desperate need for stroke to be treated as a medical emergency, just like heart attacks and for more comprehensive education to raise awareness about the signs of stroke. The results also demonstrated that many staff were very proud of the service they provided and many patients and carers praised the good quality of care they received.

Also identified were a number of areas which would benefit from improvement, including: improved communication between staff and patients and staff and other staff, improved psychological support, more rehabilitation to meet individual needs, more stroke specific community services to enable timely discharge and more support for carers from staff.

The project, which was funded by Sheffield Hospital's Charitable Fund via the CLAHRC SY, will play a significant role in shaping stroke services for the future. The researchers are now working closely with some of the stroke units involved to develop ways to improve aspects of care in line with the priorities that have been identified.

For more information on the Improving Stroke Unit Quality Project, visit: http://www.clahrc-sy.nihr.ac.uk/resources-papers.html

Pioneering pharmacy-led service

Consultant Gastroenterologist Dr Kapil Kapur has been working with the Pharmacy team to develop a new innovative clinic at Barnsley Hospital in which patients' medication will be monitored by the Pharmacy team, relieving pressure on outpatient clinics.

The new pharmacy-led clinic is currently monitoring 25 patients who have stomach conditions. Patients are initially seen about their medication and then followed up by telephone, enabling us to be flexible as well as making the clinic work for patients. Instead of attending outpatients to have regular blood tests, which can be time-consuming, they give blood at their local GP practice. Through this route, their blood is still tested at the hospital but their medication is monitored by the pharmacy team. This is delivering benefits for patients who no longer have to attend outpatients, often on a weekly basis.

We are committed to improving the quality of care we offer and making our contribution to wider health improvement through our research and you can read more about our work in this area in the Quality Account on pages 55 to 142.

The Patient Experience Team

The Patient Experience Team at Barnsley Hospital consists of three parts: Patient Advice and Liaison (PALS); Complaints and Voluntary Services. Work includes the wider patient experience engagement and improvement activities such as focus groups, patient journeys/stories and surveys.

Over the last year, a number of service improvements have been implemented. In PALS and Complaints an electronic patient feedback and incident reporting system has been introduced, consolidating the information gathered in these processes allowing us to track trends, drill down into detail and report effectively.

This is part of a robust Patient Experience Strategy, which at its core aims to ensure that we really hear the voices of the people who rely on our services and use this to inform the way we work.

The Friends and Family Test (FFT) has been successfully implemented to the Commissioning for Quality and Innovation (CQUIN) timescales. Every patient who stays a night in the hospital or who visits the Emergency Department is now being asked whether they would recommend the ward or department to their friends and family if they needed similar care or treatment.

This has moved us quickly into developing real time, detailed Patient Experience feedback systems and we are currently phasing in centrally coordinated survey questions across all areas of the Trust, based on asking key questions in comparable ways to understand patient experience as fully as possible and identify areas of excellence to model best practise.

Reviewing how we work with volunteers at Barnsley Hospital has also been a focus this year and roles and training have been revised. New opportunities for volunteering have been created, including involvement in the Patient Led Assessment of the Care Environment (PLACE) work and supporting gathering Patient Experience data.

Volunteers

There are 210 active volunteers operating in different roles both within the hospital and externally at The Well (cancer services based at The Core building in central Barnsley); monthly outreach clinics for audiology and Barnsley Hospital Radio (in the Trust and outside broadcasts from Barnsley Football Club).

Charitable Funds – Barnsley Hospital Charity

The main purpose of the charitable funds held on trust is to apply income for charitable purposes relating to the general or any specific purposes of the Barnsley Hospital NHS Foundation Trust or to purposes relating to the Health Service. This year the Trust recruited a Fundraising Manager to maximise the benefits of the very generous donations we receive each year and to raise the profile of its Charitable Funds, now known as Barnsley Hospital Charity (charity registration number Charity 1058037). Since her appointment, there have been several significant achievements including:

- Developing and implementing a Charitable Funds Policy
- Procuring a bespoke online payment system creating multiple opportunities for donors to engage
- Engaging with local voluntary organisations and the development of a specific charity volunteers framework

- Establishing a new charity brand and developing partnerships, most notably with Horizons College, Barnsley FC, Barnsley Premier Leisure and John Laing
- Developing an internal staff guidebook to encourage more bids to the charity
- Initiating a legacy strategy

Charitable donors continue to be able to use the Just Giving website, a well used and trusted method for giving money to charities.

Last year £811,110 was raised in donations and legacies to go towards helping staff and patients.

Some of the successful bids made to the Board of Trustees of Barnsley Hospital Charity in the last year for use of the charitable funds included:

- £1604 for a Phlebotomy Chair for Ante Natal Day Unit
- £1109 for a TV and Chairs for patients waiting room in Gynaecology
- £500 for a TV or similar equipment for Acute Medical Unit
- £3,000, from the Late Hawley Trust for the Community Child Health Assessment Tool (and training for three consultants) to support diagnosis of children with autistic spectrum disorder
- £1,731 for wall mounted shelf units for the HDU room on the children's ward - supported by funding from the Late H F Hawley Trust
- £1,070 for equipment for the Neo Natal Unit, funded by donations given in memory of Judith Sands, a well respected lead nurse within the Children's unit

Sustainability and carbon reduction

The Trust recognises the importance to society of sustainable development and the crucial role our environmental performance has to play in achieving sustainability. The Trust is fully committed to sustainability and reducing our carbon footprint through our Board approved Sustainable Development Management Plan. Our goal is to become a low carbon sustainable hospital and to achieve this we need to ensure appropriate behaviours are encouraged in our staff, patients, visitors and suppliers. The challenge for the Trust is to deliver high quality care and services in a sustainable manner.

A mission statement underpins the Trust's Sustainable Development Management Plan:

"Barnsley Hospital's aim is to protect the environment in which we operate encouraging all sustainable measures and to distinguish Barnsley Hospital NHS Foundation Trust as a committed, environmental steward".

The Sustainability Committee, which is chaired by the Chief Operating Officer and represented by a number of stakeholders, meet bi-monthly to discuss issues which promote energy efficiency, sustainability and agree areas for improvement. The Trust is focusing its efforts in areas that offer the greatest carbon saving potential, these include: energy, transport, water consumption, waste and procurement.

Energy
Our buildings are where we work and deliver life saving treatments 24 hours a day. They are also where we consume the most amount of energy and contribute 22% of our carbon footprint. Energy costs for the Trust in 2012-13 were £1.68m representing an increase of 15% on the previous year. Energy usage was up by 9.7% with CO_2 emissions increasing by 6.9% on the previous year. These increases are a result of wholesale energy market price increases and higher site energy requirements.

Combined Heat and Power Unit (CHP)
In order to achieve the NHS carbon reduction target and mitigate against rising energy prices the Trust invested in a 1,067 kWe Combined Heat and Power (CHP) unit to meet the majority of the sites electricity demand through onsite generation. The CHP is expected to go live in May 2013 and set to reduce CO_2 by 24% per annum. In addition energy costs are expected to reduce by £360,000 per annum. The Trust is currently in the process of applying to register for the Combined Heat and Power Quality Assurance (CHPQA) scheme. As the CHP unit meets the requirement for good quality CHP; certification will exempt the Trust from Climate Change Levy for all gas input and is expected to save around £50,000 per annum.

Water
Annual water consumption has increased by 21.2% and expenditure on water increased by 15.4% on the previous year. These increases can be attributed to some leakages through burst pipes over winter, washing of underground tanks for legionella control and an increase in the cost of water. The drainage infrastructure at the Trust requires substantial investment to reduce consumption and cost control.

Procurement
The environmental impact of what and how we procure and dispose of goods and services is a significant part of our activities. The decisions we take and the processes we follow can reduce the environmental effect and deliver both carbon and fiscal savings. Reducing the carbon associated with what and how we buy is becoming an increasing priority and greater emphasis will be placed to reduce the carbon footprint of purchased goods and services.

Other measures include:

- **Building roofs:** Work has been on-going to fit new roof coverings for Pathology, Cardiology, Maternity and Estate buildings. High performance insulation has been fitted to improve thermal comfort and minimise fabric heat losses.
- **Windows:** Work has been on-going to replace all windows to the main Trust buildings. In addition to improving the visual aesthetics of the building they will also improve thermal comfort and minimise fabric heat losses.
- **Display Energy Certificates (DEC)**: Display Energy Certificates were completed for all public buildings with floor areas above 500m^2 ahead of the changes to the Energy Performance Building Directive. Further changes in 2015 will require DEC certificate for floor areas above 250m^2. The Trust will look to improve the operation performance of buildings.
- **Carbon Reduction Commitment (CRC):** The Trust is a participant in the Carbon Reduction Commitment. In 2012, the Trust was ranked 38th from 192 organisations within the health sector.

- **Energy Display Dashboard:** The Trust installed Automatic Meter Reading Equipment in 2010 to improve energy management at the site. Taking this one step further the Sustainability Committee approved the installation of an Energy Dashboard to be fitted in the restaurant area providing staff and visitor's real time energy data. This is expected to create intrigue and interest and positively influence behaviour.
- **Raising Awareness**: Engagement with stakeholders is one of the key drivers to improving energy efficiency and sustainability. Two events were held in the Trust for Climate Week and NHS Sustainability Day in conjunction with EDF Energy and Yorkshire Water. There are plans to develop e-learning toolkits to raise awareness and a sustainability section on the Trust's website.
- **Appointment of Energy Manager:** The Trust has appointed an energy and sustainability manager to drive the sustainability agenda forward. His focus is on ensuring legislative compliance, energy efficiency, CO_2 reduction, raising awareness, implementing new technologies, utility contract negotiation, energy data monitoring and reporting and DEC and CRC compliance.

Key objectives for 2013-14:

- Continue to identify areas to improve energy efficiency and sustainability
- Improve the quality of data collection for effective monitoring and targeting
- Achieve certification for the Combined Heat and Power Quality Assurance (CHPQA) standard
- Improve awareness across the Trust through developing e-learning training
- Add sustainability content to website and intranet.

Summary of Key Carbon Emission Indicators

Area		**Non-financial data (applicable metric)**	**Non-financial data (applicable metric)**		**Financial data (£K)**	**Financial data (£K)**
Year		**2011/12**	**2012/13**		**2011/12**	**2012/13**
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust	1,026 tonnes	986 tonnes	Expenditure on waste disposal	151,474	176,563
Finite resources	Water	90,468 m3	109,632 m3	Water	85,012	102,678
	Electricity	9,296,826 kWh	9,666,707 kWh	Electricity	834,372	896,859
	Gas	21,327,975 kWh	23,908,884 kWh	Gas	610,555	784,626
	Other energy consumed (oil)	27,213 litres	2,000 litres	Other energy consumed (oil)	18,765	1,400

The installation of a Combined Heat and Power unit will save approximately 22% of our energy carbon footprint once running and will save us around £360,000 a year on energy costs.

Financial Review

Summary of In-Year Performance

2012/13 was set to be a challenging year for the Trust in terms of managing the finances. This was in the context of the wider economic climate, its impact on public sector spending in general and NHS bodies in particular. Recognising the challenges, the Trust set itself a modest financial surplus plan for the year and exceeded this, ending the year with a £1.369 million surplus.

Our overall financial management performance and assessment of the level of financial risk is measured by our regulator Monitor based on a range of indicators (Financial Risk Rating). These are scored on a scale of 1-5 (a score of 1 being very poor performance and high risk and 5 representing the best performance and lowest risk). A financially robust and stable Foundation Trust should aim to maintain a Financial Risk Rating of 3 as a minimum at all times. This Trust planned and achieved a Financial Risk Rating of 3 for 2012/13 and has clear financial plans going forward to maintain this in 2013/14 and beyond (see table for 2012/13 performance below).

Financial Risk Rating - Compliance Framework to Plan

Financial Criteria	Weight %	Metric to be scored	Rating categories 5	4	3	2	1	YTD Calculated Position	YTD Actual Rating	YTD Actual Weighting
Achievement of Plan	10%	EBITDA achieved (%of plan)	100	85	70	50	<50	96.41%	4	0.40
Underlying Peformance	25%	EBITDA Margin (%)	11	9	5	1	<1	5.37%	3	0.75
Financial	20%	Net return after financing	3	2	-0.5	-5	<-5	1.16%	3	0.60
Efficiency	20%	I & E Surplus margin net of dividend (%)	3	2	1	-2	<-2	0.87%	2	0.40
Liquidity	25%	Liquidity ratio** (days)	60	25	15	10	<10	31	4	1.00
		Financial risk rating weighted average of financial criteria scores								3.15

The main factors that again affected the overall performance and financial position of the Trust during the year, were undoubtedly the operational pressures caused by the increasing volumes of unscheduled care patients that presented for treatment at the hospital. We had been planning to reduce our overall inpatient beds but were unable to do so due to the increasing volumes. This trend, linked to an ageing population and the health demographics has been a key factor in the development of a business case during 2011/12 to totally redesign the hospital admissions processes through our Emergency Department. The business case was agreed during early 2012/13 and the capital investment for this development is £1.8m.

Another key factor impacting on our financial performance in the year was the continuing increasing emphasis on clinical quality indicators and key performance targets. Through our contract with primary care commissioners for the provision of services, we have a vast range of measures and indicators that we are monitored on and which if we fail to achieve can result in financial penalties (payments withheld). To manage performance the Trust needs to ensure we have good systems and processes for recording information about the wide range of indicators and targets and has continually been looking at ways to improve this. During 2012/13 we commenced the enabling work to develop a more modern electronic patient record system. This will be a key focus for the Trust in the next year.

Income from Activities

The income from our core patient related activities was £145.311m in 2012/13, a 3.5% increase overall on the previous year. This increase predominantly reflects the significant year on year increase in virtually all areas of activity (as shown in the table below).

Point of Delivery	**2011/12**	**2012/13**	%age Change
Elective inpatients	4,708	**4,371**	**-7.2%**
Day cases	21,790	**22,925**	**5.2%**
Non-elective inpatients	34,695	**35,676**	**2.8%**
Outpatients	268,025	**275,787**	**2.9%**
A&E	78,217	**79,953**	**2.2%**
Other non payment by results (PBR)	2,605,315	**2,717,608**	**4.3%**

The biggest areas of activity increase related to day cases which are a result of internal efficiencies, other non PBR which predominantly relates to increases in Pathology activity and non-elective care. There was also a significant decrease in the number of elective inpatients when compared to 2011/12.

Our income includes some non recurrent funds, which we received over and above tariff payments to recognise the operational pressure in the hospital with regard to responding to the increases in demand. Appropriately managing and controlling demand for non-elective care is a key area of work for the Trust in partnership with other key stakeholders in the community.

As in the previous year we were eligible for a payment under CQUINs (Commissioning for Quality and Innovation) where we were eligible for 2.5% of our clinical income. We slightly underachieved some of these quality targets but achieved the majority of this income. In 2013/14 2.5% of our clinical income will again be available under CQUIN. This means we really need to continue our work associated with quality improvement.

Other Operating Income
The Trust receives other sources of income for services not directly linked to patient care activities. These include education and training and research and development, services to other NHS bodies and a range of non clinical activities.

Expenditure
Year on year expenditure (our operating costs) did increase overall by 3.5% (over £5.6m) more than the previous year. The vast majority of the increase was attributable to the pay bill. This was not in relation to pay awards as the NHS again had a pay freeze in 2012/13, but largely the impact of the high volume of agency staffing we engaged during the year. Agency costs were £6.0m during 2012/13 compared to £6.2m in 2011/12. This expenditure links to the increase in demand and operational pressure in the hospital. The biggest pressure in relation to agency expenditure was medical staffing and in particular vacancies in medicine as well as additional cover required to meet clinical demand. A detailed medical workforce review was carried out in 2012/13 to help address these issues.

Efficiency Targets
Like every NHS organisation, the Trust is challenged to meet significant year on year efficiency targets. The national efficiency requirement is 4%. This requires us to look at ways of saving money by providing what we do differently. We are committed to providing best value for money but without any adverse impact on the quality of clinical care. During the year the plans to generate efficiency savings performed well. We achieved savings of £7m against our target of 7.2m. This was a considerable achievement. A large proportion of the savings in 2012/13 came from workforce and estates initiatives linked to our transformation programmes. The increased use of technology has contributed significantly in helping the Trust to streamline a range of functions and we will continue to exploit the use of technology as a key driver in making savings going forward.

Capital Expenditure
During 2012/13 the Trust invested £10.4 million in new capital. Broadly this was split into our main four categories of spend as:

- Estate upgrades and backlog maintenance - £ 5.9m
- Information Management and Technology - £ 0.6m
- Medical and surgical equipment - £2.2m
- Strategic Schemes - £1.7m

We did spend 93% of our capital allocation. The very slight underspend was a direct result of adverse weather impacting on the progress of our backlog maintenance programme.

At the end of the financial year we have revalued our estate. After obtaining an indication of the change in building indices from the District Valuer, it was decided that a full revaluation should be undertaken in compliance with audit requirements. This resulted in a reduction in value of £2.7m.

Forward Look
Establishing the contract baseline for activity was again a key issue for us given the trend of increases and volatility we had seen in 2012/13. However there is little doubt, looking at the overall trends and the national direction of travel and policy drivers, that some elements of traditional hospital care are beginning to change. Not withstanding the increases we have seen in unscheduled care, we have seen a very minor but steady decline in some areas of planned elective care. This is partly the changes to 'care settings' where we have seen a shift from overnight inpatient stays to more day case activity (where patients are treated and discharged in the same day). The next stage is a shift from day case work to outpatient procedures.

The national tariffs which determine the income we receive are increasingly being designed to incentivise Trusts to move in this direction. We are fully cognisant of this and we are constantly looking at the way we work to ensure it is in line with best practice guidance. Linked to these shifts are real 'demand management' strategies by primary care GPs where there is a drive to ensure that patients are managed appropriately and only referred for hospital care when absolutely necessary. Conversely from a preventative healthcare perspective we are seeing rises in activity linked to screening programmes as an increasing emphasis on early detection of health problems to ensure timely treatment. All of these factors impact on and are driving the development of our service plans.

For 2013/14 we have set aside a significant amount of investment to resource the priorities in our business plan and have realigned our resources where appropriate to reflect the cost pressure areas we have been experiencing linked to activity. Inevitably the scale of the economic challenge nationally and the way this is reflected in tariffs is a key challenge.

The tariff for 2013/14 is 1.0% less than last year which after accounting for inflationary pressures means that in real terms this is 4%. We fully expect this deflationed tariff to continue as this is the stated intent to meet national efficiency requirements and our medium term plans are built up on this basis. This continues the significant efficiency challenge over the next few years and this is undoubtedly the biggest financial risk not only for 2013/14 but over the medium term. To address this, in 2012/13 we adopted a fundamentally different approach based on eight transformational programmes which are linked to sustainable efficiency. The programmes will not only rationalise the way we deliver our services, but will also help us achieve the scale of financial savings that are required.

Fundamentally, however, the Trust also recognises that what we need to deliver overall in terms of service change and improvement is not wholly achievable by just looking at what we do internally as an organisation but requires a much more system wide, partnership approach. The overall changes in the policy direction as set out in the new Health and Social Care Act 2012, provides opportunity and challenge, responding both to the integrated collaborative agenda at the same time as increasing choice and competition through such initiatives as Any Qualified Provider. The Trust recognises that how it responds to this will be critical to its longer term financial sustainability.

The Trust has worked closely with Barnsley Clinical Commissioning Group through the development phase of their formal authorisation to develop a collaborative approach in understanding and meeting the needs of the local population. The CCG Commissioning Plan 2013/14 clearly sets out their intention to work closely with the Trust. The plan builds on the collaborative approach undertaken with all partners across health and social care to encourage the introduction of new and innovative ways of working to improve the overall health of the local population; reduce the health inequalities that exist across Barnsley and improve productivity and efficiency of the services delivered.

The Trust has developed a transformation workstream identifying service redesign and greater collaboration with other providers both within the borough of Barnsley but also across the acute providers of Mid Yorkshire, South Yorkshire and North Derbyshire - Working Together. All provider Boards in the relevant organisations have now agreed in principle to the approach. A programme management approach will be adopted and we are committed to this approach. A full programme of clinical engagement has been in place over the last year to review services and develop clinical challenge on the sustainability and viability of each service.

Principal risks and uncertainties

Our risk assessment process is designed to identify, manage and mitigate business risks. The table below gives examples of risks from 2012/13 and 2013/14 associated with achieving our business plan and what we did and are doing to manage them. The risks listed do not comprise all those associated with Barnsley Hospital NHS Foundation Trust and are not set out in any order of priority. Additional risks not currently known to the management team and Board, or deemed to be less material, may also have an adverse effect on the business of the hospital.

Risk and impact	Mitigating activities
Service performance	
Targets Failure to achieve targets impacts on our financial and operational performance and our reputation	- Regular integrated performance reports to Board - Regular monitoring of activity, including divisional dashboards - Monthly review of position of CQUINs with NHS Barnsley
Variable high levels of unscheduled patient flow Threat to A&E quality indicators and adjusting bed and staff capacity	- Regular integrated performance reports to Board - Monthly review and performance monitoring - Patient satisfaction monitoring - Bed capacity and patient flow maintained through daily bed reports - Daily reports to Chief Operating Officer - Action plan to improve throughput monitored at Transformation Delivery Group
Imaging Failure to deliver 24 hour imaging	- Imaging plan in place to extend service hours

target for stroke patients	- Part of 2011/12 business plan - Regular reports to the executive team
Winter bed capacity Insufficient beds to manage surges in patient flow resulting in breaching of targets	- Winter plan - Alternatives to admission in place - Integrated performance reports - CSU performance meetings - Daily performance reporting
Clinical quality and governance	
European Working Time Directive (EWTD) Failure to comply with the EWTD impacts on patient safety and financial performance	- Regular audits and monthly reviews - Roll out of 'hospital at night' programme and nurse practitioner model Out-of-hours on call arrangements
Infection prevention and control Failure to meet healthcare acquired infection standards impacts on patient safety	- On-going publicity and awareness campaigns - Enhanced domestic cleaning contract - Deep clean programme - Included in mandatory training - Bare below elbow action plan
Data quality Insufficient data quality procedures impacts on reporting	- Policy development - Monthly performance reporting
Patient safety Lack of systems to keep patients safe leads to increased incidents, complaints and litigation	- Monthly performance reporting - Quality, Safety and Effectiveness Board and Complaints Review Group reviews themes and trends - Online monitoring
Care Quality Commission registration Failure to meet CQC requirements would lead to poor quality and risk profile	- Reporting procedures and mechanisms in place - Escalation procedures in place - Quarterly performance monitoring
Financial stability	
Cost improvement programme Failure to deliver cost improvement programme impacts on the Trust's financial stability	- Monthly performance monitoring - Reports to Transformation Board
Sustainability agenda Failure to achieve legislative requirements will result in financial penalties and reputational damage	- Monthly performance monitoring - Good Corporate Citizenship registration - Sustainable development management plan - Registered with carbon reduction commitment scheme
Estate	
Failure to align estates strategy with business strategy will impact on the	- Detailed business cases - Monthly monitoring

Trust's future	
Workforce	
Resistance to workforce changes will impact on right skills and capacity to deliver high quality services	- Agreed establishment and staff rostering - Policies and procedures to manage vacancies, bank staff, appraisals and sickness in place
Organisational development	
Failure to respond to challenges rising from scale and pace of NHS reform and economic situation for us and our partners	- Robust service level agreements - Strengthen and build partnership relationships

Barnsley Hospital NHS
NHS Foundation Trust

Quality Account

2012-2013

What is a Quality Account?

NHS hospitals have always had to publish their annual financial account.

Since April 1 2010 as part of a movement across the NHS to be open and transparent about the quality of services provided to the public, all NHS foundation hospitals must also publish a Quality Account. A Quality Account is a report about the quality of services by an NHS healthcare provider.

Foundation trusts are required to include a quality report as part of their annual report. This quality report has to be prepared in accordance with our annual reporting guidance, which also incorporates the quality accounts regulations. All trusts have to publish quality accounts each year.

Patients, members of the public and our own staff can use each year's Quality Account to assess the level of care we provide. The quality of services provided by all other NHS organisations can be seen by viewing their Quality Account on the NHS Choices website: www.nhs.uk

Table of contents

Statement from the Chief Executive

At Barnsley Hospital NHS Foundation Trust (BHNFT) we are committed to "providing the best care for all" and to continually improve the quality of services we offer.

This is our fourth Quality Account, which clearly demonstrates the progress we have made in recent years. It also gives us the opportunity to clearly and openly set out our commitment to quality and to monitor the standards of care we provide to the communities we serve.

Last year the hospital made significant progress and improvements on the quality and safety of our services in 2011/12. We have continued to build on our previous years' successes in regards to infection rates and reduction in patient safety incidents.

We have continued to actively reduce our infection rates particularly for Clostridium Difficile (C Diff) infections. This has been achieved through a sustained effort by all professionals and support staff and we have concluded the year with zero Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia cases, and have over achieved on the Department of Health's national target of 31 cases for C Diff by only having 22 actual cases this year.

The hospital has continued the work of "Leading in Patient Safety" which started in 2009/10. Our commitment to safety is demonstrated through monthly safety walkabouts with Board Directors and other members of staff, and has resulted in changes to the environment and practice that have positively impacted both on patients' and staff's experience.

The clinical effectiveness of all interventions delivered throughout the hospital is underpinned and supported through our participation in national clinical audits. In this way the hospital is able to compare and benchmark its performance with other similar sized hospitals. To support this approach in 2012/13 the hospital participated in twenty three national clinical audits and three national confidential enquiries.

Recognising that improving the working lives of our staff is essential if real improvements in patient care are to be achieved, alongside the Productive Ward Programme which has been progressing within the hospital for the last three years, we have also re launched the Productive Operating Theatre Programme. These programmes, we believe, will increase the time our staff have to care for patients, improving staff satisfaction and ultimately the patient experience.

The Board of Directors has reviewed the overall vision and strategic aims and objectives of the hospital that has led to our simple and clear vision of "Provide the Best Healthcare for all". We are seeking to continually improve our patients' experiences by listening

to them, working with our Governors, Foundation Trust members, partners and others to learn from what has gone well, and more importantly how we can improve our services.

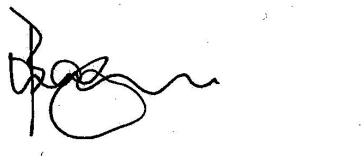
We are moving in the right direction and are proud of our achievements in 2012/13 particularly in:

- Reducing the number of hospital acquired infections
- Investing in and the developments achieved through our Tissue Viability Team
- Improving patient experience through listening and responding to what our patients are saying
- Improving services for those with learning disabilities through investment in specialist nursing support
- Achieving a clear improvement in our staff survey results

We are not complacent, however, and recognise that we still have much more to do.

As you read this report, I hope that our commitment to delivering high quality care and improvements led by the Board of Directors and Council of Governors, and our willingness to listen and learn, will be demonstrated.

The information contained within the Quality Account has been widely shared across our organisation and with our external partners. To the best of my knowledge I believe the content to be accurate.



Paul O'Connor
Chief Executive
Barnsley Hospital NHS Foundation Trust
May 2013

Part Two

2a: Our Priorities

The following section takes you through our priorities for 2012/13. This section reviews how we did in 2012/13 and what we are going to do in 2013/14.

Our priorities for improving quality for our patients fall within three core domains:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Each section will include:

i) Patient Safety

General Statement

How we did in 2012/13

What we will do in 2013/14

Other patient safety priorities

ii) Clinical Effectiveness

General Statement

How we did in 2012/13

What we will do in 2013/14

Other clinical effectiveness priorities

iii) Patient Experience

General Statement

How we did in 2012/13

What we will do in 2013/14

Other patient experience priorities

Our commitment to outstanding quality of care for our patients and placing patient safety and experience at the heart of all we do continue to be our central priority.

Our priorities for improving the quality of services we offer are identified each year by the hospital's Quality Safety Improvement and Effectiveness Board (QSIEB) and Strategic Risk Group (SRG). These Committee's have a wide clinical and managerial representation. The annual proposals are then presented to both the hospital's Clinical Governance Committee (a committee of the Board chaired by a Non Executive Director) and the Council of Governors before being finally authorised by the hospital's Board of Directors.

Each Clinical Service Unit within the organisation has an established quality reporting structure that feeds into the Hospital's QSIEB and Clinical Governance Committee. Quality Dashboards are reviewed on a monthly basis; these cover a wide range of quality metrics with specific focus on monitoring the quality account priorities on a quarterly basis.

This provides a clear route through which any concerns about the quality of care we are providing can be addressed.

In addition to the regular reviews we are also informed by the standards for performance set by Monitor, please see table on page 64 to compare the national indicators against what we have achieved please see table B – national indicators (page 116). The indicators set out standards to measure our performance against and therefore inform the areas of focus for our Quality Account each year, whilst also providing a platform to ensure that performance is maintained in subsequent years.

For each of the priorities identified we have included three indicators or measures in order to monitor progress and success.

The priorities for improvement developed for 2013/14 have also been influenced by issues raised with us during the year by key stakeholders both with our staff and outside our organisation, including our Council of Governors, NHS Barnsley (our commissioners), the Parliamentary and Health Services Ombudsman and Barnsley Local Involvement Network (LINk, now Healthwatch). Furthermore, patient surveys and complaints received in 2012/13 have been pivotal in influencing our priorities for the forthcoming year and for the Trust to set quality standards to improve patient experience and the standard of services delivered. These are discussed in detail in 2A iii). In addition, investigating and learning from patient safety incidents and results of national and local audits, measuring our clinical effectiveness, adds to influencing and directing our priorities. Please see section 2A i), ii) for more details.

Our robust governance processes and transparency to share information with the public, that encourages external scrutiny, provides the Trust Board with assurances that rigor is applied to safe standards of service delivery and continually improve the quality of care.

The statements and results outlined in this report serve to offer assurance to the public that our organisation is:

- Performing to essential standards such as securing Care Quality Commission registration
- Measuring our clinical performance, for example through participation in national audits
- Involvement in national projects and initiatives aimed at improving quality such as recruitment to clinical trials
  (Please see section three)

Monitor- compliance framework 2012/13

Indicator	Threshold
Clostridium Difficile – meeting the Clostridium Difficile objective	0*
MRSA – meeting the MRSA objective	0
All cancers: 31-day wait for second or subsequent treatment, comprising either:	
surgery	94%
anti cancer drug treatments	98%
radiotherapy	94%
All cancers: 62-day wait for first treatment, comprising either**:**	
from urgent GP referral to treatment	85%
from consultant screening service referral	90%
Maximum 18 week waits from referral to treatment in aggregate – admitted	90%
Maximum 18 week waits from referral to treatment in aggregate – non-admitted	95%
Maximum 18 week waits from referral to treatment in aggregate – patients on an incomplete pathway	92%
All cancers: 31-day wait from diagnosis to first treatment	96%
Cancer: two week wait from referral to date first seen, comprising either:	
all cancers	93%
for symptomatic breast patients (cancer not initially suspected)	93%
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%
Data Completeness: Community Services comprising:	
Referral to treatment information	50%
Referral information	50%
Treatment activity information	
The inclusion of further data items may be introduced later in 2012/13, comprising:	
Patient identifier information	50%
Patients dying at home/care home	50%
Care Programme Approach (CPA) patients , comprising either:	
receiving follow-up contact within seven days of discharge	95%
having formal review within 12 months	95%
Minimising mental health delayed transfers of care	≤7.5%
Admissions to inpatients services had access to crisis resolution home treatment teams	95%
Meeting commitment to serve new psychosis cases by early intervention teams	95%
Data completeness: identifiers	97%
Data completeness: outcomes for patients on CPA	50%
Category A call – emergency response within 8 minutes	75%
Category A call – ambulance vehicle arrives within 19 minutes	95%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A

*Barnsley Hospital NHS Foundation Trust target = 31

i) - Patient Safety

General Statement

The hospital continues to be committed to patient safety, and delivering high quality safe patient care across all the services it provides. Patient safety and quality are central to the hospital's business plan and nursing strategy each year in order that the hospital can deliver its vision of **"providing the best healthcare for all".**

The hospital committed to the National Safety First Campaign when it was introduced in 2010 and continues to perform well to improve patient safety. The hospital has taken part in the Annual Patient Safety First themed patient safety week each year and committing to other high profile patient safety initiatives across the year.

Patient safety is led by the Board of Directors through a full schedule of patient safety visits to clinical areas across the hospital each year, supporting staff to improve environments and procure equipment to continually improve all our services and reduce patient safety incidents.

The tables on the next two pages set out the priorities for improving quality for 2012/13 and our priorities to be delivered for 2013/14.

Patients are at the heart of everything we do and as organisation, we believe in being open and honest when things don't go well. Therefore as part of our risk management process including the investigation of incidents, we ensure that the results of any findings are fed back to the patient or their families.

As part of engaging with the wider public and our stakeholders, we produce a number of reports, covering patient safety and quality data. This is on a monthly and quarterly basis, includes complaints and incidents, with analysis of any themes and trends identified. These are sent to a number of stakeholders such as our CCG (Clinical Commissioning Group) for review and agreement on areas to improve.

We reinforce our patient safety culture through comprehensive staff training programmes for all our staff. These include mandatory and essential to role training which are monitored and reported on a monthly basis.

These were the priorities for improving quality for the year 2012/13

Priorities	National CQUIN Priority	Issue for Commissioners /Local CQUIN	Quality Account Priority
Safety			
To improve our knowledge of individual patients nutritional status			●
VTE Risk assessment (90%)	●		
NHS Safety Thermometer 1	●		
To reduce catheter associated urinary tract infections (CAUTI)		●	
Paediatric safeguarding (missed appointments)		●	
Paediatric safeguarding (A & E)		●	
Patient falls (Part of Safety Thermometer)	●		
Ensure that the modified early warning score (MEWS) was implemented and that all who triggered were treated appropriately		●	
Clinical Effectiveness			
Ready to go no delays			●
Achieve stretch targets for the number of patients seen in less than 4 hour in the Hospitals Accident & Emergency (A&E)		●	
Reduce the time to correspond with patient's General Practitioner (GPs) following outpatient attendances		●	
Ensure that all patients over 75 years old are assessed for dementia within 48 hours		●	
Patient Experience			
To reduce the incidence of hospital acquired pressure ulcers			●
To deliver an improvement on the 2011/12 patient experience questions in patient satisfaction survey		●	●
To reduce the number of discharge related complaints			●

This is a table of our priorities for improving quality for the year 2013/14

Priorities	National CQUIN Priority	Issue for Commissioners /Local CQUIN	Quality Account Priority
Safety			
NHS Safety Thermometer 2 & patient falls	●		
VTE Risk assessment (95%)	●		
To increase “Harm Free Care”			●
Introduction of discharge care bundle for respiratory patients		●	
Delivery of medication planning objectives		●	
Clinical Effectiveness			
To improve outcomes for patients by improving effectiveness across 3 different indicators			●
To find, assess, investigate, and refer patients over 65 years of age with dementia	●		
Intraoperative fluid management	●		
“Digital First” reduce inappropriate face to face contacts	●		
Improve timeliness and quality of communication with patients' General Practitioner (GPs) following outpatient attendances at the Hospital.		●	
Improve timeliness and quality of communication with GPs following patient’s discharge from Hospital.		●	
Patient Experience			
To improve patient experience across three targeted pathways			●
To implement the Friends and Family Test at the hospital	●		
Carers for people with dementia are signposted to relevant advice and support	●		
To deliver an improvement on the 2012/13 patient experience questions in patient satisfaction survey		●	

How well have we done this year?

During 2012/13 our quality account safety goal was to:

"To improve our knowledge of individual patient's nutritional status"

Why this Priority?

The importance of nutrition and hydration in hospital is well recognised; it is an important focus during any patient's hospital stay.

The hospital has been screening patients on admission for the past three years, and on a regular spot-check audit scores of all our patients. We improved our performance, but did not meet our goal of weighing 90% of eligible patients on admission.

The weight of patients is required for both measurements during admissions to assess weight gain or loss and for drug calculations. Therefore, weighing patients on admission contributes to our knowledge of individual patient's nutritional status.

How were we going to do this?

Indicator 1: To review and refine eligibility criteria for weighing of patients and confirm a standardised way to record patient weight across the hospital.

How did we do in delivering this?

Indicator 1: The eligibility criteria for weighing of inpatients was reviewed, and revised. An audit of the recording of patients' weight was undertaken once a quarter.

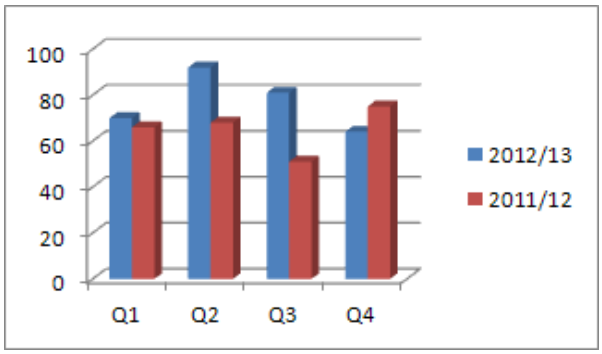
How were we going to do this?

Indicator 2: Ensure that 90% of all eligible patients weighed on admission assessed through a quarterly spot audit of patient notes.

How did we do in delivering this?

Reporting Period	% Patients Weighed (last year figures shown in bracket)
Q1 (Apr to June 2012)	**70 (66)**
Q2 (July to Sept 2012)	**92 (68)**
Q3 (Oct to Dec 2013)	**81 (51)**
Q4 (Jan to Mar 2013)	**64 (75)**

The hospital has seen some improvement against this target in 2012/13, but performance dipped in quarter 4. Regular reporting through the dashboard will take place to



ensure that we improve on this indicator.

How were we going to do this?

Indicator 3: Ensure that 100% of admitted patients on inpatient wards will be nutritionally screened.

How did we do in delivering this?

Reporting Period	% Assessed
Q1 (Apr to June 2012)	**91**
Q2 (July to Sept 2012)	**94**
Q3 (Oct to Dec 2013)	**92**
Q4 (Jan to Mar 2013)	**82**

The hospital has introduced a number of initiatives over this period to further enhance the nutritional care of our patients. These included:

- We reissued our nutritional guidance developed in 2011/12 as this provides the strategy to deliver high quality nutritional support to all our patients
- Continued monitoring and audit of the hospital's red tray and red beaker pathways; the procedural tools to deliver the hospital's goals, ensuring that all staff fully understood how best to support patients requiring nutritional assistance
- Nutritional inspections by the senior team supported by Governors across all clinical areas have been included as part of the scheduled patient quality checks in order to both emphasise the importance of nutrition for all our patients
- The Nutritional Steering Group has been established; this group is being led by the hospital's senior dietician. This group has delivered a number of hospital-wide initiatives to raise the profile of nutrition.

Our patient safety priorities for the year ahead

During 2013/14 The hospital will focus on the following safety priority:

"To increase 'harm free' care"

Every day more than a million people are treated safely and successfully in the NHS. However, the advances in technology and knowledge in recent decades have created an immensely complex healthcare system.

This complexity brings risks, and evidence shows that things will and do go wrong in the NHS; that patients are sometimes harmed no matter how dedicated and professional the staff.

The indicators we have used to deliver this priority have been derived from both national and local lessons learnt.

How we are going to do this

Indicator 1: Pressure Ulcers

Building on last year's patient experience priority this has now moved to a safety priority for 2013/14. The Hospital will have a 'zero tolerance' to hospital-acquired grade 3 and grade 4 pressure ulcers.

What is a pressure ulcer?

A pressure ulcer is damage that occurs on the skin and underlying tissue. A grade 3 or grade 4 is a more severe or serious pressure ulcer.

Pressure ulcers are a major source of morbidity in hospital care settings. Without proper treatment and care patients will have an extended period of debilitation requiring increased length of hospital stay and additional care.

The hospital has invested in a dedicated team to support and educate all staff on the prevention and treatment of pressure ulcers.

All staff are encouraged to report concerns, near misses and incidents onto our Risk Management data-base system. This enables us to monitor investigations, measure outcomes and implement lessons learnt to reduce reoccurrence and report on trends to our governances committees and board.

The current work includes undertaking a detailed investigation into every hospital acquired grade 3 and grade 4 pressure ulcers. This analysis and the lessons learnt will be reported to the hospital's SRG and learning and actions is communicated Trust-wide to reduce the incidence of this mainly preventable condition.

Last year we had 17 grade 3 or 4 pressure ulcers. This year we will reduce this to zero avoidable pressure ulcers.

Indicator 2: To reduce the number of adverse outcomes associated with medication (drug) errors.

The hospital recognises that mistakes can occur in the prescribing, dispensing or administration of medicines.

The consequences can be serious for patients, their family and friends, and for the health professionals involved.
We are therefore committed to making drug treatment as safe as possible.

Indicator 3: To reduce the number of planned transfers to another ward from the hospital's Critical Care Unit after 8pm at night.

Critical care provides higher levels of care for patients who are acutely/critically ill. Critical care departments provide much higher levels of clinical staff to patient ratios, to deal with the more intensive needs of this patient group.

As patients start recovering from the acute or critical phase of their illness they will be assessed to see if they can be cared for on a routine ward. This process often happens at the start of the day. However, transfers are often delayed until later in the day which often results in a less than satisfactory senior medical staff handover of their care needs.

A number of studies have shown that patients who are transferred to another ward from critical care units at night are at a higher risk of harm.

Critical care facilities are a limited resource in all hospitals and consequently in emergency situations the most well patients may need to be transferred to another ward earlier than normal to accommodate a much sicker patient; this indicator will not address this situation. However it will address planned transfers in a more structured way to provide this step down in care intensity.

How we are going to do this

Planned transfers will be allocated a bed as a priority within four hours of decision to transfer, ideally before 5pm to support a robust senior medical handover.

Improvements will be measured in actual numbers and average time to discharge for planned discharges.

Other patient safety indicators

The hospital continued to work closely with its commissioners, NHS Barnsley to monitor and improve performance across a number of quality indicators in addition to the commissioning for quality and innovation indicators (CQUIN) discussed in Part Three of this report.

These indicators include:

- Serious incidents and 'never events'
- Incident rates
- Complaints
- Medication errors
- Falls rates
- Single sex accommodation breaches
- Safeguarding reviews

The hospital continues to deliver actions to continually improve performance against these indicators. The QSIEB and risk management team provide Trust wide information to learn from patient safety incidents to reduce rates of harm.

One example of this is the hospital's Falls Prevention Group, which has undertaken a self assessment against the Royal College of Physicians "Falls Safe" guidance. The results of which were encouraging in that all but two initiatives were already well established at the hospital. The other two good practice suggestions were actioned immediately to ensure that the hospital delivers best practice in this area.

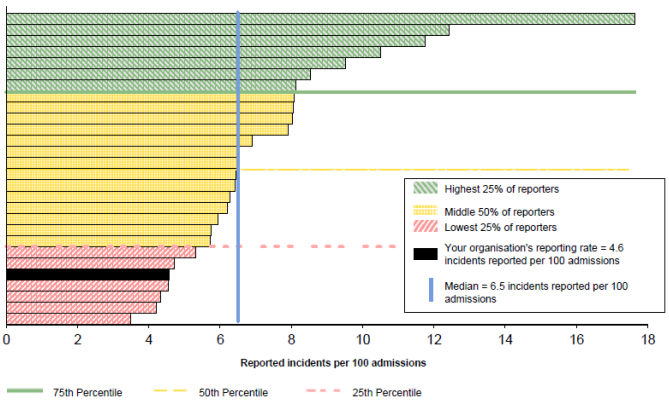
We are implementing a new incident reporting system in the hospital in April 2013 and this will make the reporting of all incidents much easier.

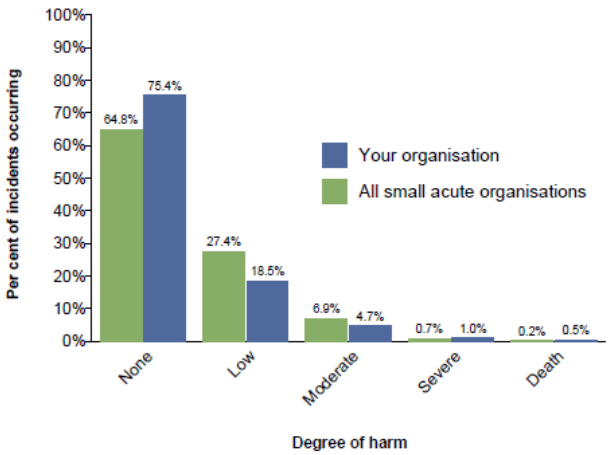
Research suggests that a high level of patient incident reporting is a mark of a 'high reliability' organisation with a stronger safety culture, as learning from incidents is crucial to reducing harm when patients have, or could have been harmed (near miss).

This indicator will encourage reporting and learning in order to reduce adverse outcomes and harm to our patients.

Adverse outcomes will be measured as a percentage of total incidents reported the base line being 2012/13 year end figures.

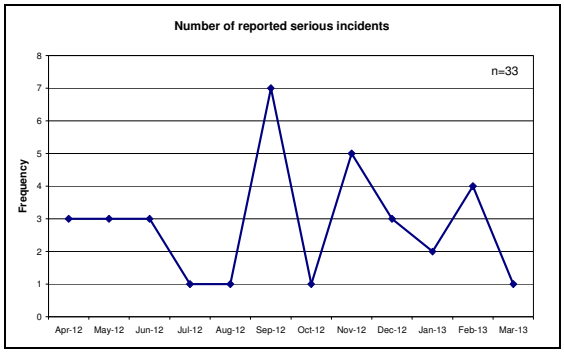
The National Reporting and Learning System (NRLS) provide comparative reporting rates of incidents. We are benchmarked with similar small acute hospitals. The tables below show that we report a low number of incidents and the degree of harm reported is moderate or less.





Serious incidents and 'never events' are taken very seriously. When a serious incident or never event is identified it is escalated to a Director. It is then thoroughly investigated by an internal independent review team. A report and action plan is completed. The action plan is monitored by the SRG on a monthly basis.

The graph below shows the number of serious incidents we had during 2012/13. We had a total of 38 serious incidents, which includes four never events.



HSMR (Hospital Standard Mortality Ratio): Simply described as the actual deaths occurring in a hospital compared to those deaths that could be expected to happen.

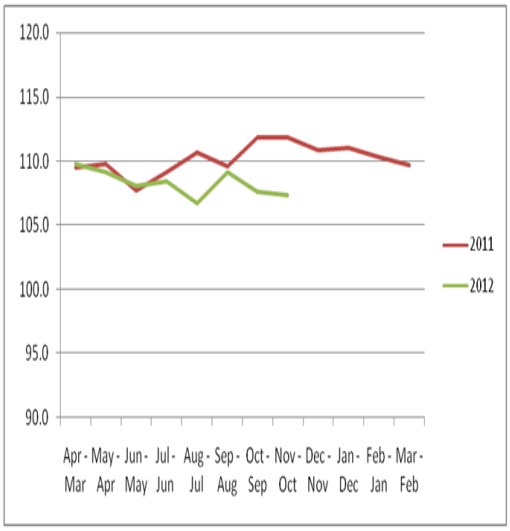
The hospital Board has been monitoring this on a monthly basis as the hospital's figure was running slightly above similar sized hospitals in the area.

The hospital developed an action plan to improve this rate, and is now beginning to see a reduction in the HSMR. (See table opposite).

The hospital has established a target to reduce this rate further to 100 by October 2013.

The hospital remains focused on improving our HSMR rate. During 2012, an independent assessor undertook an external review of our hospital deaths, which confirmed a high level of quality of care delivered in the hospital. However, the pace of continuing to improve our HSMR rate must be enhanced. The action plan and the related audit outcomes will therefore continue to be reviewed by our Clinical Governance Committee.

HSMR Trend last available 2 years data (rolling 12 months)



In addition to this, a Mortality Steering Group (MSG) has been established and chaired by the Medical Director. The focus of the MSG is to continually monitor the HSMR rate for the hospital and regularly audit all deaths.

Summary Hospital-level Mortality Indicator (SHMI) covers all deaths of patients admitted to hospital that occur in a hospital setting, as well as those that occur up to 30 days after discharge from hospital.

The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a hospital. SHMI values are scored and categorised into one of the following three bandings:

- higher than expected (Band 1)
- as expected (Band 2)
- lower than expected (Band 3)

The hospital's SHMI latest position (July 2011 to June 2012) is 108.0 and is 'as expected', Band 2.

Preventing and reducing infection in hospitals has been a national priority since 2009, with challenging year on year improvement targets across the country. The aim being to:

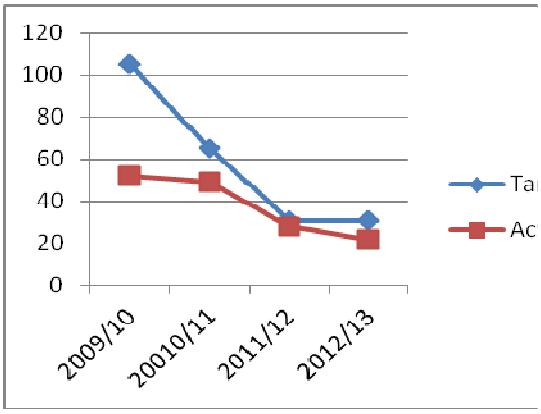
1) Eliminate the incidence of MRSA bacteraemia infections, and
2) To reduce the variation of C Diff infections across all hospitals by 2014.

Barnsley Hospital NHS Foundation Trust has performed well in meeting the challenge introducing a number of improvements throughout the hospital in order to deliver a year on year reduction in actual cases.

The hospital reduced its MRSA bacteraemia incidence to zero by 2010 and continues to perform well to reduce C Diff over performing against targets year on year (see below):

Year	Target	Actual	Improved on target by:
2009/10	105	52	53
2010/11	65	49	16
2011/12	31	28	3
2012/13	31	22	9

C Diff number



The C Diff rate in 11/12;

BHNFT 20.1
National 21.8

Rate per 100,000

ii) - Clinical Effectiveness

General Statement

The hospital has arrangements in place to support the delivery of safe and effective, patient care and services. Clinical effectiveness is made up of a range of quality improvement activities and initiatives such as clinical audit and research.

Priority 1
Reduce the incidence of hospital acquired pressure ulcers

Why this Priority?

Pressure ulcers represent a major burden of sickness and reduced quality of life for patients**.** The impact of pressure ulcers is psychologically, physically and clinically challenging for both patients and NHS staff.

Treatment costs vary depending on the grade of ulcer, from £1,064 for a grade 1 ulcer to £24,214 for a grade 4. The cost of preventing and treating pressure ulcers in a 600 bed acute trust has been estimated at between £600,000 and £3million a year.

Reducing pressure ulcers is one of the High Impact Nursing Actions from the Chief Nursing Officer of England's improvement in care initiatives.

The goal of this priority for 2012/13 was to further reduce the number of people who develop a newly acquired pressure ulcer following admission.

Achievement in regards to this has been measured across three different indicators.

How were we going to do this?

1. Incidence of people who have developed one or more new pressure ulcer after 24 hours of admission.
2. The number of incident forms completed for grade 2 ulcers and above which develop in an episode of care.
3. The numbers of root cause analysis investigations undertaken for patients with Grade 3 pressure ulcers and above.

Indicator 1

To achieve a 10% reduction from the 2011/12 year end baseline by the end of the year.

Indicator 2

100% achievement of incident forms completed.

Indicator 3

100% achievement of completed root causes analysis investigations for all grades 3 and above pressure ulcers.

How did we do in delivering this?

Indicator 1

The detailed performance is shown opposite.

Indicator 2 and Indicator 3

These were fully achieved.

Indicator 1 2012/13 Performance

Pressure Ulcer Grade	Quarter	2011/12	2012/13
2	1 (Apr – Jun)	56	29
	2 (Jul – Sep)	29	27
	3 (Oct – Dec)	22	25
	4 (Jan – Mar)	19	69
Total		**126**	**150**
3	1 (Apr – Jun)	2	5
	2 (Jul – Sep)	4	2
	3 (Oct – Dec)	3	0
	4 (Jan – Mar)	1	5
Total		**10**	**12**
4	1 (Apr – Jun)	0	5
	2 (Jul – Sep)	1	1
	3 (Oct – Dec)	0	0
	4 (Jan – Mar)	0	0
Total		**1**	**6**

This year has seen the introduction of the hospital's own Tissue Viability Team, which has definitely increased the knowledge and training of staff, and has consequently increased reporting and accuracy of grading.

Performance has shown a slight increase in grade 2 and grade 3 pressure ulcers, however this can be attributed to improved reporting mechanism. Nonetheless, our nursing team, including Tissue Viability Team are focused on monitoring through the Essential Care Indicator audits.

The hospital will therefore continue to drive this issue as a priority with 'zero tolerance' of avoidable grade 3 and grade 4 pressure ulcers in 2013/14.

Our clinical effectiveness priorities for the year ahead

During 2013/14 the hospital will focus on the following clinical effectiveness priority:

'To improve patient outcomes by improving our effectiveness across three different areas'

How are we going to do this?

Progress on this priority will be measured through a number of indicators:

- To reduce the average length of hospital stay for urgent care patients over 65 years of age
- To increase the number of patients discharged within 24 hours across three of the identified ambulatory care conditions, specifically; cellulitis, deep vein thrombosis and low risk chest pain
- To reduce the number of patients readmitted to hospital within two days of discharge

Indicator 1: To reduce the average length of hospital stay for urgent care patients over 65 years of age.

National studies indicate elderly patients develop more complications the longer their stay in hospital. The hospital is currently involved in a number of Transformation Programmes and is specifically looking to improve the urgent care pathway. The hospital is additionally working with the King's Fund on the urgent care pathway relating to frail elderly patients.

To establish an improvement target the hospital has assessed its own performance and this is showing an average length of stay for this group of patients of 8.4 days. The hospital benchmarked this performance against its peer group (small acute trusts). The best performance in this peer group is indicating a 7-day length of stay. The hospital will therefore aim to reduce its average length of stay for urgent care patients over 75 years of age by one day. This will be achieved through the outputs of the transformation work.

Indicator 2: To increase the number of patients discharged within 24 hours across three of the identified ambulatory care conditions, specifically; cellulitis, deep vein thrombosis and low risk chest pain.

By reducing the number of admissions for patients with low risk illnesses in order to improve patient care and improve the effectiveness and efficiency of bed usage.

A number of conditions have been identified and incentivised to be treated without the need for hospital admission. These conditions are referred to as Ambulatory Care Conditions.

The hospital is currently developing an observations unit that will be located adjacent to the hospital's Emergency Department. The objective of this unit will be to facilitate caring for these kinds of patients in a day care setting without the need for admission to the main hospital.

In order to measure the success and effectiveness of this facility the hospital will measure the number of patients cared for as a day case/without admission, against all these ambulatory care conditions with particular focus on the three conditions identified above.

Indicator 3: To reduce the number of patients readmitted to hospital within two days of discharge.

This indicator has been established to ensure that we are delivering effective patient discharges. Patients are in fact ready for discharge and that any continuing care needs have been fully addressed when patients leave our care.

2012/13 year end performance will be used to provide the base line. The hospital will then measure readmissions against this base line to measure our improvement in delivering effective patient discharge.

Last year we had a number of 1044 readmissions within two days of discharge. This year we will reduce this by 10%, so by 104 patients end of the year.

Other clinical effectiveness priorities

Other clinical effectiveness indicators being monitored by the hospital include:

Venous Thromboembolism (VTE)

VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE)

National guidelines were therefore introduced in order that all patients admitted to hospital are risk assessed for VTE and proactive treatment is provided to patients assessed as high risk.

In 2011/12 and 2012/13 the hospital has delivered the 90% target for risk assessing all patients and providing the appropriate treatment.

Patients who are readmitted to hospital within three months or suffer a fatality because of suffering from a VTE are fully investigated by identified medical leads, to understand the cause of the VTE and disseminate any learning to prevent further recurrence.

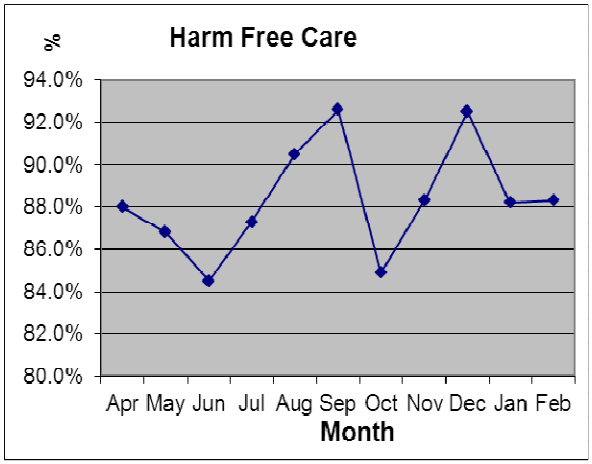
The focus on this priority will continue into 2013/14 as a national CQUIN priority with an increased target.

NHS Safety Thermometer

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient care. The Safety Thermometer for 2012/13 measured four clinical conditions - venous thromboembolism, urinary tract infection, pressure ulcers and patient falls. The hospital implemented this national measurement system and aimed to deliver a high level of harm free care. This information is collected through scheduled spot-check audits that are entered into a national toolkit to provide individual Trust's harm free care percentages.

These clinical conditions were consequently a clear focus of our annual quality priorities.

Patient Safety Thermometer 2012/13 performance trend is shown over:



This is the first year this information has been collected nationally in this way and the hospital is working to continually improve the quality of the information collected.

iii) - Patient Experience

General Statement

At Barnsley Hospital NHS Foundation Trust (BHNFT) we place great value in knowing and understanding the experiences of our patients and their carers and relatives. It is those experiences that continue to help us plan and deliver high quality health care.

To ensure that we provide a consistently excellent service the hospital has a number of inpatient and outpatient forums that drive and support clinical teams to improve. These groups are led by the Head of Patient Experience and have a wide membership including clinical staff, carers, patients and Governors. These groups have a responsibility for identifying key areas from improvement arising from patient and carer feedback, assisting with plans and monitoring their implementation.

To achieve a wider organisational impact these groups report into a Patient Experience Board to inform the hospital's Patient Experience Strategy. The hospital has radically reviewed the Patient Experience Strategy during 2012 and the revised document was approved by the hospital Board in December 2012.

How well have we done this year?

Over the past year we have made good progress against many of the priorities set during 2011/12. To judge our performance we set ourselves a number of improvement targets and our performance against these targets is indicated below.

Our patient experience priorities

The following information describes how we have measured our success using the national Patient Survey results and our complaints information to see whether patients were told about the side effects of medications and if they were worried who to contact.

How well have we done this year?

To help judge the quality of care provided we have set our performance against our priority as well as measuring and monitoring other clinical effectiveness performance measures.

Our priority
'Ready to go, no delays'

Why This Priority?

Our patients clearly stated within the Quality Survey that untimely (late) discharge was amongst their highest criticism of quality care within the hospital. This also incorporated that their perceived delay was related to patients waiting for their prescriptions.

This is also one of the top themes within both complaints and patient surveys.

We are aware that this is highly complex and has multiple areas in which we need to improve from communication with the patient to the prescribing and timely dispensing of drugs to patients.

We do however feel that by getting our processes right, we can improve the experience of our patients.

Indicator 1: To achieve an improvement on two key composite questions from the CQC Inpatient Survey. These are question 64 and question 69 where we did not perform as well as expected:

(a) Discharge: not fully told of side effects of medication
(b) Discharge: not told who to contact if worried

How were we going to do this?

Target: To improve score, by 1%.

How did we do in delivering this?

Q64	2009	2010	2011	2012
Told	42.5%	45.5%	36.6%	37%
Not told	57.5%	54.5%	63.4%	63%

The hospital has seen marginal improvement of 0.4%. The hospital's pharmacy staff are currently developing a leaflet to support patients with their medications following discharge, which should provide additional support to our patients on this issue.

Q69	2009	2010	2011	2012
Told	68.9%	81.4%	73.3%	80%
Not told	31.1%	18.6%	26.7%	20%

A total of 80% of our patients did know who to contact if they were worried following discharge, the hospital seeing an improvement of 6.7%.

We will continue to focus on the other discharge issues identified within the Patient Survey in order to fully support our patients when they leave hospital.

Complaints Performance

Indicator 2: To reduce the number of complaints the hospital receives related to patients discharge experience

How were we going to do this?

Targets: To achieve a 5% decrease in the number of complaints predominantly relating to discharge of our patients. In 2011/12 we received 11 complaints where discharge was the main focus. This was 4.04 % of all complaints. Also to: achieve a 10% reduction on complaints featuring discharge. There were 71 complaints where discharge was featured within the complaint this was 26% of all complaints.

How did we do in delivering this?

In 2012/13 we received 17 complaints where discharge was the main focus. This was 7 % of all complaints and is an increase from the previous year of 11 being the main focus, 4.04% of all complaints.

However, a reduction was seen in where discharge was featured with 42 complaints referring to discharge, 17% of all complaints. Previous years figures were 71 (26%) being featured in complaints referring to discharge.

The Complaints Performance table on the next page illustrates the performance breakdown in more detail.

Our mother's care on the new Acute Medical Unit *We are a large family but none of us were ever turned away or made to feel we were a nuisance. The nursing care was marvellous, everything was fully explained and support was always there for us and mam*

Complaints Performance table

2011/12	Complaints Received	Discharge Focus (DF)	Discharge Mentioned (DM)	% Change DF	% Change DM
Q1	57	1	19	1.8%	33.3%
Q2	61	1	13	1.6%	21.3%
Q3	80	5	15	6.3%	18.8%
Q4	74	4	24	5.4%	32.4%
Totals	272	11	71	4.0%	44.9%
2012/13					
Q1	57	1	19	1.8%	33.3%
Q2	54	3	7	5.6%	13.0%
Q3	62	2	9	3.2%	26.1%
Q4	72	11	7	15.3%	9.7%
Totals	245	17	42	6.9	17.1%

Our patient experience priorities for the year ahead

During 2013/14 the hospital will focus on the following Patient Experience priorities:

To improve patient experience across three targeted pathways.

Indicator 1: All hospital inpatients with Learning Disabilities will be seen by someone with specialist learning disabilities skills within two days of admission and be offered an "All About Me" Passport.

2012 saw the appointment of a specialist nurse to support our patients with learning disabilities. This nurse forms part of the hospital's Safeguarding Team. The in-year focus has been to:

- Increase learning disability training for all staff.
- Work with residential homes to identify and support patients that may require admission to hospital
- Develop "All About Me" Passports for existing patients across the wider health community to provide seamless adjustments when this patient group requires a hospital admission.

The specialist team will see all patients with a learning disability as soon as practicably possible following their admission.

Indicator 2: The Palliative Care Team will increase the number of staff trained on the "Last Days of Life Care Pathway".

Our Governors told us that they wanted to see a patient experience initiative that focussed on care of the dying.

The hospital currently has a low number of staff trained on the specialised element of this care delivery. The hospital therefore intends to train 30% of front line qualified nursing staff in 2013/14 and 50% by 2015.

The training will be primarily face-to-face training, provided by the End of Life and Palliative Care Team on a monthly basis. This will be supplemented by a newly developed e-learning package that will be launched in June 2013.

Indicator 3: To ensure that 90% of patients over 75 years of age are assessed for signs of dementia.

About 750,000 people in the UK have dementia – and this number is expected to double in the next thirty years. The Government is committed to improving the care and experience of people with dementia and their carers. The aim is to transform dementia services to achieve better carer awareness, early diagnosis and high quality treatment at every stage and in every setting, with a greater focus on local delivery of quality outcomes and local accountability for achieving them.

Other patient experience priorities

To improve the discharge planning arrangements for our patients.

An internal audit was commissioned on the discharge planning arrangements at the end of 2011. A number of recommendations to improve discharge planning were reported from this audit.

How were we going to do this?

Target: To deliver a comprehensive action plan to address all the reported recommendations of this audit.

How did we do in delivering this?

The discharge planning action plan has been delivered except in recommendation 1 as this was dependent on the installation and commissioning of the second Computerised Tomography (CT) scanner, which is now in place. This recommendation is therefore now being progressed to completion.

These achievements have obviously had a positive impact on patient experience as the hospital's response to patient needs scores have improved in the Inpatient Survey.

"Brilliant care throughout my Total Knee Replacement all the ward nurses were brill, physio team were fab, I would also like to thank the consultant and the pre assessment sister for all their care & encouragement throughout 10 out of 10"

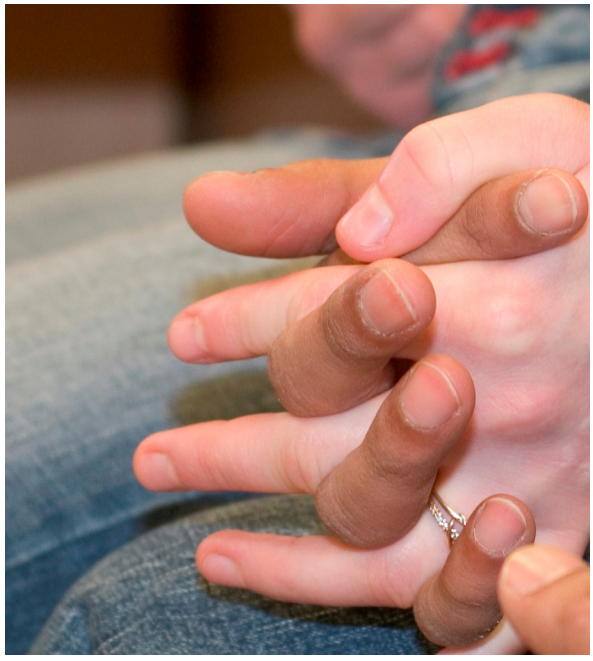
2b: Statements of Assurance

The following section includes responses to a nationally defined set of statements, which will be common across all Quality Accounts.

The Statements serve to offer assurance to the public that our organisation is:

- Performing to essential standards such as securing Care Quality Commission registration
- Measuring our clinical performance, for example through participation in national audits
- Involvement in national projects and initiatives aimed at improving quality such as recruitment to clinical trials

"The care and attention from all staff/ doctors is excellent/ 1st class. This hospital would put private hospitals to shame, the whole experience of being in this hospital is that everything is done for patient first and foremost and not money. This has been throughout my six month treatment"



Information on the Review of Services

The purpose of this statement is to ensure that we have considered quality of care across all our services. The information that is reviewed and monitored through our quality committees is from all clinical areas.

Information at individual service level is considered by the individual Clinical Service Units and Departments and then any issues emerging are escalated on an exception basis through to our quality committees.

During 2012/13 BHNFT provided no sub-contracted NHS service.

BHNFT has reviewed all the relevant data available on the quality of care in the 43 services (see list on page 86). The income generated by the health services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of relevant health services by the BHNFT for April 2012 to March 2013.

The information on the review of services, reviewed data which aims to cover three dimensions of quality- patient safety, clinical effectiveness and patient experience. Some areas e.g. re-admission rate, end of year national data was not available at the time of compiling this report and therefore our own data collection has been used. This will therefore only provide an overview and not a valid comparison with previous year's performance.

In addition to internal monitoring systems, we also use the data made available to trusts by the Information Centre with regards:

- To re-admission rates, 0 to14 and 15 or over. The re-admission to hospital forms part of the Trust 28 days of being discharged from hospital which forms part of the Trust during the reporting period
- To the Trust's responsiveness to the personal needs of its patients during the reporting period.
- To the percentage of employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.
- To the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.
- To the rate per 100,000 bed days of cases of C Diff infection reported within the Trust amongst patients ages 2 or over during the reporting period
- To the number of patient safety incidents reported within the Trust during the period, and the number and percentage of such patient safety incidents resulted in severe harm or death

Where possible and as required by the NHS (Quality Accounts) Amendment Act Regulations 2012, a comparison has been made of the numbers, percentages, values, scores or rates of each of the above indicators with:

a) the national average; and
b) those NHS trusts and NHS foundation trusts with the highest and lowest of the same.

Please see Table C – Evaluation of Performance

Table C – Evaluation of Performance provides an explanation of how we did in comparison to the national average, where available and steps taken to improve the quality of outcome measures. This has been considered as part of the Integrated Performance Report, which is considered by the hospital Board of Directors monthly.

- Accident and Emergency (ED)
- Anticoagulant
- Audiology
- Breast surgery
- Cardiology
- Chemical pathology
- Clinical Haematology
- Cystic fibrosis
- Dermatology
- Diabetic medicine
- Direct access endoscopy
- Ears, Nose and Throat (ENT)
- Endocrinology
- Gastroenterology
- General medicine
- General surgery
- Genito-urinary medicine
- Geriatric medicine
- Gynaecology
- Haematology
- Hepatology
- Histopathology
- Immunology
- Intensive Treatment Unit (ITU)
- Low vision
- Medical microbiology
- Midwifery
- Neonatology
- Obstetrics
- Oral Surgery
- Orthodontics
- Paediatrics (diabetes, cardiology, ENT, trauma and orthopaedics, dermatology)
- Palliative medicine
- Radiology
- Respiratory medicine
- Retinal screening
- Rheumatology
- Specialist nursing
- Stroke
- Therapy services
- Trauma and Orthopaedics
- Urology
- Vascular surgery

Information on participation in clinical audit

From 1 April 2012 to 31 March 2013, there were 36 national clinical audits and three national confidential enquiries, which covered NHS services that BHNFT provides.

In 2012/13 36 national clinical audits and 3 national confidential enquiries covered relevant health services that BHNFT provides.

During 2012/13 BHNFT participated in 64% national clinical audits 100% national confidential enquiries which it was eligible to participate in.

Of the 13 national audits that the BDGH did not participate in, 11 of these were not part of the National Mandatory Audit, defined by the National Clinical Audit and Patient Outcomes Programme (NCAPOP)

We did not participate in two of the NCAPOP audits as follows:

Maternal infant and new-born programme (MBRRACE-UK): The launch of the audit was delayed until 01 April 2013 so will appear in the 2013/14 quality account.

Cardiac arrhythmia (HRM): The majority of our patients are referred to the Royal Hallamshire Hospital leaving insufficient numbers to allow us to participate in the audit.

The national clinical audits and national confidential enquiries that BHNFT was eligible to participate in during 2012/13 are as outlined Table A and A i)

Table A i)

Alcohol Related Liver Disease (ARLD)	participated 66% (2/3)
Subarachnoid Haemorrhage (SAH)	participated 100% (5/5)
Tracheostomy study	On-going

The national clinical audits and national confidential enquiries that BHNFT participated in during 2012/13 are as outlined in Table A and A i)

The national clinical audits and national confidential enquiries that BHNFT participated in, and for which data collection was completed during 2012/13, are listed in Table A and A i) alongside the number of cases submitted for each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. Please see Table A i) and A ii).

The reports of 23 national clinical audits were reviewed by the provider in 2012/13 and BHNFT intends to take the actions to improve the quality of healthcare provided, please see below:

Epilepsy 12 Audit (Childhood epilepsy): the audit aimed to facilitate health providers and commissioners to measure and improve quality of care for children and young people with seizure and epilepsies and to contribute to the continuing improvement of outcomes for those children, young people and their families. The results of the audit showed that there needed to be more focus on child behaviour, emotional, learning and school issues for children with epilepsy and seizures. This is to be introduced as part of the initial clinical assessment.

National Hip Fracture Database (NHFD): NHFD was developed in 2007 and is a clinically led, web-based audit. The audit was set up in collaboration with the British Orthopaedic Association (BOA) and the British Geriatrics Society (BGS).

We are better than the national figures for patients operated on within 36 and 48 hours of admission (National average 67% BHNFT 73%). The patients that did not receive surgery within the recommended time were mostly medically unfit. More slots have been added to the Trauma List to enable patients to be operated on in a timely manner. Local guidelines are being implemented for Advanced Nurse Practitioners to carry out bone health assessments and prescribing of secondary prevention with the aim of 100% of patients to be assessed.

National Audit of Dementia: This audit was established in 2008 to examine the quality of care received by people with dementia in general hospitals. This is the second round of this audit. Overall assessment of patients has improved since round one of the audit including physical, mental health, social and environmental assessments. The Butterfly scheme has been launched within the hospital to alert staff that the patient has dementia. Dementia awareness training has been introduced in the last twelve months and improvements in staff training around vulnerable adults.

The reports of 227 local clinical audits were reviewed by the provider in 2012/13 and Barnsley hospital intends to take the following actions to improve the quality of healthcare provided. (Please see page 96).

The Healthcare Quality Improvements Partnership (HQIP) oversees the NCAPOP.

In addition to the national audits, the hospital also participated in 227 local audits. These audits included those undertaken for local initiatives and reasons, such as:

- Commissioning for Quality and Innovation (CQUINS).
- Baby Friendly Initiative supported by the United National Children's Fund (UNICEF).

Table A ii) – National Audit Progress 2012/13

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/reporting details	NCAPOP
Peri- and Neonatal					
Maternal infant and newborn programme (MBRRACE-UK)	✓	✗	NA	Testing during January 2013, launch planned February 2013. Leads identified.	✓
Neonatal intensive and special care (NNAP)	✓	✓	100%	Quarterly reports received and action planned locally.	✓
Children					
Paediatric pneumonia (British Thoracic Society)	✓	✗	-	Did not participate	✗
Paediatric asthma (British Thoracic Society)	✓	✗	-	Did not participate	✗
Epilepsy 12 audit (Childhood epilepsy)	✓	✓	100%	Audit complete and action planned locally. Next phase of the audit to be started April 2013.	✓
Paediatric intensive care (PICANet)	✗	**NA**	-	Undertaken at specialist paediatric hospitals. Not applicable to BHNFT.	✓
Diabetes (RCPH National Paediatric Diabetes Audit NPDA)	✓	✓	100%	Awaiting National report	✓

[1] Applicable to BHNFT
[2] Participated in

Table A ii) – National Audit Progress 2012/13

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/reporting details	NCAPOP
Paediatric cardiac surgery (Congenital Heart Disease Audit CHD)	×	NA	-	Paediatric cardiac surgery is not undertaken at BHNFT.	✓
Paediatric fever (College of Emergency Medicine	✓	✓	100%		×
Child health programme(CHR-UK)	×	NA	-	Not applicable to BHNFT	✓
Acute care					
Emergency use of oxygen (British Thoracic Society)	✓	×	-	Did not participate	×
Adult community acquired pneumonia (British Thoracic Society)	✓	×	-	Did not participate	×
Non invasive ventilation (NIV) - adults (British Thoracic Society)	✓	×	-	Commenced 1st February. Consultants in process of identifying Junior Doctor to participate	×
National cardiac arrest audit (NCAA)	✓	×	-	Did not participate	×
Adult critical care (ICNARC CMPD)	✓	✓	100% of patients admitted to ITU	Report received annually. There are plans to also include SHDU when an audit clerk has been recruited.	×
Renal colic (College of Emergency Medicine)	✓	✓	100%		×

Table A ii) – National Audit Progress 2012/13

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/reporting details	NCAPOP
Patient outcome and death (NCEPOD)	✓				✓
Blood and Transplant					
National comparative audit of Blood Transfusion (NHS Blood and Transplant)	✓	✓	100%	Awaiting report	×
Potential donor (NHS Blood and Transplant)	×	NA		Not applicable to BHNFT	×
Long term conditions					
Diabetes (National Adult Diabetes Audit)	✓	✓	100%		✓
Pain database (National Pain Audit)	×	NA		Submitted by Doncaster and Bassetlaw	✓
Inflammatory bowel disease (UK IBD Audit)	✓	✓		The audit began on 1 January 2013 and is due to be completed until 30 June 2014	✓
Parkinson's disease (National Parkinson's Audit)	✓	×	-	Do not participate	×
Adult asthma (British Thoracic Society)	✓	×	-	Do not participate	×
Bronchiectasis (British Thoracic Society)	✓	×	-	Do not participate	×

Table A ii) – National Audit Progress 2012/13

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/reporting details	NCAPOP
National review of asthma deaths (NRAD)	✓	✓		Cases reviewed however did not meet the criteria of the audit	✓
Cancer					
Lung cancer (NLCA)	✓	✓	100%	We submit data for all patients who are eligible for the audit.	✓
Bowel cancer (NBOCAP)	✓	✓	100%	We submit data for all patients who are eligible for the audit.	✓
Head & neck oncology (DAHNO)	✓	✓	100%	We now only enter data for our part of the pathway. The remainder of data is submitted by STH following Network MDT.	✓
Oesophago-gastric cancer (NAOGC)	✓	✓	100%	We submit data for all patients who are eligible for the audit.	✓
Elective procedures					
National joint registry (NJR)	✓	✓	76.1%	Our response rate is above average	✓
Elective surgery (National PROMs Programme)	✓	✓	75.1%	Latest information available is November 2012. In 2012/2013 the correct cohort for Groin Hernia repairs was not being identified. This has now been rectified and this figure should improve for 2013/2014.	×

Table A ii) – National Audit Progress 2012/13

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/reporting details	NCAPOP
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	×	NA	-	Do not participate	×
Coronary angioplasty (NICOR Adult cardiac interventions audit)	×	NA	-	Do not participate	✓
National vascular registry	×	NA	-	Do not participate	✓
Carotid interventions (CIA)	×	NA	-	Do not participate	✓
Adult cardiac surgery audit (ACS)	×	NA		Do not participate	✓
Renal disease					
Renal replacement therapy (Renal Registry)	×	NA		Do not participate	×
Renal transplantation (NHSBT UK Transplant Registry)	×	NA		Do not participate	×
Cardiovascular disease					
Acute coronary syndrome or acute myocardial infarction (MINAP)	✓	✓	100%	All eligible patients	✓
Heart failure (Heart Failure Audit)	✓	✓	100%	All eligible patients	✓

Table A ii) – National Audit Progress 2012/13

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/reporting details	NCAPOP
Sentinel stroke national audit (SSNAP - combined Sentinel and SINAP)	✓	✓	100%	All eligible patients	✓
Cardiac arrhythmia (HRM)	✓	×	-	Do not participate	✓
Pulmonary hypertension	✓	NA		Patients transferred to Sheffield	×
Trauma					
Hip fracture database (NHFD)	✓	✓	100%	On-going data collection – National report published annually	✓
Severe trauma (Trauma Audit & Research Network TARN)	✓	✓	100%	All eligible patients	×
Older People					
National audit of dementia (NAD)	✓	✓	100%	All eligible patients	✓
Fractured neck of femur (College of Emergency Medicine)	✓	✓	100%	All eligible patients	×
Psychological conditions					
Prescribing observatory for mental health services (POMH)	×	NA		Not applicable to BHNFT	×

Table A ii) – National Audit Progress 2012/13

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/reporting details	NCAPOP
National audit of psychological therapies (NAPT)	×	NA		Not applicable to BHNFT	✓
Suicide and homicide for people with mental health illness (NCISH)	×	NA		Not applicable to BHNFT	✓

Examples of outcomes from completed local audits

The reports of 227 local clinical audits were reviewed by the provider in 2012/13 and BHNFT intends to take the following actions to improve the quality of healthcare provided.

Protective Lung Ventilation in ICU Patients

The aim of the audit was to measure compliance against the Royal College of Anaesthetists guidance and where necessary provide recommendations and a protocol to optimise protective lung ventilation.

Because of this audit a flow chart on protective lung ventilation was developed and the ICU daily review charts were amended.

These actions have improved the care of patients who are ventilated on ICU.

Obstetrics: Audit of management of Shoulder Dystocia

The aim of the audit was to measure compliance against CNST standards set by the Royal College of Obstetricians. Results showed that all the information was not consistently recorded. As a consequence of these results a proforma was designed ensuring that the whole of the patient information was included. Re-audit has demonstrated an increase in compliance.

NICE Clinical Guideline 100 & 115 – Drug Treatment of Alcohol Withdrawal

The audit looked at the hospital's compliance to the NICE clinical guidelines on 'drug treatment of alcohol withdrawal'. The audit highlighted the fact that there was no care pathway in place for patients withdrawing from alcohol. Documentation was also poor. To improve the process of caring for patients on this drug treatment an alcohol withdrawal pathway was developed. Training for staff providing the treatment has also been provided.

Termination of Pregnancy (TOP) Process and Documentation

The legal forms used for pregnancy termination were audited. As a result of the audit, a new checklist has been introduced and the booking system for patients referred by their GP has been amended. A department induction process for new junior doctors has also been introduced.

Doctors Handover in the Medicine CSUs

The hospital has delivered an on-going audit programme during 2011 and 2012 to evidence a safe handover of care from one shift team to another on the medical wards at the hospital, to ensure continued patient care. The standards for handover used were taken from national guidance.

This was audited on four occasions and as a result a new electronic system has now been introduced. The system is logical to use and provides a robust process for recording handover activity between shift teams. The re-audit shows a significant improvement in compliance with the national guidance standards.

"They are kind, caring and are understanding, they leave you alone to deal with your news, but are always on hand."

Participation in clinical research

The inclusion of this statement demonstrates the link between our participation in research and our drive to continuously improve the quality of patient care and patient services. The fact that there is a good research culture within the hospital plays a part in attracting and retaining high quality staff.

The Research & Development Strategy and Business Plans are now embedded into the hospital's overall strategy and business plans. This in part is reflected in the collaborative work currently being undertaken to facilitate the procurement of a Clinical Research Facility, which will enable even more research work to take place at the Hospital.

The number of patients receiving relevant health services provided by BHNFT (BHNFT) in 2012/13, that were recruited during that period to participate in research approved by a research ethics committees 419. This figure is included on the National Institute for Health Research (NIHR) Portfolio and captures a variety of research themes.

This figure will increase over the following months as a further concentration on NIHR eligible studies intensifies and after placing an emphasis on high recruiting studies. We expect the annual recruits to NIHR eligible studies to triple in the forthcoming year.

Further research on a commercial basis is also being undertaken within this Trust, but because of the nature of funding etc. the figures are not captured in the NIHR portfolio.

During 2012 the hospital was involved in conducting, hosting and recruiting to 104 clinical and other well-designed research studies. Of these studies, 38 were adopted onto the NIHR portfolio.

Fifty-nine clinicians plus further research staff participated in research approved by a research ethics committee and our Research Governance Committee in 2012; this number are staff from across almost the whole spectrum of hospital specialities.

Successes

- Our work on seeking to identify ways of measuring patient and public involvement in research is informing national policy and outcome measure development
- Our work on patient education is empowering patients and leading to better musculoskeletal health quality and outcomes
- Our work in developing new treatments for arthritis is transforming the morbidity as well as the mortality for patients with arthritis
- Our work in developing biomarkers for arthritis is helping to develop targeted and personalised medicine
- Our work in Testosterone therapy has led to a continuing international reputation and one where the results of our research has continued to change practice locally, nationally and worldwide. This work along with research into diabetes has led to improved quality of life, improved diabetic control and morbidity.

Our work into stroke research has resulted in increased funding for stroke

services, which in turn has led to better working relationships between primary and secondary care.

There were 120 publications in peer reviewed journals in 2010-2012.

The Collaboration for Leadership in Applied Health Research and Care for South Yorkshire (CLAHRC SY)

CLAHRC's remit is to undertake high quality applied research, translate research into practice, and increase partner organisations' capacity to do more of the same. In the last year several CLAHRC SY projects have been undertaken within BHNFT, which have direct implications for patient care.

The Advance Nurse Practitioner evaluation draws to its close. A recent interim report highlights the benefit of these roles, through their influence on patient safety and team working, as a consequence of their highly developed communication and clinical skills.

A qualitative study on the experience of adolescent Type I diabetics has contributed to the development of the WICKED (Working with Insulin, Carbohydrates, Ketones & Exercise to Manage Diabetes) diabetes programme, an age specific course teaching the skills of diabetes self-management for this age group, which will be trialled over the coming few years.

The 'Acute Medical Care for Frail Older People' project is part of a wider King's Fund Patient and Family Centred Care Programme. This project aims to put patient experience at the centre of care and redesign the care pathway for Frail Older People in Barnsley and will be completed by April 2014.

The 'Built Environment in Acute Care for Older People' project is contributing to the future development of the BHNFT estates strategy by informing the design specification of a 'model standard ward' for older people.

This project is nearing its conclusion and, together with the King's Fund project, has informed the bid to the Department of Health 'improving the environment of care for people with dementia' programme. If successful, this development will transform the inpatient environment in acute care for Frail Older People in Barnsley.

The innovation and implementation of evidence-based care will be strengthened by the development of the Academic Health Science Network (AHSN) and the next generation of CLAHRC. In the future, the hospital, CLAHRC and the AHSN will work closely together to ensure the translation of high quality evidence into practice, and support the hospital's effort within the Commissioning for Quality and Innovation (CQUIN) framework.

Commissioning for Quality and Innovation (CQUIN)

A proportion of BHNFT income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between BHNFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:

http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The CQUINS for 2012/13 covered a range of national and local goals. The monetary total for income in 2012/13, conditional upon achieving quality improvement and innovation goals, was £3.238 million; we achieved 81% of this income (£2,623,008). The 2012/13 CQUIN scheme included four national and six local indicators. The hospital's performance against these indicators is shown on the next page.

2012 /13 CQUINs		Quarter 1		Quarter 2		Quarter 3		Quarter 4		
Ref	Indicator	Value	Actual	Q2 Values	Actual	Q3 Values	Actual	Q4 Values	Actual	Total Value
	NATIONAL									
N1	VTE	£32,383	Achieved	£32,383	Achieved	£32,383	Achieved	£32,383	Achieved	£129,531
N2	Patient Experience	£0	N/A	£0	N/A	£0	N/A	£194,297	Achieved	£194,297
N3	Dementia (age 75+ >48 hours)	£0	N/A	£0	N/A	£0	N/A	£194,297	Failed	£194,297
N4	NHS Safety Thermometer	£0	N/A	£43,177	Achieved	£43,177	Achieved	£43,177	Achieved	£129,531
	LOCAL									
L1	CAUTIs	£97,149	Achieved	£97,149	Achieved	£97,149	Achieved	£97,149	Achieved	£388,594
L2	Outpatient Letters	£129,531	Failed	£129,531	Achieved	£129,531	Achieved	£129,531	Achieved	£518,125
L3	Paediatric Safeguarding (missed appts)	£129,531	Achieved	£129,531	Achieved	£129,531	Achieved	£129,531	Achieved	£518,125
L4	Paediatric Safeguarding (A&E)	£129,531	Achieved	£129,531	Achieved	£129,531	Achieved	£129,531	Achieved	£518,125
L5	MEWS	£129,532	Achieved	£0	N/A	£129,532	Achieved	£0	N/A	£259,063
L6	A&E 4 hour waits	£97,149	Achieved	£97,149	Failed	£97,149	Failed	£97,149	Failed	£388,594
	Total	£744,805		£658,451		£787,982		£1,047,045		£3,238,282
	Achieved	£615,274		£561,302		£690,834		£755,599		£2,623,008
	At Risk	£0		£0		£0		£0		£0
	Failed	£129,531		£97,149		£97,149		£291,446		£615,274

Quality of data

Good quality data underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made

In 2012/13, good progress has continued with the action plans relating to data quality following all the previous audits. The Internal Audit Department is monitoring progress with all previous external audit recommendations.
BHNFT will be taking the following actions to improve data quality:

- Information Assets/System Managers are continually audited and updated with new requirements through spot check audits and the Information Assurance Group meetings. This gives assurance the hospital is compliant with all Information Governance (IG) Toolkit requirements and ensures training and all reference documentation is in place to allow staff to carry out their duties effectively.
- Data collection for all Key Performance Indicators (KPI) is being audited and the findings are presented at IGB. This gives assurance the data collection processes followed by the hospital are robust which ensures the published figures are accurate. Any issues identified are addressed immediately.
- Training and raising awareness of data quality continues to be a Trust priority. The data quality e-learning package is now available and data quality has been included with various other training packages including 'Cradle to Grave' training, the lifecycle of a patient's health record, Junior Doctors induction training and one-off refresher training courses.
- The data quality dashboard continues to be developed and it is communicated to all Clinical Directors. Any issues relating to missing or incorrect inpatient and outpatient data will be discussed at monthly Clinical Service Unit meetings.
- A working group has been formed with representatives from the PCT/CCG and clinicians which aims to improve communication between the hospital and GP Practices, which will improve patient safety and care.

Regulation and Compliance

Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care services in England. From April 2010 all NHS Trusts have been legally obligated to register with the CQC. Registration is the licence to operate and to be registered, providers must by law, demonstrate compliance with the regulatory requirements of the CQC (Registration regulations 2009).

BHNFT is required to register with the CQC and its current registration status is active registration, without conditions.

The Care Quality Commission has taken enforcement action against BHNFT during 2012/13.

The hospital uses the CQC quality risk profile information provided regularly as one of the ways to monitor and control risks to maintaining full registration. A number of other assurance processes are also in place.

BHNFT has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13 (please see below). BHNFT intends to take following actions to address the conclusion or requirements reported by the Care Quality Commission (please see below). BHNFT has made the following progress by 31 March 2013 in taking such action (please see page 104).

Information on the quality of data

Secondary Uses

BHNFT submitted records during 2012/13 to Secondary Uses Service (SUS) for inclusion in hospital episode statistics, which are included in the latest published data of April 2012 – January 2013.

The percentage of records in the published data included:

- The patient's valid NHS number was: 99.5% for admitted patient care; 99.7% for outpatient care; and 98.5% for accident and emergency care
- The patient's valid General Medical Practice Code was 100% for admitted patient care, 100% for outpatient care and 100% for accident and emergency care.

Clinical Coding

Clinical coding is the translation of medical terminology written by the clinicians to describe a patient's diagnosis, complaint, treatment or reason for seeking medical attention, into a coded format, which is nationally and internationally recognised.

The clinical coded data is used for the following:

- Statistics
- Planning
- Funding
- Clinical audit
- Epidemiological Studies

The accuracy of this coding is a fundamental indicator of the accuracy of the patient records.

The hospital was subject to the Payment by Results (PbR) and IG clinical coding audit.

The IG audit undertaken covered a random sample of 200 episodes of care across the whole range of services covered by a mandatory PbR tariff.

Results of the IG toolkit audit are as follows:

	Correct (%) 2012	Correct (%) 2013
Primary Diagnosis	95.0	97.0
Secondary Diagnosis	86.2	91.0
Primary Procedures	94.3	93.4
Secondary Procedures	96.7	93.7

There was a slight dip in compliance for primary and secondary procedures; however the hospital

achieved Level 2 compliance, which is satisfactory.

BHNFT was subject to Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period of diagnosis and treatment coding (ICD-10 codes W00 to W19-falls, DZA11, DZB11, DZC11-pneumonia) were incorrect coding 6.9% for falls admission and 6.7% were for pneumonia

The PbR audit undertaken covered 120 episodes of care with a diagnosis of Pneumonia and patients admitted with a fall under Geriatric, General Medicine and Trauma and Orthopaedic specialties.

Results of the PbR audit are as follows:

	Correct (%) 2012	Correct (%) 2013
Primary Diagnosis	87.5	95.0
Secondary Diagnosis	83.1	94.0
Primary Procedures	93.3	91.0
Secondary Procedures	97.3	96.0

The results of the audits should not be extrapolated further than the actual sample audited. The results of the audits did however show that improvement in the quality of the clinical coding was achieved in these areas.

Actions to improve clinical coding quality at the hospital continue via:

- Monitoring, spot checking and auditing of clinical coding by senior clinical coding staff, ensuring feedback is given to all coders.
- Continuous internal and external training of coders to ensure clinical coding skills are kept up to date.
- Improving communication between clinicians and coders
- Validation of specified diagnoses from clinicians on a weekly basis.

Information Governance

The hospital's Information Governance Assessment Report overall score for 2012/13 was 83% satisfactory compliance following Information Governance Board (IGB) sign-off (1 March). This compares with 82% satisfactory compliance for 2011/12.

The IG Toolkit is available on the Connecting for Health Website www.connectingforhealth.nhs.uk

The information quality and records management attainment levels assessed within the IG Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

Serious Incident

A single incident occurred in 2012 after the hospital's internal processes for the delivery of a new system of work were not met. This led to a breach of patient confidentiality and consequently a serious incident.

The hospital adopted an open and honest approach to the incident and conducted a thorough investigation with escalation to the hospital's Commissioner's, the SHA and the Information Commissioner's Office (ICO).

Individuals affected by the breach of confidentiality were duly informed by

the hospital and a support line was operated through the Patient Advice and Liaison service.

The ICO were satisfied that the hospital had the necessary internal processes in place and had they been followed correctly the breach may have been prevented. They gave the recommendation that all staff involved in projects involving personal data are fully trained in the requirements of the Data Protection Act, and that they have received the relevant training in the roles that they are undertaking. This recommendation has been taken forward.

CQC Special reviews or investigations

Termination of Pregnancy

The hospital was visited on the 21 March 2012 as part of the CQC's national targeted programme assessing arrangements for termination of pregnancy across all care providers.

The hospital received an initial draft report in April 2012 and then received a final report at the end of May 2012. The report highlighted a minor concern concerning record keeping which the hospital immediately actioned.

The CQC revisited the hospital on the 4 October 2012 to re- assess record keeping compliance and found the hospital to be fully compliant; this was formally reported at the end of October 2012.

Ionising Radiation Medical Exposure Regulations 2000 IR(ME)R

The hospital was visited on the 1 May 2012 to assess the hospital's compliance with the IR(ME)R regulations; the CQC outlined a number of changes that they would like to see within the hospital's imaging departmental procedures. These changes were all made and submitted to the CQC and the hospital was declared compliant in December 2012.

Full Outcomes Inspection

The hospital were visited on the 28 January 2013 and were assessed across four outcomes in four clinical ward areas and the hospital were found to be fully compliant against all outcomes in all clinical areas the final report was published at the end of February 2013.

What everyone else is saying about us

The information provided on the NHS Choices Website in March 2013 rates BHNFT as

 4.5/5 stars

And rated specifics as follows:

Cleanliness

Staff co-operation

Dignity and respect

Involvement in decisions

Same-sex accommodation

Patient feedback is invaluable to help us to continually improve the quality of services and patient care we provide. This feedback is gained in a number of different ways - NHS choices, other social media, the CQC, national inpatient and outpatient surveys as well as through our own staff using an electronic patient data collection system.

CQC In-Patient Survey 2012

All NHS adult inpatient areas are subject to an annual patient survey reported via the Care Quality Commission (CQC). Whilst other areas of NHS care (e.g. outpatient) are also surveyed in this manner, the adult inpatient survey is the only area that is routinely surveyed on an annual basis.

This was the tenth survey of adult inpatients and involved 156 acute and specialist NHS Trusts. A total of 64,500 patients responded providing a national response rate of 51%.

The hospital's response rate was 46% which is 5% below the national average and translates into an overall total of 375 respondents.

Currently the Matrons, through their regular report to the Chief Nurse and the Clinical Governance Committee, are routinely surveying approximately 200 patients each month. This translates to over 2,000 patients across the year providing direct feedback on their current view of their experience as a patient in the hospital.

In comparison the CQC inpatient survey provides information from patients who experienced at least one night of hospital stay during June, July or August 2012, not under the age of 16 and not admitted to either maternity or psychiatric units. The results reflect the views of patients who received treatment in summer 2012 and completed the postal survey questionnaire later in the autumn. Thus, whilst clearly a valuable source of information, the report findings have been viewed by the hospital in conjunction with messages from the Matrons' work streams.

The full CQC report was published on the CQC website on the 16 April 2013.

On reviewing the hospital's scores against the thresholds for each of the 73 questions the following picture emerges:

Achieves or surpasses the threshold for the highest scoring 20% of NHS Trusts - **Green**	1 questions
Within the remaining 60% of Trusts – **Amber**	72 questions
Is within or below the threshold for the lowest scoring 20% of NHS Trusts - **Red**	0 questions

Friends and Family Test (FFT)

From April 2013 all health care organisations providing inpatient or Accident and Emergency (A&E) services will be required to promote a response from those using these services to the following question.

"How likely are you to recommend our ward/A&E to friends or family if they needed care or treatment?" with responses ranging from extremely likely to extremely unlikely.

The initial target response rate is 15%.

The results of the national survey will be published in July 2013 on the NHS Choices website.

We have been delivering FFT since the beginning of February as part of our wider patient experience strategy. All patients who have spent a night here or been discharged from the Emergency Department (ED) are now being asked how likely they are to recommend our wards and departments to friends and family in need of similar treatment.

The Chief Nurse has written to all staff describing the FFT as an important national initiative aiming to improve patient care by giving an insight into how well hospitals are performing in the eyes of their patients, and assisting people in making decisions about their care. She has also set staff the following challenge:

"One way to help ensure we're delivering a consistently good patient experience is to ask ourselves the same question - would we recommend this hospital to our friends and family"?

Starting on 22 March, we are launching a three-week campaign to get staff views on what would need to start, stop or change for patients to happily recommend this hospital to friends and family.

We will then use the results to plan important service improvements.

Patient Experience CQUIN – linked to the CQC Patient Survey

The Commissioning for Quality and Innovation (CQUIN) payment framework links a proportion of providers' income to the achievement of local quality improvement goals. Single, composite measure "Improving responsiveness to personal needs of patients" for each organisation has been defined for inclusion as a CQUIN indicator.

This composite measure is made up of the following five survey questions, the results of which are summarised on the right.

Improving responsiveness to personal needs of patients (CQUIN)		
	2011	**2012**
Q 32Were you involved as much as you wanted to be in decisions about your care and treatment?	64.6%	68.8%
Q 34 Did you find someone on the hospital staff to talk to about your worries and fears?	54.6%	58.3%
Q 36 Were you given enough privacy when discussing your condition or treatment?	77.6%	82.4%
Q 56 Did a member of staff tell you about medication side effects to watch for when you went home?	36.6%	47.2%
Q 62 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	73.3%	80.3%
CQUIN 2011	61.3%	
CQUIN 2012	67.4%	

The hospital did achieve this target of 67.4%. The final results are achieved through benchmarking with all other Trusts.

Patients have their say on inpatient experience

The 2012/13 inpatient survey indicates that the hospital scored 'about the same' as other acute trusts on 69 out of the 70 questions in the survey.
On the question of whether hand gels were available for patients and visitors to use, the hospital scored extremely highly, with a score of 9.9 out 10 - amongst the best performance in the country.

Other high scores were seen on issues such as not feeling threatened by other patients or visitors, with a score of 9.6, and not sharing a sleeping area with a member of the opposite sex, with a score of 9.4, although these scores still showed no major differences from most other trusts in the country.

There were areas where there is room for improvement were identified and include being given information on how to complain about the care a patient has received, which scored only 1.4 out of 10, and patients being asked to give their views on the quality of care they received, which scored 0.9 out of 10.

The hospital saw significant improvements on last year's scores in five areas, all within the area of 'leaving hospital'. These included patients being given written information about what they should or should not do after leaving hospital, members of staff explaining the purpose of medicines to be taken home, and members of staff telling patients who to contact if they were worried about their condition or treatment after they left hospital.

The hospital did not see a significant decline on any questions since 2011 and the response rate was 46%, 1% higher than in 2011 but 5% lower than the national average.

NHS Constitution

We continually review our legal obligations to the NHS Constitution in relation to the rights and pledges of patients, public and staff. Our reviews show that we were compliant and updates on how we are doing are now regularly taken to the Board.

Staff Survey

We work with our staff to help them deliver the hospital's vision to provide the best healthcare for all.

To recognise and reward our staff we have introduced the "Brilliant Staff Awards" where a monthly award is given to a nominated individual and team.

In order to continually improve and motivate our staff the hospital uses the valuable annual information collected as part of the national NHS staff survey to identify key themes.

The results of the 2012 NHS staff survey were published on the 28 February 2012. A total of 202,000 NHS staff was invited to participate by postal questionnaire. Responses were received from 101,000 staff, a response rate of 50% (compared to 53.7% in 2010).

The results are primarily intended for use by NHS organisations to help them review and improve staff experience so that staff can provide better patient care. The Care Quality Commission will use the results from the survey to monitor ongoing compliance with essential standards of quality and safety. The NHS Commissioning Board will use the results to help make better commissioning decisions. The survey will also support accountability of the Secretary of State for Health to Parliament for delivery of the NHS Constitution.

Improvements have been made in some key areas and levels of job satisfaction and staff engagement have improved on last year. Of 28 key findings, 11 were better than in 2011, one remained the same, 9

deteriorated and 7 cannot be compared to previous results due to changes in the questions.

Our best scores ranked in the top 20% of all acute Trusts and our worst scores where we have been ranked in the bottom 20% have been included here:

Top 5 Ranking

- Percentage of staff receiving health and safety training in last 12 months
- Percentage of staff experiencing physical violence from staff in last 12 months
- Percentage of staff having equality and diversity training in last 12 months
- Percentage of staff believing the hospital provides equal opportunities for career progression or promotion
- Percentage of staff saying hand washing materials are always available

Bottom 5 Ranking

- Percentage of staff suffering work-related stress in last 12 months
- Staff motivation at work
- Percentage of staff agreeing that their role makes a difference to patients
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- Percentage of staff having well structured appraisals in last 12 months

To this end the hospital will continue with the project launched in 2011 - 'Together we will make it better'.

'Together we will make it better'. A different approach, where staff are 'in control', where they tackle an issue or theme by coming up with ideas.

The difference in this approach is that staff are catalysts, or agents, for change.

These teams were established in 2011 through manager and staff nomination of people who they thought would be able to initiate change in different focus groups.

Each group was facilitated by the learning and development team and include an executive sponsor and staff side colleagues.

This work continued in 2012 and saw some really good results; a number of these teams were nominated for Heart Awards (a staff accolade presented at an annual event to praise our staffs' achievements throughout the year).
In addition to this, the hospital has established a Workforce Board, which meets bi-monthly, and reports into the Non-Clinical Governance and Risk, a committee of the Board of Directors.

This committee reviews and monitors a number of work force measures that help to show us when issues need to be addressed to provide a good working environment for our staff.

This committee has also provided the impetus and overarching steer to review and update a number of policies and procedures to better support our staff.

The Health and Safety Board has also been reinvigorated during this year, placing a higher emphasis on mitigating health and safety risks and

providing assurance that the right actions are being taken hospital wide.

The health and safety training we provide to our staff has been completely reviewed during the year and a new risk assessment training programme will be delivered from now on to better meet the competencies our staff have said they need.

Complaints & Patient Advice Liaison Service (PALS)

The information on the following page gives an overview of the formal complaints received by BHNFT between April 2012 and March 2013, along with the informal complaints and concerns dealt with by the PALS Team in the same period.

We assess and monitor the improvements we action from every single complaint. We carry out monthly analysis and reviews of our complaints in order to learn and improve from the feedback and experiences of our service users and the following are just some of the improvements we have made in 2012/13;

- Liaison with Weston Park to identify a streamlined pathway of returning test results to correct location and consultant within the hospital.
- Refresher training has been offered to staff where required for inputting data onto PAS (electronic Patient Administration System) to improve accuracy of information.
- Individual staff members have been monitored where it has been highlighted that procedures or behaviours are not of an acceptable standard. Examples include injection procedures, assessment of patients with abdominal pain, adherence to uniform policy, communication skills, intravenous medicines management, assessing patients with learning disabilities.
- Ophthalmology consultants will request shared care with the Paediatric department for children requiring sedation during a procedure.
- Emergency department guidelines have been produced regarding patients with specific spinal problems.
- Customer care training has been revised and is being rolled out across the hospital.
- The patient's property form has been reviewed to ensure better recording.
- Security team to receive customer care training.
- Additional chest drain training has taken place to improve competency of all doctors carrying out this procedure.
- Additional clinical audits have taken place including patients receiving correct appointments in the Outpatients department, pain and analgesia in the Emergency department, mobility assessments in the Emergency department.
- Imaging protocols and the clinical pathway for patients with breast augmentation have been reviewed to minimise the chance of cancers being missed in this group of patients.
- Child Death Rapid Response protocol has been reviewed and the Police and Coroner have been informed of the reviewed protocol.

Complaints received by the Ombudsman

In 2012/13 the Ombudsman accepted two complaints for investigation. Those investigations are still ongoing and the Trust awaits a decision from those investigations.

In the year 2011/12 the Ombudsman accepted two complaints for investigation and the final reports from those investigations were received in this financial year. One complaint was partly upheld, the other fully upheld by the Ombudsman.

These complaints have been fully investigated by the hospital and the Ombudsman investigators. Action plans have been developed and are being implemented and monitored by this hospital.

Valuable learning has been identified in both cases.

The Discharge Policy has been amended to include information about out of area patients who choose not to return to BHNFT for treatment.

Improvements have been made to the booking-in process in the Emergency Department for collecting GP details, and the implementation of digital dictation. The new system will lead to a more effective and efficient way to complete communications from consultation to informing GPs of any outcomes.

Complaints & Patient Advice Liaison Service (PALS) Information

	Formal Complaints	PALS Concerns
All aspects of clinical treatment	201	204
Attitude of Staff	11	74
Communication to Patients	14	208
Appointments	9	152
Admission/discharge/transfer arrangements	11	57
Operations: delays/cancellations	0	45
Privacy & Dignity	4	10
Failure to Follow Procedure	3	11
Consent to treatment	0	1
Hotel Services (inc food)	0	7
Other	12	58
Transport	0	11
Patient's property & expenses	2	16
Personal records	2	9
Aids and appliances	0	7
Policy & commercial decisions	2	0
Mortuary/PM arrangements	1	0
Support/Advice (PALS only)	0	614
Total	272	1484

Patient Reported Outcome Measures (PROMs)

PROMs are a way of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. In order to collect this information, questionnaires are completed by patients before and after surgery and a health gain is calculated by subtracting the score before the operation from the score after the operation.

Data has been collected since 2009 on four different surgical operations, which are; groin hernia, hip and knee replacements and varicose vein surgery.

For Yorkshire and the Humber Strategic Health Authority the participation and response rates across all procedures are generally in line with, or slightly ahead of the national average. Both rates are higher for hip and knee replacements than for groin hernias or varicose veins. (Indicator for clinical effectiveness, patient safety and patient experience).

With regards to health gain scores it is recognised that the population of Barnsley generally has poorer health than other areas of the country and therefore reported health scores are recorded lower than average within the initial questionnaire resulting in a lower reported health benefit following surgical intervention. This is most significant for the hip replacement scores.

The latest published data as at March 2013 is published on the next page.

Little can be discerned from the 2012/13 information, as the volumes reported on to date are too small to be statistically meaningful. However, participation rates for hip and knee replacements that had reduced in 2011/12 appear to have recovered to better levels.

PROMs procedures are reported across three elements:

1. General health and well being
2. "How do you feel today" assessment
3. A section specific to the condition.

The refreshed 2011/12 information reports that our position regarding hip replacements is improved, showing only one alert (condition-specific) where previously we had two (general health and well being and condition-specific).

An analysis of these results illustrates:

⇒ The most notable change is that we are no longer an outlier for the general health gain element for hip replacements. (Indicator for Clinical effectiveness and patient safety)

⇒ Our condition-specific health gain position is also improved. This is through the review of responses of case mix adjusted questionnaires 1 and 2 which captures the improvements in the patients health following the procedure.(Indicator for patient experience and patient safety)

A detailed action plan is currently being delivered to further improve our performance. This includes the development of a Hip Rehabilitation group and extending the use of the enhanced recovery programme across the orthopaedic pathways. (Indicator for patient experience and clinical effectiveness)

"Staff and doctors are exceptional and make you feel like an individual. They are caring, compassionate and friendly"

The latest published data as at February 2013 is detailed below:

		BHNFT				National			
Procedure	**Measure**	**2009/10 (Finalised)**	**2010/11 (Finalised)**	**2011/12 (Provisional)**	**2012/13 (Provisional)**	**2009/10 (Finalised)**	**2010/11 (Finalised)**	**2011/12 (Provisional)**	**2012/13 (Provisional)**
Hip Replacement	EQ-5D	0.337	0.335	0.321	*	0.411	0.405	0.423	0.437
	EQ-VAS	5.797	6.186	10.146	*	8.955	9.182	10.129	10.863
	Oxford Hip	16.560	15.942	16.166	*	19.655	19.717	20.270	20.889
	Participation Rate	84.5%	94.5%	85.7%	89.9%	76.3%	78.8%	80.8%	79.5%
	Completed Q1	175	189	168	71	48,515	54,991	42,848	28,511
Knee Replacement	EQ-5D	0.245	0.264	0.332	*	0.295	0.299	0.313	0.312
	EQ-VAS	-0.121	2.556	5.801	*	3.043	3.110	5.056	4.824
	Oxford Knee	12.846	13.863	15.955	*	14.624	14.873	15.369	15.509
	Participation Rate	90.4%	100.0%	76.2%	96.3%	78.4%	83.7%	85.4%	86.9%
	Completed Q1	328	335	291	157	56,925	63,023	48,575	32,603

Groin Hernia Repair	EQ-5D	0.082	0.089	0.0.98	*	0.082	0.085	0.089	0.091
	EQ-VAS	-3.277	-2.931	-0.942	*	-0.932	0.538	-0.256	-0.603
	Participation Rate	50.5%	43.6%	46.7%	38.1%	55.0%	55.7%	59.0%	62.9%
	Completed Q1	148	115	147	43	37,765	37,939	30,482	20,945

Varicose Veins	EQ-5D	*	*	0.06	*	0.094	0.091	0.094	0.093
	EQ-VAS	1.195	*	-0.023	*	-0.366	-0.091	0.298	0.520
	Aberdeen	-4.462	*	-9.447	*	-7.930	-7.518	-8.173	-8.326
	Participation Rate	45.1%	46.2%	47.4%	53.6%	43.4%	47.7%	48.3%	33.3%
	Completed Q1	55	43	45	30	15,137	15,394	9,498	3,906

= Negative alarm (between 95% and 99.8% lower control limits)
= Negative alert (below 99.8% lower control limit)
= Numbers of linked questionnaires too low for statistical processes
2009/10 data was finalised August 2011
2010/11 data was finalised August 2012

*

Table B - National Indicators

Indicator	Reporting Period	Trust Scores	National Average	Highest Score NHS FT	Highest Score NHS Trust	Lowest Score NHS FT	Lowest Score NHS Trust
Summary Hospital Mortality Indicator (SHMI)	Jul 11 to Jun 12	108	100	71	71	126	119
	Oct 11 to Sept 12	106	100	68	71	121	115
The Palliative Care Indicator	Jul 11 to Jun 12	0.7%	Not Available	3.3%	2.8%	0%	0%
	Oct 11 to Sept 12	0.8%	Not Available	3.2%	2.8%	0%	0%
Patient Reported Outcome Measures (PROMs)	Refer to table on page 114						
% of patients readmitted to the hospital within 28 days of being discharged.							
Age 0-14 years	2010/11	9.59	9.99	14.13	16.98	5.80	3.69
	2012/13	2.39%	These are locally calculated figures using the national PbR definitions for 30 day readmissions. They are not comparable with the externally published data which uses outcomes framework definitions and is standardised.				
Age 15 or over	2010/11	10.15	9.64	12.53	18.57	3.26	4.34
	2012/13	6.51%	These are locally calculated figures using the national PbR definitions for 30 day readmissions. They are not comparable with the externally published data which uses outcomes framework definitions and is standardised.				
Patient Survey - responsiveness to patients needs	2011/12	67.4	67.4	85 (Only gives Trust codes so not able to split between FT and non FT)		54.6 (Only gives Trust codes so not able to split between Ft and non FT)	
% of staff employed by the hospital who would recommend the hospital as a provider of care to their friends or family	2012/13 (sample size 800, 500 returned = 67.1%)	3.66	3.57	4.08		Not known	Not known
% of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)	Q3 2012 /13	92.1%	98.1%	99.9%	99.5%	88.5%	84.6%
The Rate of C Diff per 100,000 bed days	2011/2012	20.1	21.8	Not known	Not known	Not known	Not known

The number and rate of Patient Safety Incidents and the number and % that resulted in severe harm or death	2012/2013 (April-Sept NRLS Data) October to March data has not yet been released	Total no. of patient safety incidents reported =4.6% Deaths=0.5% Severe=1%	Total no. of patient safety incidents reported =6.5% Deaths=0.2% Severe=0.7%	Not known	Not known	Not known	Not known
	2012/13	Total Incidents reported = 3618 No harm = 3028 Low = 471 Moderate = 73 Combined as Severe/Death =46	Total figures for 2012/13 – Information generated from local Sentinel system. The last 6 months data has not been submitted to NRLS and published. Therefore, there has been no data cleansing with the information provided in this section and may change following national publication. Please note that we will update the Quality Account once the NRLS data is published.	Not known	Not known	Not known	Not known

Indicator	**Data Source**
Mortality (SHMI)	National Information Centre
PROMS	National Information Centre
Patient Survey	National Information Centre
Staff Survey	National Information Centre
VTE	National Information Centre
C Diff	National Information Centre (HPA)
No. of patient safety incidents	NRLS and internal Sentinel system

Table C – Evaluation of Performance

BHNFT considers that this data is as described for the following reasons:	BHNFT intends to take and has taken the following actions to improve this score, and so the quality of its services, by:
The Summary Hospital Mortality Indicator (SHMI) is higher than the national level.	The Trust has a full plan in place see page 72 of this report.
Palliative care indicator. Currently the National Average figures have not been released. However, the Trust will continue to monitor any new information to be released.	The Trust will benchmark and review its performance against the standards achieved, when they are released.
Patient Reported Outcome Measures (PROMS). The Trust has seen an improvement in the general health gain for patients undergoing hip replacements. The Trust remains an outlier for knee replacement patients.	The Trust has a full action plan in place to improve the outcomes for knee replacement patients.
Patient's readmitted to the hospital within 28 days. The Trust has not received data for 11/12 and 12/13. Previous performance of the Trust is at the national average.	The Trust is vigilant in monitoring the re-admission rate across the Trust and the data is incorporated into the dashboard.
Patient Survey. The Trust achieved the national average responsiveness to patient's needs.	The Trust is implementing a number of different ways of ascertaining the patient's views in order to improve services.
Staff employed by the hospital recommended the hospital as a provider of care to their friends and family at a higher rate than the national average.	The Trust has an organisational development framework in place which is aimed at increasing engagement and empowerment of our staff.
The Trust achieved the national level of over 90% of VTE assessment.	The Trust is auditing and working with clinical teams to improve the rate of risk assessment on admission for VTE.
The Trust is pleased with the continuous reduction in the rate of patients with C Diff.	The Trust maintains its focus on reducing the rate of hospital associated infections.
The rate of reporting of patient safety incidents is lower that the national average and the death and severe harm is slightly higher that the national average. The Trust monitors closely the rate of patient safety incidents	The Trust has now implemented a new risk management reporting system (DATIX) which will improve access for all staff for reporting incidents. Managers and Senior staff will also be able to monitor investigations recommendations and actions to improve care and reduce reoccurrence. The system will comprehensively produce reports and triangulate against other factors such as complaints, PALS and claims.

Part Three

Other Information
Review of Quality Performance

The following section presents information relating to the quality of services that we provide.

The information will outline our performance against National Priorities and Core Standards as well as the measures agreed locally as part of our Quality Account last year.

It is important to note the standards set by Monitor Compliance Framework 2012/13 (please see page 64). These standards along with our previous performance sets the agenda for discussion and agreement with our Commissioners in approving and setting our priorities for 2013/14 (please see page 61).

In Part 2 we have demonstrated how we have performed with nationally set priorities including setting new standards and goals to improve the quality of care in 2013/14. This section shows comparisons with national priorities.

Overview of our performance in 2012/13 against the key national priorities from the Department of Health's Operating Framework and against the Department of Health's National Core Standards

We have chosen our areas for performance improvement through engagement with patients, staff, Governors and the Board of Directors. This has involved discussions of last year's areas for improvement and consideration of areas that the aforementioned groups would like to see improvement on. Each domain has at least three indicators and associated metrics for improvement. These will be reported to the Board on a monthly basis as part of the Board's Integrated Performance Report. These indicators are also aligned to the Quality, Innovation, Productivity and Prevention (QIPP) agenda. Please see tables D and E with regards to performance on key identified priorities for 2012/13. Please also see table C, the Evaluation of Performance.

The headline measures for improving quality (safety, effectiveness and patient experience) were identified as:

- Reducing Health Care Associated Infections (MRSA and C Diff)
- Patient Experience Survey
- Patient Access - Referral to Treatment Times (Maximum time of 18 weeks from referral to treatment)
- Eliminating Mixed Sex Accommodation
- Delivering the A&E Quality Indicators
- Delivering Cancer Targets
- Reducing Emergency Readmissions

Health Care Associated Infections (HCAI)

This year we have had zero MRSA bacteraemia cases and only 22 of C Diff against a target of 31 cases.

Utilising feedback from the patient surveys, it is notable that patients are commenting and are satisfied with our levels of cleanliness and standards of practice.

Overall compliance with hand hygiene currently rests at 99.4%, which demonstrates the efforts we have made to raise the performance to meet our 100% target. Hand hygiene compliance is reported monthly to the Board of Directors, and quarterly reports from infection, prevention and control are provided quarterly for the Board.

We have also declared 100% compliance with screening for MRSA; this standard requires all patients to be screened on admissions as an emergency or prior to admission for surgery.

Patient Experience

As described in section 3 of the report the hospital has delivered the national CQUIN responsive to patient needs, as measured through the CQC Patient Survey. The hospital has invested in the development of its Patient Experience Team, increasing the number of staff to respond to patient enquiries.

As you will see from both the Patient Survey section and the Complaints section of the report, some progress is

being made in improving the experience we provide to our patients.

The hospital approved the updated Patient Experience Strategy at the December 2012 Board meeting and will continue to drive this agenda and learn from our patients and staff through FFT and our on-line Staff Echo survey of this scheme.

Access

The hospital has delivered against the access targets to ensure that all our patients are treated within 18 weeks from their referral.

Additionally the hospital has ensured that access for vulnerable patients is considered and managed to the highest standards. Examples are detailed below:

Safeguarding Adults

Safeguarding vulnerable adults is one of our key priorities. The hospital works in partnership with the Barnsley health and social care community to ensure a strong partnership approach. There is a Safeguarding Adults Steering Group that oversees the safeguarding agenda within the hospital. The flow of information into this group comes from two main sources, the Deputy Chief Nurse who is a member of the Barnsley Safeguarding Adults Board, and the Named Nurse for Safeguarding Adults who is a member of several of the Barnsley partnership sub groups. This enables the Safeguarding Adults Steering Group to be fully appraised of local and national developments.

Staff receive training to enable them to identify signs of possible abuse and are aware of the procedures to follow and who key members of staff are who have in-depth knowledge to assist and give advice. This includes implementation of the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards, which help to protect the rights of those patients who do not have capacity to make decisions for themselves.

Learning Disabilities

The hospital continues to make progress in the work on improving the experience of patients within the hospital who have learning disabilities. Progress continues in the development of the "All About Me Passport' that patients carry so that their care, treatment and preferences are known.

Work has also been taking place to produce information leaflets in easy read format. We have appointed a Specialist Nurse in this area this year to lead and further improve the quality of services and adaptation to support this group of patients.

A reasonable adjustments document has been developed to help staff to consider adjustments to care delivery that are suited to individual patient's needs. This links with the development of individual care pathways that support the needs and preferences of patients with learning disabilities. It includes visits to become familiar with clinical areas before their planned admission and arrangements for family and carers to remain on wards during hospital stays.

The culmination of this work has been the commitment of the hospital to the Mencap charter 'Getting it Right'. The Board of Directors has endorsed this.

Ethnicity Needs

For any patient who does not speak or read English the hospital can provide information in a range of different languages and can also arrange interpreter services. The hospital can accommodate a range of different types of meals, including Halal, and patients and visitors have access to a chapel and a prayer room for their spiritual and religious needs.

Dementia

A Dementia Strategy Steering Group has been established to support the implementation of our Dementia Strategy, a plan which details our actions to ensure that patients with dementia receive high quality care and treatment that is delivered in environments that are proved to help keep patients calm and eliminate anxiety related to a change of circumstance.

"Dementia screening" and "dementia mapping" are central to helping and supporting our patients and this year we have trained a large group of our staff to be able to undertake these specialist processes.

The hospital has performed really well in the second round of the national dementia audit. We have improved from the last round and are significantly better than the national average in the vast majority of domains.

Areas of good practice are:

- Nutrition
- Patient routines and preferences
- Early discharge planning top quartile
- Length of stay 12 days versus national average of 14 days
- More patients returning to own home Barnsley 46.4% against a 34.6% national average
- Pressure ulcer assessment better than national average and doubled since first round of audit

Eliminating Mixed Sex Accommodation

The hospital has been fully compliant with all the standards associated with delivering this requirement from June 2011 onwards, but unfortunately we were unable to meet the standard for one patient in March 2013.

The hospital is committed to organising its facilities to eliminate mixed sex accommodation. We will continue to work hard to provide this to make sure all patients are treated with dignity and respect at all times.

Delivering the A&E target

The Accident and Emergency Department (ED) less than four hours to treatment target of 95% for all patients has proved problematic for the hospital this year due to above average increase in numbers of patients attending the hospital.

A full list of actions and refurbishment work is being progressed to ensure that the hospital is able to deliver this requirement and provide a high quality service to our emergency patients.

Cancer

The hospital continues to perform well against the numerous cancer targets, except in two cases where patients'

choice for attending in quarters 3 and 4.

Readmissions

All readmissions to the hospital are investigated in order that the hospital can understand the causes, and implement solutions to continually improve performance.

Monitor Risk Ratings

Monitor authorises and regulates NHS Foundation Trusts and supports their development, ensuring they are well governed and financially robust.

BHNFT is a Foundation Trust and as such performance is checked by Monitor.

Monitor uses a risk-based approach to determine its level of intervention. Hospitals are rated across three criteria, Finance, Quality and Governance. Risk ratings are then assigned and displayed publicly on Monitor's website.

The Financial Risk Rating (FRR) is scored 1-5, 1 being a high risk organisation and 5 being a low risk.
Foundation Trusts are required to maintain a FRR rating of at least 3.
The Governance Risk Rating (GRR) is rated across four grades: Red, Red Amber, Amber Green and Green, Red depicting high risk and Green Low Risk.

Most foundations are monitored on a quarterly basis unless they are indicating high risks against these measures.

The hospital has to provide a forecast of how they will perform over the next year against their FRR and GRR. The table opposite details what we said we would do against our actual performance for the year.

Reporting Period	Plan		Actual	
	FRR	GRR	FRR	GRR
Quarter 1Apr-Jun 2012	3	Green	3	Green
Quarter 2 Jul-Sep 2012	3	Green	3	Green
Quarter 3 Aug-Dec 2012	3	Green	3	Amber/Green
Quarter 4 Jan-Mar 2013	3	Green	3	Amber/Green

The hospital has consistently delivered the financial plan throughout the year.

The governance risk rating has unfortunately not been delivered to plan in 2012/13. This rating was reduced as the hospital failed to deliver the 95% maximum waiting time of four hours from arrival to admission, discharge or transfer in ED. The hospital failed this target in Quarter 3 and Quarter 4 as a result of an increase in demand at a time when the hospital faces a higher pressure on the hospital's available beds. The hospital's senior operational team are working both hospital-wide and with the wider health community to recover this position and deliver a timely consistent service for our patients in 2013/14.

The hospital has already added to its plans and has introduced new procedures and processes. The hospital has also commissioned an external review to help us assess our care pathways to identify further actions to restore our performance.

The hospital also marginally failed on the 93% cancer targets for breast

symptomatic in Quarter 3 and two week waits in Quarter 4. Trying to manage these targets whilst offering patients appointment choices to meet their personal commitments is often problematic and on these occasions the hospital marginally failed to deliver this balance.

"The response from the staff at Surgical Assessment Unit was tremendous and I was very well looked after. Everyone there was very kind, helpful and professional."

Table D – Overview of Performance against the 2012/13 National Priorities and Core Standards

National Priority	2010/11	2011/12	2012/13	National Target 2012/13
C Diff	49	28	22	31
MRSA	0	0	0	0
All Cancers 31 Days – subsequent treatments (Surgery)	100%	100%	100%	94%
All Cancers 31 Days - subsequent treatments (Drug Treatments)	100%	100%	100%	98%
All Cancers 31 Days – Radiotherapy	N/A	N/A	N/A	N/A
All Cancers 62-day GP urgent referral to treatment	91.3 %	95.5 %	92.7 %	85%
All Cancers 62 Days – Consultant upgrades	88.5 %	94.9 %	93.5 %	80%
18-week referral-to-treatment target: Admitted patients treated	96.7 %	95.7 %	96%	90%
18-week referral-to-treatment target: Non-admitted patients treated	98.7 %	98.1 %	98.2 %	95%
All Cancers: 31-day diagnosis to treatment	99.3 %	99.8 %	100%	96%
All Cancers: two week wait	96.5 %	96.5 %	94%	93%
Symptomatic Breast Patients – two week wait (non cancer referrals)	95.3 %	94.3 %	93.9 %	93%
Screening all elective in-patients for MRSA	100%	100%	100%	100%
Total time in A&E: four hours or less	95.5 %	95.6 %	93.8 %	95%

NB: Data source – National Information Centre

Table E – Identified areas of priorities			
Priorities	**National CQUIN Priority**	**Issue for Commissioners /Local CQUIN**	**Quality Account Priority**
Safety			●
To improve our knowledge of individual patients nutritional status	●		
VTE Risk assessment (90%)	●		
NHS Safety Thermometer 1			
To reduce catheter associated urinary tract infections (CAUTI)		●	
Paediatric safeguarding (missed appointments)		● ●	
Paediatric safeguarding (A & E)	●		
Patient falls (Part of Safety Thermometer)			
Ensure that the modified early warning score (MEWS) was implemented and that all who triggered were treated appropriately		●	
Clinical Effectiveness			●
Ready to go no delays			
Achieve stretch targets for the number of patients seen in less than 4 hour in the Hospitals Accident & Emergency (A&E)		●	
Reduce the time to correspond with patient's General Practitioner (GPs) following outpatient attendances		●	
Ensure that all patients over 75 years old are assessed for dementia within 48 hours		●	
Patient Experience			●
To reduce the incidence of hospital acquired pressure ulcers			
To deliver an improvement on the 2011/12 patient experience questions in patient satisfaction survey		●	●
To reduce the number of discharge related complaints			●

For additional information on key priorities please see section 2A i), ii) and iii).

Part Four

Annexes

Statements from stakeholder organisations

In order to ensure the information contained in the Quality Account is accurate, fair, and gives a representative balanced view, our Quality Account has been shared with:

- **Barnsley Healthwatch (was Barnsley LINk)**
- **Barnsley Clinical Care Commissioning Group, as our lead commissioner**
- **Overview and Scrutiny Committee**

Additionally comments have been sought from the Hospitals Council of Governors.

We are grateful for the time and effort they have put in to provide us with their comments, which are included on the following pages.

Annex 1

Barnsley Healthwatch comments on BHNFT Quality Account 2012/13

Barnsley Healthwatch welcomes the opportunity to comment on Barnsley Hospital NHS Foundation Trust's 2012/13 Quality Account.

The following comments have been compiled by Healthwatch.

Healthwatch Barnsley Came into force on the 1st of April 2013 and received the Quality Account for Barnsley Hospital Foundation Trust on the 5th of April 2013. Healthwatch has e-mailed members with the Barnsley Hospital Quality Account asking for feedback, we also featured the Quality Account on our Website, Facebook and Twitter. Due to Healthwatch Barnsley being a new organisation with limited time and resource at this early stage, we have on this occasion been unable to collate community views on the Quality Account to share in this report. We are however planning on ensuring the data we collect from the 1st of April will enable us to identify who attends the hospital on a regular basis, with recent experience of the service and an opinion to share. The aim to bring together a focus group on a yearly basis to review the quality account, with the support of a representative of the hospital, to provide information on the quality account and answer any questions relating to the document. Thus ensuring participants are fully informed and able to comment effectively.

Barnsley Clinical Commissioning Group comments on BHNFT Quality Account 2012/13

The Barnsley Clinical Commissioning Group (BCCG) welcomes the opportunity to comment on Barnsley Hospital NHS Foundation Trust's 2012/13 Quality Account.

The following comments have been compiled by a group of (BCCG) members.

The account was presented to our Quality and Patient Safety Committee last week where members discussed the various sections contained within the account.

We welcomed the report which is clearly presented, concise and covers salient points which we already had knowledge of.

From our discussions we have the following comments which we hope will be helpful: -

We compliment you on the work you have undertaken with PROMS and look forward to the outcomes from the Friends and Family Test.

We would also like to express our appreciation on the significant progress made with respect to patient's knowledge of medication upon discharge.

We recognise the work that has been undertaken regarding HSMR and look forward to further improvement. Future clarification is suggested on the presentation of data.

Suggestions include: -

- Including surrounding areas
- Dividing the data into cohorts

- Benchmarking data against national databases.

We would have liked to have seen more information regarding the delivery of the A&E target in 13/14 as this is so critical in the forthcoming year.

We couldn't see reference to the continuing work being carried out on early warning scores, from the account it looks like this work has been completed.

In relation to the staff survey, in light of the challenging year ahead, we share your concern regarding the aspects ranked lowest being in relation to staff moral and staff appraisal however we appreciate that the data is from some months ago and should not be seen in isolation.

Infection control - whilst acknowledging the achievement of the 12/13 trajectory it must be noted that in comparison to other similar DGHs the trajectory was more lenient and that the reduced trajectory for 13/14 is more challenging to which the CCG is committed to working on with you.

With the increasing number of people suffering from dementia, as commissioners we would have liked to see more emphasis being placed beyond the nationally mandated work on assessment and diagnosis e.g. reference to CQUINS for identification and support of carer's which we know is occurring.

We are looking forward to seeing the development and innovations from the appointment of the Learning Disability Liaison Nurse who was appointed in early 2012.

We are pleased to see that BHNFT were able to make changes to the record keeping procedure for TOPs to satisfy the CQC when they are inspected in October 2012, however we would have preferred to see some more detail as to what the record keeping concerns were initially as the information presented does not fully outline the nature of the problem that the CQC found though note its resolution.

We hope the above comments are useful and look forward to working with you over the next year 2013/2014.

BHNFT Council of Governors comments on BHNFT Quality Account 2012/13

The BHNFT's Council of Governors welcomes the opportunity to comment on BHNFT's 2012/13 Quality Account.

The following comments have been compiled by the Council of Governors.

At the Governors' General Meeting held in April, the Strategy & Performance sub-group was mandated to prepare and submit a collective response on behalf of the Council of Governors. The QA was discussed at the sub-group meeting held on 14th May and our collective response subsequently agreed. Copies of the initial draft of this submission were issued to all governors to ensure that any objectives or amendments could be received and taken into account before the final reply was agreed.

In terms of general content overall, the governors have been even more involved this year with the development of the QA and are pleased to support its content.
We have looked in particular at each of the agreed indicators and priorities for

2012/13. As governors we attend and observe Board meetings where these items are regularly reported on. Throughout the year we have requested and received more information on the performance of many of these areas at our sub-group and general meetings, supporting the Board's focus on key points such as HSMR, serious incidents and A&E pressures. We have also been pleased to be involved with and support developments such as the new Acute Medical Unit, which Governors have visited – bringing valuable improvement to the patient experience and clinical effectiveness. Additionally we have used our continuing programme of unannounced inspections to be able to talk directly to patients and learn their views on how they are being looked after as well as making our own observations on the environment and the care they receive during these visits and the fortnightly patient environment action team (PEAT) visits that governors were also involved with throughout the year. Some of us have also been patients at the hospital over the past 12 months and been able to share and reflect upon our personal experiences, as well as share learning and comments from the members whom we represent and who share their experiences – good and bad – with us throughout the year too, all of which we bring to the Trust and all of which is acknowledged, listened to, discussed and used for learning and improvements.

Collectively this has given us awareness and assurance on the Trust's focus and progress on patient safety, clinical effectiveness and patient experience, and confidence of the Trust's appetite for acknowledging areas for improvement and on-going work to address these. The comments below highlight just a few of the points we have noted in year

- Patient Safety
  - Continuing good performance on infection prevention & control (IP&C) is notable, including zero cases of MRSA and a further reduction in Clostridium Difficile. The Trust's focus on IP&C and hygiene is often complimented by patients in our governors' visits.
  - The Trust's response to the OFSTED report Children's services in Barnsley was valued; whilst few criticisms were found in terms of health services it was encouraging to note the Trust's involvement with the community-wide work in this important area of safeguarding.
  - It is disappointing to note the Trust's reduced performance on weighing in the final quarter of 2012/13 despite good progress in quarters 1-3.
  - Recording of five never events is disappointing but the governors value the Trust's transparency in sharing information on each such event, the thorough investigations undertaken and the lessons learned.
  - The governors also support the Trust continuing to encourage more patients to complain – to help us learn and drive further

improvements to patients' services. We are keen to hear more about the changes to the Trust's monitoring of complaints (and compliments!) so that when we read the regular complaints reports we can more easily see the actions taken.

- Clinical effectiveness
  - Supporting the indicator for assessing patient over 75 years old, the introduction of the Butterfly scheme has been appreciated - helping staff to be more aware of any patients with memory, orientation or anxiety problems
  - Whilst improvement in HSMR (and SHMI) has been slower than hoped – but still notable - the Board's continuing focus on this is appreciated and fully supported by the governors.

  - In terms of discharge, as mentioned earlier some governors have had personal experience as an inpatient this year and have commented on the better information provided (with medication etc.) at discharge, which is a welcome improvement.

  - The sub-groups have also continued to receive updates on the wide-ranging transformation programmes, which will help to support further improvements in patient pathways and consistency in care.

- Patient Experience
  - As mentioned, we have actively sought feedback directly from patients whilst in hospital as part of our governors' visits. This has been overwhelmingly positive – but there is always opportunity for learning (see comment above re complaints).

  - Progress against the 2012/13 indicators is noted.

  - Continuing pressure on the Trust's services has resulted in breaches in the <4 hours target for quarters 3 and 4 of 2012/13 and as a consequence a small number of patients have experienced longer waits in A&E. Amongst other work, the opening of the new AMU has helped to keep these numbers lower than they might have been. Governors are keen to support the Trust's robust action plan to redress this position as quickly as possible to improve patients' experience, as well as achieving national targets.

Staff are vital to the delivery of these critical elements of patient safety, clinical effectiveness and patient experience. Governors were pleased to note the continuing focus and improvements on the uptake of mandatory training and appraisals – and plans for further work and support for staff in the year ahead.

Health & Social Care Overview Committee comments on BHNFT Quality Account 2012/13

We have been unable to put your Quality Account before Members for comment as the existing four scrutiny commissions are currently being restructured and will no longer meet.

From the end of May they will be replaced by a single Overview and Scrutiny Committee. Unfortunately this will be too late to meet your deadlines on this occasion, but this body will be able to comment on the Quality Account in the future. Please send any future.

Please accept our apologies for any inconvenience caused.

Note of thanks

Following receipt of comments from both internal and external stakeholders, BHNFT would like to thank them for the valid points they have raised and where these have been pertinent to the Annual Quality Account, these have been taken into consideration for the final version. However, where there are specific queries raised relating to specific issues as a result of incident investigation, these have been addressed as part of the investigation process and by implementing improvements as part of lessons learnt.

Annex 2

Independent Auditor's Report to the Council of Governors on BHNFT Quality Account 2012/13

The external auditors have reviewed the returns submitted by the FT for three indicators. The indicators were all mandated by Monitor. The criteria for the three indicators are described below:

All Cancers 62 Day Urgent Referral to Treatment

- The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

- An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen by a consultant.

- The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – two week wait).

- The clock start date is defined as the date that the referral is received by the hospital.

- The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition, or it is the date that cancer was discounted when the patient was first seen, or it is the date that the patient made the decision to decline all treatment.

Clostridium Difficile (C Diff)

- A C Diff infection is defined as a positive C Diff result on a faeces sample from a patient (during the period under review).

- Reports of C Diff cases include all Positive C Diff results detected in the laboratories, whether clinically significant or not, whether treated or not.

- The indicator excludes specimens taken on or after the 4th day admission where the date of admission is 1.

- Positive results on the same patient more than 28 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

The additional mandated indicator replacing the local indicator which is:

- The number and rate of patient safety incidents that occurred within the hospital during the hospital's reporting period; and

- The percentage of such patient safety incidents that resulted in severe harm or death.

Annex 3

Statement of Directors' responsibility in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare a Quality Account for each financial year.

Monitor has issued guidance to Foundation Trust Boards on the form and content of Annual Quality Reports 9 which incorporate the above legal requirements, and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2012/13*;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2012 to June 2013**;**
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013**;**
  - Feedback from the Commissioners on the 2012/13 Quality Report
  - Feedback from Governors on the 2012/13 Quality Report
  - Feedback from LINks/ Local Healthwatch on the 2012/13 Quality Report
  - The hospital's annual Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 reviewed monthly internally (annual results incorporated into the annual report in May 2013).
  - The latest national patient survey dated April 2013
  - The latest national staff survey dated December 2012
  - The Head of Internal Audit's annual opinion over the hospital's control environment dated May 2013;
  - Care Quality Commission quality and risk profiles dated April 2013

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these

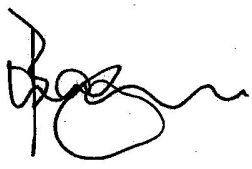
controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

28th May 2013 Date Chairman



28th May 2013 Date Chief Executive

Part Five

Glossary

Acronyms Used

Acronym	Description
ACS	Acute Coronary Syndrome
AMT	Abbreviated Mental Test
BL	Baseline
CABG	Coronary Artery Bypass Graft
CAUTIs	Catheter Associated Urinary Tract Infections
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DAHNO	Data for Head and Neck Oncology
DAS	Disease Activity Score
FRR	Financial Risk Register
GP	General Practitioner
GRR	Governance Risk Register
GUM	Genito-Urinary Medicine
HES	Hospital Episode Statistics
HQIP	Healthcare Quality Improvement Partnership
IBD	Inflammatory Bowel Disease
IG	Information Governance
LINks	Local Involvement Networks

Acronym	Description
MAU	Medical Assessment Unit
MEWS	Modified Early Warning Score
MINAP	Myocardial Ischemia National Audit Programme
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAS	National Audit of Schizophrenia
NCAPOP	National Clinical Audit Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEDs	None Executive Directors
NHSBT	NHS Blood and Transplant
NHSLA	NHS Litigation Authority
NICE	National Institute for Clinical Excellence
NICOR	National Institute for Clinical Outcome Research
NIHR	National Institute of Health Care Research
NIV	Non Invasive Ventilation
NNAP	Neonatal Audit Programme
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PbR	Payment by Results
PEAT	Patient Environment Action Team
PICANet	Paediatric Intensive Care Audit Network
POMH	Prescribing Observatory for Mental Health

Acronym	Description
PROMs	Patient Related Outcome Measures
QIPP	Quality, Innovation, Productivity and Prevention
QSIEB	Quality & Safety Improvement & Effectiveness Board
RATPAC	Randomised Controlled Trial of Point of Care (Cardiac markers A/E)
RCOG	Royal College of Obstetricians and Gynaecologists
RCPH	Royal College of Paediatric Health
SHO	Senior House Officer
SINAP	Stroke Improvement National Audit Programme
SPECS	Speech-Controlled Environmental Control System
STH	Sheffield Teaching Hospitals
SUS	Secondary Uses Service
TED	Thrombo Embolus Deterrent
VSGBI	Vascular Society of Great Britain & Ireland
VTE	Venous Thrombo-Embolism

Glossary of Terms

Term	Description
Annual Plan	A forward plan detailing the hospital's objectives for the year
Adverse Event Rate	Number of untoward medical occurrences or incidents
Board of Directors	A body of appointed members who are responsible for the day-to-day management of the hospital and is accountable for the operational delivery of services, targets and performance
Clinical Commissioning Group	Clinical Commissioning Groups are groups of local GPs that are responsible for commissioning (buying) health and care services on behalf of and in partnership with patients and local communities
C.Difficile	A type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital
Clinical Governance Committee	A board of directors who meet to ensure the hospital responds to the clinical issues raised in national/local reports, patient surveys, serious untoward incidents, clinical incidents and inquests
Clinical Service Unit	A collection of 14 units responsible for the day-to-day management and delivery of services within their area
Council of Governors	An elected group of local people who are responsible for helping to set the direction and shape the future of the hospital based on members' views
Foundation Trust members	BHNFT has more than 12,500 members who provide a local voice and have a say on how the hospital is run. Members are local people and staff from all walks of life who elect the governors on the Council of Governors and help to shape hospital services in Barnsley to benefit local people
Governors	An elected group of 20 public and patient representatives and six staff representatives
Kings Fund	An independent charity working to improve health and health care in England

Term	Description
Methicillin-Resistant Staphylococcus Aureus bacteraemia cases (MRSA)	A type of bacterial infection that is resistant to a number of widely used antibiotics
Productive Operating Theatre Programme	Helps theatre teams to work more effectively together to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and staff experience
Productive Ward Programme	Focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency
Quality Dashboards	A visual representation of quality indicators used for monitoring and reporting purposes
Quality Safety Improvement and Effectiveness Board (QSIEB)	A sub-committee of the Clinical Governance Committee responsible for monitoring operational actions, to reduce patient safety and quality risks
Staff Echo	An on-line forum for staff to help the hospital shape services improvements
Strategic Risk Committee	To provide assurance that the hospital has robust systems and processes for managing, monitoring and learning from Serious Incidents, Inquests and Claims.
Tissue Viability	The preservation of tissue and complex and chronic wound management, such as the treatment for pressure ulcers (a type of injury that break down the skin and underlying tissue caused when an area of skin is placed under pressure)
Zero Tolerance grade 3 and grade 4 pressure ulcers	Nil incidents of severe pressure ulcers (full thickness tissue (skin) loss)

Governance

Our approach to governance

Corporate governance

Our governance structure
The Trust is managed by the Board of Directors, which is accountable to the Council of Governors. The Governors act as the voice of local people and are responsible for helping to set the direction and shape the future of the hospital.

The Board of Directors and Council of Governors enjoy a strong and continually growing working relationship. The Trust Chairman chairs both the Board and the Council and acts as a link between the two. Each is kept advised of the other's progress through a number of systems, including informal updates, attendance at each other's meetings, verbal and written reports and the exchange of minutes.

Page 160 highlights the number of Council of Governors general and sub-group meetings attended by members of the Board, to enable more opportunities for listening to governors, sharing information and responding to challenges. In addition, we welcome our governors among the public attendants at every meeting of the Board of Directors held in public. In August 2012, ahead of the requirements of the Health and Social Care Act and reflecting its ethos of transparency and openness, the Board changed its programme to ensure meetings were held in public each month. A limited amount of business continues to be held in private session where required, the agenda and minutes from which are shared with our Governors. Additionally the Board continues to meet jointly with the governors at least once annually, by invitation to join one of the private meetings.

Throughout 2012/13 the Board also continued its 'open door' approach with governors, being pleased to respond to questions and requests for information on any subject. Governors' views and the feedback they provide on behalf of the members they represent, are always welcomed. Some governors also sit on Trust-wide committees and forums (e.g. Patients Experience Group, Equality and Diversity Steering Group, Learning Disabilities Working Group, Organ Donation Committee), providing feedback to the wider Council. They also continued to take part in internal inspections, helping them to have a growing understanding of the Trust's work and providing a fresh perspective on services and the hospital. This helps to inform and shape the hospital's future direction and improve services for our patients. Conscious of their growing role and responsibilities, Governors drafted a Code of Conduct for the Council of Governors, which was implemented in February 2013.

Code of Governance
The Trust complied with the provisions of the Code throughout 2012/13, with one exception. In 2012 the Council of Governors appointed Mr Paul Spinks as Non-Executive Director for a period of three years and four months; the Code recommends appointment up to three years. The Non-Executive Directors are appointed on a rolling programme and the slightly extended term of office for Mr Spinks was proposed and agreed in order to bring future appointments into a routine of expiry at the calendar year end, i.e. 31 December and to limit the number of potential terms of office expiring in any one calendar year.

The Trust continues to apply the main and supporting principles of Monitor's Code of Governance, through the actions of the Board, its committees and the Trust's standing orders, policies and procedures and through the work of the Council of Governors.

We have an integrated approach to governance. You can read more about our committee structure on pages 144-147.

Monitor's Quality Framework
We have regard to Monitor's Quality Governance Framework in arriving at our overall evaluation. You can read more about this in the quality account on pages 55 to 142.

The Council of Governors

The Council of Governors comprises of 20 public governors elected by members of the Trust and six staff governors elected by hospital staff (including volunteers). These governors are supported by representatives from nine partner organisations, which include Barnsley MBC, the Sheffield Universities, Barnsley College, the Joint Trade Unions Committee and Voluntary Action Barnsley. Early in 2013, the Governors also co-opted Mr Eric Livesley (public member) to the Council of Governors. This was in accordance with the Trust's constitution which enables up to two persons to be co-opted to provide additional support.

The Council of Governors has dealt with a range of issues charged to it under legislation (e.g. appointment of the Chairman, Non Executive Directors and external auditors) and supporting the Trust in its strategic development (business plan and quality account etc.). Amongst its key actions in 2012/13 the Council also developed and introduced a Code of Conduct for Governors, reflecting their changing role and responsibilities of Governors; led the constitutional review to ensure compliance with the Health and Social Care Act 2012 (approved by Monitor in December 2012); launched an evaluation of its performance and effectiveness (to feed into a wider review in 2013/14); supported a busy stand at the Penistone Show in September, to promote awareness of their role and membership as well as the hospital itself; approved external assurance arrangements to ensure robust scrutiny of the Trust's search for a new Patient

Administration System; hosted the first regional Lead Governors' meeting; and continued to meet, exchange views and share good practice with their governor colleagues from across the region and nationally.

The Board of Directors has authority for all operational issues, the management of which is delegated to operational staff, in line with the Trust's standing orders.

The Trust values the contributions of all of its governors – public, staff and partners.

In 2012/13, the Council of Governors was made up as follows:

Public Governors

Constituency A
Covering the electoral wards of Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham

Keith Hinchliffe. First appointed 1 September 2010. Term ended 31 December 2012 (first term).
Bruce Leabeater. First appointed 1 January 2008. Term ends 31 December 2013 (second term).
Carol Robb. First appointed 1 January 2006. Term ends 31 December 2014 (third term)
Joseph Unsworth (Lead Governor). First appointed 1 January 2005. Term ends 31 December 2013 (third term).

Constituency B
Covering the electoral wards of Darton East, Darton West and Old Town

Tony Alcock. First appointed 1 January 2011. Term ends 31 December 2013. (first term).
Pauline Buttling. First appointed 1 January 2010. Term ends 31 December 2015 (second term).
Margaret Richardson. First appointed 1 January 2012. Term ends 31 December 2014 (first term).

Constituency C
Covering the electoral wards of Stairfoot, Central, Kingstone and Worsbrough

Tony Grierson. First appointed 1 January 2013. Term ends 31 December 2015 (first term)
Sharon Hodgson. First appointed 1 January 2005. Term ended 31 December 2012 (third term).
Bob Ramsay. First appointed 1 January 2005. Term ends 31 December 2014 (fourth term).

Constituency D
Covering the electoral wards of St Helens, North East, Cudworth, Monk Bretton and Royston

Derek Carpenter. First appointed 1 January 2012. Disqualified in December 2012.
Michael Dunlavey. First appointed 1 January 2010. Term ended 31 December 2012 (first term).
Glyn Etherington. First appointed 1 January 2008. Resigned July 2012 for health and personal reasons.
Dillon Sykes. First appointed 1 January 2012. Term ends 31 December 2014 (first term).
David Thomas. First appointed 1 January 2005. Term ends 31 December 2014 (fourth term).
Nathan Woodcock. First appointed 1 January 2013. Term ends 31 December 2015 (first term).

Constituency E
Covering the electoral wards of Darfield, Dearne North, Dearne South and Wombwell

Denis Gent. First appointed 1 January 2005. Died November 2012.
Wayne Kerr. First appointed 1 January 2005. Terms ends 31 December 2014 (fourth term).
Trevor Smith. First appointed 1 September 2010. Term ends 31 December 2015 (second term).

Constituency O
Covering out of area/England and Wales

Vacancy This vacancy has not been filled this year. A review of our constitution is underway which includes this constituency. Further information about vacancies can be found on page 148.

Staff Governors
Covering all staff groups – clinical support, medical, non clinical support, nursing and midwifery and volunteers

Mr Ray Raychaudhuri. Medical and dental. First appointed 1 September 2010. Term ends 31 December 2015 (second term).
Jill Marshall. Non-clinical support. First appointed 1 January 2007. Term ended 31 December 2012 (second term).
Jordan Ramsay. Non-Clinical Support. First appointed 1 January 2013. Term ends 31 December 2015 (first term).

Viv Mills. Clinical support. First appointed 1 January 2005. Term ends 31 December 2014 (fourth term).
Debby Horbury. Nursing and midwifery. First appointed 1 January 2008. Term ends 31 December 2013 (second term).
Gwyn Morritt. Nursing and midwifery. First appointed 1 January 201. Term ends 31 December 2014 (first term).
Joyce Rhodes. Volunteers. First appointed 1 January 2009. Died September 2012.
Tony Conway. Volunteers. First appointed 1 January 2013. Term ends 31 December 2015 (first term).

Partner Governors
Pauline Acklam, MBE. NHS Barnsley (from October 2006); retired October 2012.
Professor Nigel Bax. University of Sheffield (from January 2005); retired January 2013.
David Brannan. Voluntary Action Barnsley (from January 2005).
Councillor Jenny Platts. Barnsley Metropolitan Borough Council (from October 2009).
Kay Philips. Sheffield Hallam University (from June 2007).
Martin Jackson. Joint Trade Unions Committee (from January 2008).
Cara Stacey. Barnsley College (from September 2012).
Barnsley Together – appointment awaited at March 2013.

Co-opted Governor
Eric Livesey, appointed February 2013 to January 2014

Public and staff governors are subject to elections held annually for up to one-third of seats, at the end of their terms of up to three years office. In 2012 (for appointment from 1 January 2013), ten public and three staff governor seats were put forward for election; the elections were supported by the Electoral Reform Services, as independent scrutineers.

While appointed by nomination rather than election, partner governors are subject to reappointment at three year intervals.

Co-opted governors can be appointed and removed by approval of the Council of Governors at a general meeting.

Sadly two of our governors died in 2012 following illnesses – Mr Denis Gent (public governor, constituency E) and Mrs Joyce Rhodes (staff governor, volunteer's constituency). Denis had sat on the Council since its inception in 2005 and Joyce had taken on the role representing her fellow volunteers in 2009. They both made a huge contribution to the Council and the Trust and will be sorely missed. Our sincere condolences were extended to their families and friends.

One public governor resigned for health and personal reasons in 2012, Mr Glyn Etherington. He too had made a valuable input to the work of the Council. Additionally, one public governor was disqualified from the Council in December 2012, following conviction for fraud.

Thanks are also extended to two partner governors who retired in 2012/13: Mrs Pauline Acklam (NHS Barnsley) and Professor Nigel Bax (University of Sheffield) and to governors who stepped down at the end of their latest term of office in December 2012 – public governors Mrs Sharon Hodgson and Mr Keith Hinchliffe and staff governor, Mrs Jill Marshall.

It is timely to record sincere thanks to all of our governors – current and past – public, staff and partners, whose continuing support and commitment to the hospital and the improvement of services for our patients has been invaluable.

Vacancies
At the end of March 2013 there were vacancies for seven public governors, which will be carried forward to the next elections (commencing September 2013).

Following retirements and restructuring within the health community there were three partner governor vacancies. One seat is out to invitation (Barnsley Together).

This position does not affect the required majority for public vs other governors. It gives opportunity for the Council to develop and consider proposals to change its composition in 2013/14, work on which is currently on-going.

There are no company directorships held by the Governors where companies are likely to do business or are seeking to do business with the Trust.

Council of Governors and Board member attendance at Governors' meetings is noted in the table on pages 160-162.

Notes:

a) Where a governor is unable to attend two consecutive general meetings, the tenure of office may be terminated unless the absence was due to a reasonable cause; and he/she will be able to start attending meetings of the Trust again within such a period as the wider Council of Governors considers reasonable
b) Directors' attendance at the Annual General Meeting is recorded separately in the table of Board Meetings and Attendance.

Council of Governors – meetings
For the joint meeting between the Council of Governors and Board of Directors in November 2012, the Board repeated its annual invitation for governors to attend

one of its private meetings (hence the Directors' attendance is not recorded separately in the table on page 160). The meeting is in addition to the many other routes by which Governors and Directors communicate throughout the year.

Committees and sub-groups

Nominations Committee

The Nominations Committee is a formal committee of the Council of Governors. It comprises the Chairman, three public governors, two partner governors and a staff governor to consider and make recommendations to the Council of Governors for the appointment and terms of service of Non-Executive Directors, including the Trust's Chairman. The Lead Governor (as elected by the Council of Governors) holds one of the seats for public governors.

Membership in 2012/13 included:

- Mr David Brannan, Partner Governor
- Mr Bruce Leabeater, Public Governor
- Mrs Kay Phillips, Partner Governor
- Mr Bob Ramsay, Public Governor
- Mr Ray Raychaudhuri, Staff Governor
- Mr Joseph Unsworth, Public and Lead Governor
- Mr Stephen Wragg, Trust Chairman (*Committee Chair*)

When the appointment, re-appointment or performance of the Chairman is under consideration by the Committee, the Chairman is excluded from the Committee's discussions.

The meetings of the Nominations Committee were supported by internal Human Resources advisors and the Secretary to the Board throughout the year. The Committee retains the right at all times to seek internal or external expert advice at any time.

In 2012/13 the Committee led the appointment of Mr Paul Spinks as Non-Executive Director, for a term starting 1 September 2012. The appointment was progressed by open competition. As noted earlier, Mr Spinks was appointed for a period of three years and four months, which is slightly longer than the three year period recommended by Monitor's Code of Governance. The Committee believed this to be a sensible approach to bring the appointment of all Non-Executives into alignment for the end of the year (i.e. 31 December) and avoid more than half of the Non-Executive Directors falling for appointment/re-appointment in any one calendar year.

The Committee also carried out the annual review of the Terms and Conditions of Service for the Non-Executive Directors and Chairman. No changes were recommended for 2012/13.

Looking ahead to 2013/14 in March, the Committee considered (a) the re-appointment of Mr Francis Patton as Non-Executive Director for a further period of up to three years, with effect from 1 January 2014 and (b) the enhancement of the Chairman to a full-time role for the period between the resignation of the current Chief Executive, Mr O'Connor and appointment of a new substantive Chief Executive for the Trust.

Having served six years (at 31 December 2013), the proposed re-appointment of Mr Patton without recourse to open competition is unusual but was strongly supported to ensure continuity on the Board at this time of change both internally (with the resignation of the Chief Executive) and externally, with the changes in local and national commissioners – abolition of Primary Care Trusts and introduction of Clinical Commissioning Groups and Local Area Teams etc. The appointment is subject to robust review (extended to include direct input by the Lead Governor as well as the Chairman of the Trust) and renewal/review each year.

Whilst technically a matter for next year's annual report, it is noted that both recommendations were presented to the Council of Governors at its General meeting in April 2013 and unanimously approved.

During the year, the Committee also supported the appraisal (mid year and year end) of the Chairman, with a robust process led by the Lead Governor and Senior Independent Director. This includes inviting feedback from all members of the Board of Directors and Council of Governors, to ensure a transparent and robust process. It also received and considered the appraisals of the Non-Executive Directors prior to presenting its recommendations on same to the Council of Governors. The views and recommendations of the Nominations Committee following these appraisals were subsequently presented to and accepted by the Council of Governors.

Sub-groups

The sub-groups are informal groups of the Council of Governors (rather than formal committees) and are open to all Governors. They are led by a Chair and Vice-Chair, elected from among the Governors. Attendance is open to all Governors. The sub-groups are used by the Governors as a forum for in depth reviews of any issues, as well as information gathering and training. Throughout the year, members of the sub-groups appreciated the continuing support of the Chairman, Non-Executives and Directors ensuring regular attendance at all sub-group meetings to give governors more opportunity to hold the Non-Executive Directors (and the Board) to account directly.

The structure of the sub-groups continues to enable the Council of Governors to develop a more proactive approach to its role. Governors hold the Non-Executive Directors and Board to account and challenge them against delivery of the identified objectives in the Trust's business plan, which in 2012/13 was delivered

through the Trust's transformation programme, updates on which were regularly presented to the sub-groups.

Further progress of each of the sub-groups in 2012/13 is highlighted below:

Patients and Access
The sub-group has continued to focus on issues that really matter to our patients, regularly receiving and reviewing feedback from the patients experience group, the complaints (and compliments!) reports and the matrons' reports. It also continued to build the programme of governors' visits – to ward and clinical areas, enabling governors to talk to patients, to hear first hand about their experience at Barnsley Hospital and to share learning from that with the wider Council of Governors and the Board of Directors.

The Governors in this group also challenged and received assurance from the Board on the Trust's approach to the End of Life Care Pathway.

The group was also involved with the launch of the new Family and Friends Test and will monitor this closely as it becomes established throughout 2013/14, to see what learning and improvements it can provided to the Trust and our patients.

This group monitors four strands of the Trust's Transformation Programme: urgent care, consistency in care, elective care and outpatients and continues to review progress at its bi-monthly meetings.

Staff and Environment
This group continues to build its twin focus: on staff issues ranging from morale, issues reported to them by individual members of staff, to training and appraisal (uptake and quality); and the environment, including building works, plans for the estate, signage to help make access easier around the site. It supported visits of a different type, Patient Environment Action Team (PEAT) inspections, looking at the hospital's cleanliness and safety. These are changing with the introduction of the national Patient Led Assessment of Care Environment scheme (PLACE) and several Governors from this sub-group have been invited to be involved with this too as it develops in 2013/14. Governors are keen, however, to continue with some form of internal inspections as well the annual PLACE visit and have asked the Trust to address this.

The Staff and Environment sub-group monitors three of the Transformation programme workstreams: Workforce, Non-Clinical Support and IM&T and Estates.

Strategy and Performance
This sub-group continued to deliver its core duties mandated by the Council of Governors to lead on a number of mechanisms to help the governors to deliver some of their key responsibilities:

- holding the Non-Executive Directors and the Board to account for delivering its business plan each year, by ensuring the business plan objectives are assigned to and monitored by each of the sub-groups and that the Board responds to any questions on same
- reviewing the work of the External Auditors, through briefings from both the External and the Internal Auditors and considering requests for additional work to be undertaken by the external auditors prior to any proposals being submitted to the wider Council for approval
- ensuring governors have opportunity to provide input to the Trust's future planning
- ensuring governors have the opportunity to provide input to the Trust's quality accounts and helping to draft the governors' comment on the quality report, as required annually

In 2012/13 the group also called for and gave closer scrutiny to two regular Board reports:
(i) HSMR (Hospital Standardised Mortality Ratio), supporting the Board's drive to improve the hospital's position. Although not an outlier, both the Board and Governors see scope for improvement in this area, and
(ii) the quarterly submissions to Monitor (focussing on the Trust's governance and financial risk ratings).

Additionally the sub-group Chairs, together with the Lead Governor and the Associate Director of Communications and Marketing comprise the Editorial Board for the Members' newsletter. This gives the Governors more opportunity to contribute to the newsletter and engage with the members they represent.

Funding and Finance Committee
This is a small group, chaired by the Lead Governor and its membership includes three other Governors and is also joined by the Trust's Chairman. The remit of this group is to control a small dedicated budget and consider funding requests to support the work of the Governors. In 2012/13 the Committee gave its full support to the membership engagement event (Penistone Show) and this approach was fully endorsed by the wider Council of Governors.

Working groups
It should be noted that two small ad hoc working groups were also established in 2012/13. One to lead on the planning and delivery of the very successful membership event held at the Penistone Show in September 2012 and one to lead on the review of the Constitution. Both groups were open to all governors and also supported by the Chairman and Secretary to the Board. Having led and successfully gained approval of the first phase of the review of the Trust's

Constitution (to ensure compliance with the first tranche of implementation orders for the Health and Social Care Act 2012), the constitutional review working group is still active, pursing a further, wider review of the Trust's Constitution in 2013/14.

Terms of office
The terms of office of the public and staff governors are staggered, which means that approximately one third of such seats are subject to election each year.

Expenses
Governors may claim expenses and other reasonable expenses incurred on Trust business at 40p per mile in line with national guidance. They are not remunerated by the Trust in any other way.

The Board of Directors

The Board of Directors is responsible for setting and driving forward the strategic direction of Barnsley Hospital. The Board comprises of six Non-Executive Directors (including the Chairman) and five Executive Directors.

The skills and strengths provided by the Non-Executive and Executive Directors throughout the year continued to ensure that the Trust benefited from a good, well-balanced Board. The balance is reviewed throughout the year as well as whenever any director level vacancies, Executive or Non-Executive, arise.

The effectiveness of the Board is aligned to the delivery of the Trust's business plan year on year and is closely monitored by the Governors throughout the year as part of their role of holding the Non-Executive Directors and the Board, to account. As reported last year, whilst the Board's performance has thus been evaluated throughout the year, it has also looked more closely as its own effectiveness, to guard against complacency and keep pace with the Trust's new ways of working, driven by the Transformation Programme. In 2012/13 the Board began an intensive evaluation and development process, supported by the Real World Group. The process began with a 360 degree feedback process, where we invited partners and stakeholders to share their assessment of our effectiveness as a Board. Specifically it measured:

- Competence of the Board in their role
- How engaging we are in our leadership
- Effectiveness in working together as a team

This gave us a wealth of information to reflect on and has provided the basis of an on-going development programme which will take us through the year ahead.

The following were the executive and Non-Executive Directors for the year 2012/13:

Chairman	Stephen Wragg
Chief Executive	Paul O'Connor
Non-Executive Directors	Anne Arnold (until August 2012) Linda Christon Francis Patton (Deputy Chairman and Senior Independent Director) Paul Spinks (from September 2012) Stephen Houghton CBE Suzy Brain England OBE

Medical Director	Dr Jugnu Mahajan
Director of Finance and Information	Dawn Hanwell (until July 2012) Janet Ashby (interim from August 2012 (substantive from December 2012)
Chief Nurse	Heather Mcnair
Chief Operating Officer	David Peverelle

Non-Executive Director Appointments

Non-Executive Directors are usually appointed for a term of up to three years by the Council of Governors, based on a recommendation from the Nominations Committee. As reported on page 149, Mr Spinks has been appointed for an extended period (up to three years and four months).

The Nominations Committee is a formal committee of the Council of Governors and comprises the Chairman, three public governors, two partner governors and a staff governor to consider and make recommendations to the Council of Governors for the appointment and terms of service of Non-Executive Directors, including the Trust's Chairman. See page 166 for further details.

The term of office of one Non-Executive Director ended in 2012/13: Miss Anne Arnold, on 31 August 2012 (one month earlier than full term as Miss Arnold opted to retire a month sooner). Following an appointment process through open competition, Mr Paul Spinks was appointed with effect from 1 September 2012. Mr Spinks had previously been a Non-Executive at the Trust until December 2011.

The processes for all Non-Executive Director appointments, including that of the Chairman, are supported and monitored by internal human resource specialists, although the Nominations Committee retains the right to seek external advice at any time.

As senior managers, the terms of office and conditions of service of the Non-Executive Directors are detailed later in this report. The notice period for Non-Executive Directors is one month. Copies of their service agreements are available on request from the Secretary to the Board. The Council of Governors have the statutory powers for the appointment and termination of Non-Executives.

Non-Executive Directors

Stephen Wragg, Chairman
Stephen was first appointed as the Trust's Chairman in January 2009. He is a self- employed management consultant, before which he was Technical Director at W2Networking where he was responsible for customer technical solutions, customer service and satisfaction and the development of commercial data centre strategy. From 2001 to 2007 he was Head of Information and Communications Technology (ICT) at Business Link South Yorkshire and Head of ICT at Barnsley and Doncaster TEC from 1997 to 2001.

Prior to his appointment Stephen was a Non-Executive Director of NHS Barnsley; a position he held since April 2006. He holds Non-Executive posts at Barnsley Premier Leisure Trading and Barnsley Civic, is a Governor at Darton College and a Director of 360 Engagement Limited. There were no significant changes to the Chairman's commitments and the Register of Interests is published in public Board papers (see page 159).

Stephen's current term of office is until 31 December 2014.

Anne Arnold
Anne joined the Trust in December 2004, bringing her extensive experience of working with the NHS as a senior manager and as a management consultant. She worked primarily in education and is a carer. Anne is an MBA graduate and qualified accountant. She served as Chair of the Trust's Audit Committee, a member of the Finance Committee and was the Senior Independent Director until January 2012.

Suzy Brain England
Suzy Brain England joined the Trust in 2012. She also holds chair positions with Berneslai Homes, Voice UK, Derwent Living Housing Association and is also a Non-Executive Director with Avanta. She has previously held a number of chair posts, including at Kirklees Community Healthcare Services, Connexions and Ofcom's Advisory Committee for England. She was also the acting chair at Mid Yorkshire Hospitals and has held a number of executive roles, including chief executive of the Talent Foundation and Earth Centre.

Ms Brain England was appointed on 1 January 2012 until 31 December 2014.

Linda Christon
Linda joined the Trust's Board in January 2010 and is a former Regional Director of the Commission for Social Care Inspection, the body which regulated social care prior to the Care Quality Commission. She has a Law degree and a Masters degree in Business Administration. She has had a varied career in housing and

social care and has experience of working across health and social care partnerships.

Linda is the Non-Executive lead for Emergency Planning and Sustainability and is the Chair of the Clinical Governance Committee and also a member of the Non-Clinical Governance and Audit Committees. She is also a Board member of St Leger Homes in Doncaster.

Her current term of office runs until December 2015.

Stephen Houghton
Steve Houghton joined the Trust in 2012. He is leader of Barnsley Metropolitan Borough Council, a post he has held for 14 years. He brings extensive knowledge of local government and public sector accountability, as well as a strong understanding of Barnsley and its health issues. Mr Houghton is also chair of the Barnsley Local Strategic Partnership, the Health and Wellbeing Board, Special Interest Group of Municipal Authorities and a former board member and deputy chair of Yorkshire Forward.

Mr Houghton was appointed on 1 January 2012 until 31 December 2014.

Francis Patton
Francis joined the Trust in January 2008. He has spent the last 20 years working in the pub retailing sector in areas such as operational management, customer services, marketing, public relations, purchasing, investor relations, communications, human resources, learning and development and recruitment. He holds a number of Non-Executive roles and teaches part time at Leeds Metropolitan University. He is the Deputy Chairman and, since January 2012, Senior Independent Director (SID). He also chairs the Trust's Non-Clinical Governance and Risk Committee.

Francis's term of office has been extended for a further period up to December 2016.

Paul Spinks
Paul re-joined the Trust as a Non-Executive Director in September 2012. He is Chair of the Trust's Audit committee and a member of the Finance Committee. He is a qualified chartered accountant working for a firm of accountants where he specialises in audit of public sector bodies, particularly in the NHS and Local Government. Paul is a member of the Public Sector Audit Committee at the ICAEW and the Public Audit Forum Working Group on Whole of Government Accounts.

Paul's appointment is until 31 December 2015**.**

Executive Directors

Paul O'Connor, Chief Executive
Paul started as Chief Executive in March 2011, having held the position on an interim basis from June 2010. He has previously held chief executive roles in hospitals in London and Birmingham and also led the QIPP (Quality, Innovation, Performance and Prevention) Programme for NHS North West before joining Barnsley Hospital NHS Foundation Trust. Paul will be leaving the Trust at the end of May 2013 to take up a new appointment as Chief Executive for Sherwood Forest Hospitals NHS Foundation Trust.

Janet Ashby, Director of Finance and Information
Janet joined the Board as Director of finance and information in August 2012, having been the Deputy Director for two years.

Her extensive 25-year background in financial management includes senior and Finance Director roles within the Virgin Group, Arcadia Group and KPMG. As well as working at board level for ten years, Janet has also run her own consultancy. She initially came to Barnsley Hospital in 2008 to improve and develop our financial systems and in 2010 took up the post of Deputy Director, working with the team to produce the annual financial plan and manage the overall financial position.

Dawn Hanwell, Director of Finance and Information
Dawn was appointed Director of finance from 1 January 2008. She started work in the NHS in 1986 as a financial management trainee in Rotherham where she went on to gain her CIPFA qualification in 1990. Dawn has worked across the NHS in Sheffield, Wakefield, Derby and Leeds. She has worked predominantly in mental health but has also worked, for a short while, in a primary care trust and for the Department of Health. Dawn joined the Board at Barnsley in 2008, returning to Leeds Partnerships NHS Foundation Trust in July 2012 as their Director of Finance.

Dr Jugnu Mahajan, Medical Director
Dr Jugnu Mahajan became the Trust's Medical Director and Consultant Paediatrician in September 2009. Dr Mahajan, MBBS, MD, FRCPCH, Med (Med Ed), took up the post after moving from Rotherham Hospital, where she worked for 12 years as consultant paediatrician and where she was also Clinical Director for five years. Her specific areas of interest are clinical leadership, improving patient safety and professional standards.

Heather Mcnair, Chief Nurse
Heather joined the hospital from Calderdale and Huddersfield NHS Foundation Trust where she was deputy Director of nursing. Heather spent the first part of her NHS career in Leeds, working in a variety of midwifery posts including as labour ward sister at Leeds General Infirmary.

Heather became head of midwifery at Huddersfield Royal Infirmary in 1998 before becoming Deputy Director of Nursing in 2001, a post she held for 10 years. She is a qualified midwife.

David Peverelle, Chief Operating Officer
David was appointed as Chief Operating Officer in July 2008 having held a number of senior management posts in the Trust - latterly as the Director of Clinical Services. David has extensive experience of working in acute and specialist hospitals. He started his career in Barnsley as an administration trainee in 1978. Since then he has held a range of senior posts in acute and specialist hospitals which include Sheffield Children's Hospital, General Hospital Nottingham, Queens Medical Centre Nottingham and Royal Hallamshire Hospital before returning to Barnsley.

Register of Interests

The register of Directors' and Governors' interests is available from Carol Dudley, the Secretary to the Board at Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP. Telephone 01226 435000.

There are no company Directorships held by the Directors or Governors where companies are likely to do business or are seeking to do business with the Trust, other than those highlighted in the related party note in the financial statements. Where there are Directorships with companies the Trust may do business with, we have mechanisms to ensure there is no direct conflict of interest and those directors would not be involved.

Based on the Register of Directors' interests and known circumstances, there was nothing to preclude all of the Non-Executive Directors in post at any time during 2012/13 from being declared as independent. By the nature of his role, the Chairman is not included in this assessment.

Attendance at Board of Director and Council of Governors meetings

Board and Board Committee meetings:

			Board of Directors		Audit Committee		Clinical Governance Committee (CGC)		Finance Committee		Non Clinical Governance & Risk Committee		Remuneration & Terms of Service Committee (RATS)	
			Total Eligible	*Total Attended*	*Total Eligible*	*Total Attended*	*Total Eligible*	*Total Attended*	*Total Eligible*	*Total Attended*	*Total Eligible*	*Total Attended*	*Total Eligible*	*Total Attended*
Arnold	Anne	Non Executive Director	5	4	4	4			2	1			4	1
Brain England	Suzy	Non Executive Director	12	11	5	4	6	5					6	6
Christon	Linda	Non Executive Director	12	12	6	6	6	6					6	5
Houghton	Stephen	Non Executive Director	12	9							5	5	6	4
Patton	Francis	Non Executive Director	12	12							6	6	6	6
Spinks	Paul	Non Executive Director	7	6	2	2			2	2			2	2
Wragg	Stephen	Chairman	12	12					4	4			6	6
Shading denotes Committee Chair. Re Audit Committee - Miss Arnold was Chair to August 2012; Mr Spinks was Chair thereafter														
Ashby	Janet	Director of Finance & Information	8	8	6	5			2	2	4	3		
Hanwell	Dawn	Director of Finance & Information	4	3	4	4			2	2	2	1		
Mahajan	Jugnu	Medical Director	12	12			6	4	4	3				
Mcnair	Heather	Chief Nurse	12	11			6	4						
O'Connor	Paul	Chief Executive	12	12					4	3			3	3
Peverelle	David	Chief Operating Officer	12	12			6	4	4	4	6	6		
													CEO attendance by invitation	

Council of Governors meetings

Governors (and Chair)

Name		Term of office			Note	Constituency	General Meetings		Annual General Meeting	Joint meeting with Board	Sub Groups			Nominations Committee	
		1st appointed	Expiry date	Term			Total eligible	Attended	Attended	Attended	Patients & Access Total = 5 Attended	Staff & Environment Total = 7 Attended	Strategy & Performance Total = 6 Attended	Total eligible	Attended
Public Governors						**Public Constituency**									
Keith	Hinchliffe	Sep-12	Dec-12	1st			5	2					1		
Bruce	Leabeater	Jan-08	Dec-13	2nd		A: Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham	6	5	Yes	Yes	3	4	1	6	5
Carol	Robb	Jan-06	Dec-14	3rd			6	5	Yes		5	6	5		
Joseph	Unsworth (Lead Governor)	Jan-05	Dec-13	3rd			6	6	Yes	Yes	5	7	6	6	6
Tony	Alcock	Jan-11	Dec-13	1st		B: Darton East, Darton West and Old Town	6	6	Yes	Yes	5	6	6		
Pauline	Buttling	Jan-12	Dec-15	2nd			6	4					3		
Margaret	Richardson	Jan-12	Dec-14	1st			6	6	Yes		5	7	5		
Tony	Grierson	Jan-13	Dec-15	1st		C: Stairfoot, Central, Kingstone and Worsbrough	1	1			1	2	1		
Sharon	Hodgson	Jan-05	Dec-12	3rd			5	4							
Bob	Ramsay	Jan-05	Dec-14	4th			6	6	Yes	Yes	4	6	4	6	4
Derek	Carpenter	Jan-12	Dec-12	1st	Disqualified	D: St Helens, North East, Cudworth, Monk Bretton and Royston	5	4							
Michael	Dunlavey	Jan-10	Dec-12	1st			5	1							
Glyn	Etherington	Jan-08	Jul-12	2nd	Resigned		2	1			1				
Dillon	Sykes	Jan-12	Dec-14	1st			6	4			1				
David	Thomas	Jan-05	Dec-14	4th			6	3			2		3		
Nathan	Woodcock	Jan-13	Dec-15	1st			1	1					1		
Denis	Gent	Jan-05	Nov-12	3rd	Died	E: Darfield, Dearne North, Dearne South and Wombwell	4	2					1		
Wayne	Kerr	Jan-05	Dec-14	4th			6	2			3		2		
Trevor	Smith	Sep-10	Dec-15	2nd			6	4		Yes		6	2		

Chairs denoted by shading

Name		Term of office			Note	Constituency	General Meetings		Annual General Meeting	Joint meeting with Board	Sub Groups			Nominations Committee	
		1st appointed	Expiry date	Term			Total eligible	Attended	Attended	Attended	Patients & Access Total = 5 Attended	Staff & Environment Total = 7 Attended	Strategy & Performance Total = 6 Attended	Total eligible	Attended
Staff Governors						**Staff Constituency**									
Mr Ray	Raychaudhuri	Sep-10	Dec-15	2nd		Medical & Dental	6	4			3	2	4	6	2
Jill	Marshall	Jan-07	Dec-12	2nd		Non Clinical Support	5	5	Yes			5			
Viv	Mills	Jan-05	Dec-14	4th		Clinical Support	6	3	Yes	Yes		4			
Debby	Horbury	Jan-08	Dec-13	2nd		Nursing & Midwifery	6	5			1	1	1		
Gwyn	Morritt	Jan-12	Dec-14	1st		Nursing & Midwifery	6	5		Yes	4	4	2		
Joyce	Rhodes	Jan-09	Sep-12	2nd	Died	Volunteers	3	2							
Jordan	Ramsey	Jan-13	Dec-15	1st		Non Clinical Support	1	1			1	2	1		
Tony	Conway	Jan-13	Dec-15	1st		Volunteers	1	1			1	2	2		
Partner Governors					1	**Partner Organisation**									
Pauline	Acklam, MBE	Oct-06	31-Oct-12		Retired	NHS Barnsley	4	2							
Prof Nigel	Bax	Jan-05	31-Jan-13		Retired	University of Sheffield	5	1							
David	Brannan	Jan-05				Voluntary Action Barnsley	6	6	Yes	Yes	3	5	5	6	5
Martin	Jackson	Jan-08				Joint Trade Unions	6	2	Yes			2			
Cllr Jenny	Platts	Oct-09				Barnsley MBC	6	3	Yes	Yes	1				
Kay	Philips	Jan-07				Sheffield Hallam University	6	3	Yes					6	4
Cara	Stacey	Sep-12				Barnsley College	3	2		Yes	1	1			
Plus															
Wragg	Stephen	Jan-09	Dec-14	2nd	2	Chairman	6	5	Yes	☼♏♦	3	5	5	4	4

Chairs denoted by shading

Name				General Meetings	Annual General Meeting	Joint meeting with Board	Sub Groups			Nominations Committee	
				Attended			*Total = 5*	*Total = 7*	*Total = 6*	*Total eligible*	Attended
Board and Management Team attendance:											
Janet	Ashby				3	Yes			1		
Suzy	Brain England				2	Yes	1				
Hilary	Brearley				4	Yes		7			
Linda	Christon				1		1		1		
Steve	Houghton				1						
Elaine	Jeffers				1	Yes	1		2		
Liz	Libiszewski				1	Yes	1	1	2		
Paul	O'Connor				3	Yes				1	1
Francis	Patton				1	Yes	1	1	1	2	2
David	Peverelle				3						
Helen	Stevens				2	Yes		1			
Jugnu	Mahajan				1		1				
Heather	Mcnair					Yes	2	1			
Paul	Spinks					Yes					

Notes

1 Whilst appointed by nomination rather than election, Partner Governors are subject to re-appointment/nomination at 3 year intervals
2 Re the Nominations Committee, Mr Wragg did not attend meetings relating to his own appraisal or terms & conditions, nor the terms & conditions of the Non Executive Directors. On such occasions Mr Unsworth assumed the Chair, as Lead Governor
3 It is acknowledged that some Governors cannot attend every meeting due to other commitments and/or health issues. On the rare occasions that they have not explained their absence for two consecutive meetings, it is challenged (with the support of the wider Council of Governors) and support offered where appropriate to facilitate their return to the Council and/or, if necessary, to terminate their appointment. No such instances arose in 2011/12
4 Sub-group meetings are an open forum for Governors. As well as regular attendees, several governors attend on a more ad hoc basis and are welcome to do so.
5 There were three further sub-groups/committees of the Council of Governors: the Funding & Finance Committee (met once in 2012/13) and two working groups focussed on membership development (primarily via the Penistone Show) and the Constitutional review. All groups were supported by Trust Directors

Integrated governance – committees of the Board

Good governance is about making sure the Board of Directors is well informed and assured that the right systems and processes are in place. The Trust does this through its five committees which report to the Board. The Committees are also monitored through the Trust's audit processes and regular reports from each are presented to the Board.

Achievements in 2012/13

- Tested our compliance with the revised Monitor Code of Governance
- Tested our compliance with Monitor Quality Governance Framework
- Embedded and established the revised integrated governance arrangements which are now providing a robust infrastructure to support and deliver effective integrated governance
- Developed arrangements to support the new CSU management arrangements
- Procured and implemented a new incident reporting system which is easier for staff to use and is able to provide improved management reports

This list, which is by no means exhaustive, demonstrates how the effectiveness of these committees is evaluated, by providing real challenge internally, promoting and monitoring improvements to governance systems, providing assurance to the Board on progress and alerting the Board to issues of potential concern. Furthermore, each of the Committees also provides an annual overview report on its work.

Audit Committee

The Audit Committee's purpose is to provide the Board of Directors with assurance on the effectiveness of processes around corporate objectives. This assurance is validated through the Annual Governance Statement.

The Committee also provides the Board with an independent commentary of the fitness for purpose of the Board Assurance Framework and the effectiveness of the governance, risk management and internal control mechanisms. It focuses on the work of the Internal Audit Annual Plan and liaises with external audit in relation to the findings.

Membership of the Committee in 2012/13 comprised the following Non-Executive Directors:

- Miss Anne Arnold, (until 31 August 2012 – *Committee Chair*)
- Mr Paul Spinks (from 1 September 2012 – *Committee Chair*)
- Mrs Linda Christon
- Mrs Suzy Brain England OBE

Whilst the Committee includes at least one member with recent and relevant financial experience (see outline of Non-Executives' skills above), the Committee

is supported at every meeting by the Trust's Director of Finance and Information. As stated on page 173, the Directors are responsible for ensuring that the accounts are prepared in accordance with regulatory and statutory requirements.

The Trust's internal Audit function is provided by Assure.

The Board of Governors appointed PricewaterhouseCoopers LLP (PWC) as external auditors of the Trust for the 5 year period commencing 1 April 2007 and re-appointed for the 3 year period commencing 1 April 2011. The audit fee for the statutory audit was £51,244 (2011/12 £49,800) including VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. The audit fee for the subsidiary organisation, Barnsley Hospital Support Services Limited was £5,400 inclusive of VAT (2011/12 - £ Nil). The audit fee for Barnsley Hospital Charity was £4,321 (2011/12 - £4,200) inclusive of VAT.

All work commissioned from the external auditors is subject to the authorisation of the Audit Committee to ensure that the auditor's objectivity and independence is safeguarded. Any additional work proposed outside of the external auditor's core function is presented to the Council of Governors for consideration and approval.

Finance Committee

The Finance Committee ensures that the financial plans of the Trust are realistic and open and all financial risks have been identified and mitigated. In addition, the Committee provides assurance on financial reporting to the Board and an overview of Treasury Management issues. It reviews financial plans and issues, approves reports to Monitor, approves the development of financial reporting consistent with the Foundation Trust's financial regime, oversees the development and implementation of the financial information systems strategy and approves financial policies

The Committee is chaired by a Non-Executive Director, Stephen Wragg, with its membership drawn from both the executive and Non-Executive Directors.

In 2012/13 membership comprised:

- Miss Anne Arnold, Non-Executive Director (until August 2012)
- Ms Dawn Hanwell, Director of Finance and Information (until July 2012)
- Dr Jugnu Mahajan, Medical Director
- Mr David Peverelle, Chief Operating Officer
- Mr Paul Spinks, Non-Executive Director (from September 2012)
- Mr Paul O'Connor, Chief Executive
- Mr Stephen Wragg, Chairman (*and Committee Chair)*

Governance Committees

Both the Clinical Governance Committee and the Non-clinical Governance and Risk Committee are chaired by Non-Executive Directors and include Executive and Non-Executive Directors amongst their members to enable them to seek and obtain the information, actions and assurances they need to be able to report upwards to the Board.

Between them, these two Committees ensure that the structures, processes and policies and procedures are in place to provide a framework to support a hospital environment in which excellent clinical and non-clinical care flourishes. It also ensures that any risk issues are identified, managed and escalated appropriately and that actions are taken.

Clinical Governance Committee
Members:

- Mrs Suzy Brain England OBE, Non-Executive Director (from January 2012)
- Mrs Linda Christon, Non-Executive Director (*Committee Chair, from January 2012*)
- Heather Mcnair, Chief Nurse
- Elizabeth Libiszewski, Director of Quality and Performance
- Dr Jugnu Mahajan, Medical Director
- Ms Heather Mcnair, Chief Nurse
- David Peverelle, Chief Operating Officer (from June 2012)

Non-Clinical Governance and Risk Committee
Members:

- Ms Dawn Hanwell, Director of Finance and Information (until July 2012)
  Mrs Janet Ashby (from August 2012)
- Mr Stephen Houghton CBE, Non-Executive Director
- Mr Francis Patton, Non-Executive Director (Committee Chair)
- Mr David Peverelle, Chief Operating Officer
- Mrs Elizabeth Libiszewski, Director of Quality and Performance

This Committee also has a broader membership to include a diverse range of staff from across the Trust, who brings a wealth of professional knowledge and experience to the meetings. Further members include:

- Chief Information Officer
- Director of Human Resources and Organisational Development
- Associate Director of Estates and Facilities
- Head of Corporate Governance

The Remuneration and Terms of Service Committee (RATS)

Remuneration report

The Remuneration and Terms of Service Committee (RATS) is responsible for the appointment of the Chief Executive and, together with the Chief Executive, other executive members of the Board of Directors.

It reviews and recommends the terms and conditions of service for the Executive Directors and other directors and senior managers not subject to the 'Agenda for Change' conditions and reviews the performance of these staff annually. The Committee's recommendations are reported to the Board of Directors. The Committee is able to call upon internal and external human resources advice as required.

The Committee met six times in 2012/13. Its membership comprised of all of the Non-Executive Directors, including the Chairman, who also chairs the committee:

- Mr Stephen Wragg, Chairman
- Miss Anne Arnold, Non-Executive Director (until August 2012)
- Mrs Suzy Brain England OBE, Non-Executive Director
- Mrs Linda Christon, Non-Executive Director
- Mr Francis Patton, Non-Executive Director
- Mr Stephen Houghton CBE, Non-Executive Director
- Mr Paul Spinks, Non-Executive Director (from September 2012)

Attendances are shown on the table of Board and committee meetings on page 160.

The Committee is supported by the Chief Executive[3] and Director of Human Resources and Organisational Development, in attendance by invitation to ensure the Committee has access to information and advice relevant to its discussions quickly and efficiently and the Secretary to the Board. The Committee also has access to external support and advice if required.

The Trust does not currently have a policy statement on the remuneration of senior managers, but does have an agreed salary scale for Directors which is overseen by the Remuneration and Terms of Service Committee. Our Standing Financial Instructions state that the committee will make such recommendations to the Board on the remuneration and terms of service of Executive Directors (and other senior employees) to ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's financial circumstances and performance and to the provisions of any national arrangements for such staff, where appropriate. Executive Directors of the Trust

[3] Except where discussions relate to the appointment or appraisal of the Chief Executive

have defined annual objectives agreed with the Chief Executive. The Committee receives a report of their performance annually. The Directors do not receive performance related bonuses. The Directors do receive expenses in line with the Trust's Standing Financial Instructions and the Trust's Travel Policy.

Executive Directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors as appropriate. All executive Directors covered by this report hold appointments that are permanent until they reach the normal retiring age. The notice period for the Chief Executive is three months, six months for Executive Directors appointed before December 2011 and three months for those appointed after this date. Any termination payment would take account of national guidance.

The Trust pays due consideration to what is happening in the financial environment and with its other employees when determining Directors' remuneration.

Non-Executive Directors are appointed by the nominations committee, a sub-group of the Council of Governors. The committee is supported by appropriate advice and guidance from a human resources specialist. If appropriate, the nomination process may also include the services of another external agency and such other independent expert as may be considered necessary.

Salary and pension entitlements of senior managers

There were no early terminations during the year that required provisions to be made in respect of compensation or other liabilities.

The accounting policy for pensions and other retirement benefits are set out in note 1 to the accounts and details of the senior manager's remuneration can be found below. The information contained in the table has been subject to audit.

There were no significant awards made to past senior managers.

REMUNERATION REPORT

Salary and Pension entitlements of Senior Managers

A) Remuneration

Senior Managers are defined as the Executive and Non-Executive Directors of the Trust.

Name and Title	Year ended 31 March 2013			Prior Year		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
Dr J Mahajan, Medical Director [1]	120-125	45-50	0	120-125	20-25	0
Mrs H Mcnair, Chief Nurse	95-100	0	0	30-35	0	0
Mr P O' Connor, Chief Executive [2]	145-150	0	0	145-150	0	0
Mr D Peverelle, Chief Operating Officer	95-100	0	0	90-95	0	0
Ms D Hanwell, Director of Finance and Information [3]	30-35	0	0	90-95	0	0
Ms J Ashby, Director of Finance and Information [4]	30-35	0	0			
Mr S Wragg Chairman	35-40	0	0	35-40	0	0
Mrs L Christon, Non-Executive Director	10-15	0	0	10-15	0	0
Miss A Arnold, Non-Executive Director [5]	0-5	0	0	10-15	0	0
Mr P Spinks, Non-Executive Director [6]	5-10	0	0	5-10	0	0
Mrs S Brain England OBE, Non-Executive Director	10-15	0	0	0-5	0	0
Mr S Houghton CBE, Non-Executive Director	10-15	0	0	0-5	0	0
Mr F Patton, Non-Executive Director	10-15	0	0	10-15	0	0

1 Dr J Mahajan - other remuneration consists of £24,444.36 additional programmed activities and £23,335 retrospective arrears. Dr Mahajan also receives an additional payment from the Nottingham North Clinical Commissioning Group (NNCCG) for her role as secondary care governor with the NNCCG. In 2012/13 this amounted to £2,500 (appointed from September 2012).

2 At the Board's direction, Mr O' Connor was appointed as a Non-Executive Director of Medipex in February 2012. There was no remuneration attached to the role in 2012/13 or in 2011/12 and any future remuneration or fees that might become payable would be for the Trust's receipt, not Mr O' Connor. It was announced in April 2013 that Mr O ' Connor was to resign from the Trust.

3 Ms D Hanwell left the Trust on 31 July 2012.

4 Ms J Ashby was appointed as Director of Finance and Information from August 2012 and was remunerated via consultancy fees of £48,500.00 until 3 December 2012.
The table disclosure above details payroll costs for the period 3 December 2012 to 31 March 2013 for salary costs as Director of Finance and Information.

5 Ms A Arnold left the Trust on 31 August 2012.

6 Mr P Spinks commenced as a Non-Executive Director on 1 September 2012.

	2012/13	2011/12
Band of Highest Paid Director's total Remuneration £' 000s	145-150	145-150
Median Total £' s	22,412	21,798
Ratio	6.7	6.8

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

The banded remuneration of the highest-paid Director in the Trust in the financial year 2012/13 was £145,000 to £150,000.

This was 6.7 times the median remuneration of the workforce which was £22,412.

Total remuneration includes salary, non-consolidated performance-related pay (£Nil), benefits in kind (£Nil) as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Remuneration includes the staff on the Trust payroll together with agency staff and staff which the Trust has contracts for which are relevant to the calculation. These contracts are with the organisations Initial Healthcare and Chubb. On certain agency invoices used in the calculation, it is not possible to identify the agency commission. In such cases a 25% deduction has been made from the agency bill as the assumed agency commission, since this should be excluded from the calculation. A review was undertaken of charges incurred of agency staff in the last week of the financial year to identify a representative assessment of such costs as at the reporting end date of 31 March 2013.

Further details of the calculation for the Median Total and the Ratio to the Band of the Highest Paid Director are included in the ' Hutton Review of Fair Pay - Implementation Guidance '. Key extracts from this guidance are detailed below;

Following FRAB approval on 25 January 2012, the FReM has been amended to require the disclosure by public sector entities of top to median staff pay multiples (ratio) as part of the Remuneration Report from 2012/13: The FReM requirement to disclose;

‘The mid-point of the banded remuneration of the highest paid Director (see paragraph 5.2.6), whether or not this is the Accounting Officer or Chief Executive and the ratio between this and the median remuneration of the reporting entity's staff. The calculation is based on the full-time equivalent staff of the reporting entity at the reporting period end date of 31 March 2013 on an annualised basis. For departments, the calculation should exclude arm's length bodies within the consolidation boundary. Entities shall disclose information explaining the calculation, including causes of significant Variances where applicable. Further guidance is provided on the Manual's dedicated website '.

Basis of calculation for Median - The median remuneration of the reporting entity's staff is the total remuneration of the staff member(s) lying in the middle of the linear distribution of the total staff, excluding the highest paid Director. This is based on annualised, full time equivalent remuneration as at the reporting period date. A median will not be significantly affected by large or small salaries that may skew an average (mean) - hence it is more transparent in highlighting whether a Director is being paid significantly more than the middle staff in the organisation.

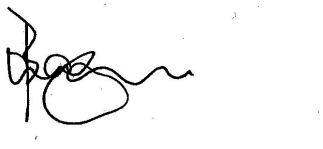
B) Pension Benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500)	Total accrued pension and related lump sum at age 60 at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 1 April 2012 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mr P O' Connor, Chief Executive	**10.0-12.5**	**175.0-180.0**	**902**	**782**	**79**	**0**
Mr D Peverelle, Chief Operating Officer	**2.5-5.0**	**165.0-170.0**	**940**	**851**	**44**	**0**
Ms D Hanwell, Director of Finance and Information	**5.0-7.5**	**135.0-140.0**	**596**	**485**	**29**	**0**
Dr J Mahajan, Medical Director	**0.0-2.5**	**110.0-115.0**	**562**	**517**	**18**	**0**
Mrs H Mcnair, Chief Nurse	**17.5-20.0**	**140.0-145.0**	**618**	**490**	**102**	**0**
Ms J Ashby, Director of Finance and Information	**0.0-2.5**	**0.0-5.0**	**6**		**6**	

As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.



Paul O'Connor Chief Executive
Date: 28th May 2013

Relations with members

Hospital Membership

Our members provide an important local voice and have a say in how the hospital is run. Members are mainly local people, but can include people from the whole of England and Wales, who elect the governors on the Council of Governors and help to shape services in Barnsley to benefit local people. Members can raise their concerns and interests with the members' office or with any of the Governors.

Becoming a member

- Helps people find out how we are performing
- Keeps them up-to-date with changes through our regular members-only newsletter
- Lets them have a say in how things are run
- Allows access to hundreds of discounts usually only accessed by NHS employees
- For more information about our members, please see below

Our members provide a local voice and have a say in how the hospital is run. To be eligible for membership, people must either:

- be employed by the Trust with a permanent contract or have worked at the hospital for at least 12 months or on a series on short-term contracts which total more than 12 months. Becoming a staff member is automatic, with a choice to opt out if they wish. Volunteers are included within the staff constituency and contracted staff have the chance to opt in; or
- live within the Barnsley Metropolitan Borough which is broken into five constituencies; or
- live in any other area of England and Wales (our 'out of area' public constituency).

Anyone at and over the age of 14 is eligible to become a member.

Membership as at 31 March 2013 was 12,585 members - made up of 9,268 public and 3,317 staff and volunteers.

Membership at the end of the year breaks down as:

Public

Constituency A – 2081 covering the electoral wards of Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham
Constituency B – 1494 covering the electoral wards of Darton East, Darton West and Old Town
Constituency C – 1712 covering the electoral wards of Stairfoot, Central, Kingstone and Worsbrough
Constituency D – 2090 covering the electoral wards of St Helens, North East, Cudworth, Monk Bretton and Royston
Constituency E – 1260 covering the electoral wards of Darfield, Dearne North, Dearne South and Wombwell
Constituency O – 631 covering out of area/England and Wales

Staff

Medical and Dental – 244

Nursing and Midwifery – 1635
Clinical Support – 532
Non-Clinical – 717
Volunteers – 189

The Governors and the Trust's membership strategy has been to continue to focus on maintaining and engaging a diverse and representative membership, reflecting our local population. This focus was one of the key drivers behind the programme of engagement events launched in 2011/12 (three events) and continued into 2012/13 (one main event).

In 2012/13, public members continued to receive quarterly editions of the members' newsletter, Barnsley Hospital News. As mentioned earlier, governors play a vital role on the editorial board to ensure that the newsletter includes news, comments and responses to issues that their members have told them they want to know about.

Staff members were kept informed through routine internal communications. The website is also well used and in the year all staff were given access to social media sites such as Twitter and Facebook, opening up further channels for communication.

Membership is spread across the constituencies, largely mirroring the overall constituency populations. At the end of 2012/13, membership levels were broadly similar to those of 2011/12.

Members can contact Governors or Directors via Carol Dudley, the Secretary to the Board at Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP. Telephone 01226 435000.

Other disclosures

Freedom of information

The Trust continues to meet its duties under the Freedom of Information Act, meeting requests for information from the public, politicians and the media. The majority of these requests are received by email and are responded to electronically within the 20 working day deadline. The Trust continues to provide the information, where it exists, free of charge if the information can be gathered at a reasonable cost. In the financial year 2012/13 the Trust received a total of 319 requests (an increase of 116 on last year), for which none received a payment.

Market values / fixed assets

At the end of the financial year we have revalued our estate. After obtaining an indication of the change in building indices from the District Valuer, it was decided that a full revaluation should be undertaken in compliance with audit requirements. This resulted in a reduction in value of £2.7m.

Political or charitable donations

There have been no political or charitable donations in the year.

Provision of goods and services

The income from the provision of goods and services for the purpose of health service for Barnsley Hospital NHS Foundation Trust is far greater than its income from the provision of goods and services.

The other income received by the Trust has not had any impact on the ability to provide goods and services for the purpose of the health service in England.

Balance sheets

There have been no post balance sheets that would affect the Trust.

Branches outside the UK

There are no branches of Barnsley NHS Foundation Trust outside the UK.

Financial risk

In assessing the financial position of the Trust, the Board does not consider there is exposure to any significant financial risk with regard to financial instruments.

Disclosure to auditors

So far as the Directors are aware, there is no relevant information of which the auditors are unaware and the Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The accounts have been prepared under a direction issued by Monitor and recorded in the accounting officer's statement later in this report. The Directors are responsible for ensuring that the accounts are prepared in accordance with regulatory and statutory requirements.

A Director is regarded as having taken all the steps that they ought to have taken as a Director in order to do the things mentioned above, and:

- made such enquiries of his/her fellow Directors and of the company's auditors for that purpose and
- taken such other steps (if any) for that purpose, as are required by his/her duty as a Director of the company to exercise reasonable care, skill and diligence.

Monitor ratings

Our Monitor ratings at the end of 2012/13 were amber-green for governance (including mandatory services) and 3 for finance. For governance this is slightly below plan, largely due to the pressures on the Trust's urgent care pathway and resulting breach of the A&E 4 hour national target. The finance rating was actually above 3 each quarter but rounded down in reporting. Full details of the Trust's ratings can be seen at Monitor's website **http://www.monitor-nhsft.gov.uk/**

Table of analysis

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating	3	4	3	3	3
Governance risk rating	Amber-Red	Amber-Red	Green	Green	Green

The year opened at amber-red for governance, reflecting the findings of the CQC inspection (2011). Robust actions, extending beyond the requirements of the CQC, ensured the Trust returned to green in Q2.

The Q1 rating of '4' for finance was in accord with the in-year plan for 2011/12.

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Amber-Green	Amber-Green

As mentioned above, the lower governance ratings in Q3 and Q4 largely reflect breaches against the A&E 4 hour national target. Q3 also included a breach against the cancer two week (breast symptoms) target (92.8%) and the all cancer two week wait in Q4 which was 92.97% (both targets = 93%).

Health and safety

Barnsley Hospital takes an active approach to ensure compliance with current health and safety and fire legislation. The Trust undertakes mandatory training for staff on an annual basis and all new starters receive induction training.

Regular reports of all non-clinical incidents and training are discussed at the Health and Safety Committee on a quarterly basis and the reports go to the Non-Clinical Governance and Risk Committee.

The Trust was inspected in March 2013 by the Health and Safety Executive and is regularly inspected for fire safety by South Yorkshire Fire and Rescue Service. No enforcement action was taken against the Trust during the year.

Occupational Health and Wellbeing Service

The Occupational Health and Wellbeing Service has this last year been successful, working collaboratively with Sheffield, Rotherham and Doncaster Occupational Health Services to form the South Yorkshire Occupational Health Partnership, in winning the South Yorkshire

CCG contract for an Occupational Health Service to be provided across the four sites. Further working together is planned for the future.

New contracts – The number of local educational establishments having a Service Level Agreement with us has now reached ten and a local manufacturing company has also signed a Service Level Agreement this last year. No contracts have been lost.

The uploading for SEQOHS (Safe Effective Quality Occupational Health Service) has been successful and an assessment visit for accreditation is planned for the 8 July 2013. This will enable our service to have verified evidence we provide a high standard, cost effective service. As part of this we have worked on a new costing system STEM (Software Tool for Efficiency Modelling) as recommended by NHS Health at Work.

As a service we continue to:

- Develop and work on the Occupational Health and Wellbeing strategy/business plan
- Benchmark by participating in MoHaWK the national clinical registry of Occupational Health
- Carry out both internal and external audits
- Collate statistics via ESR and Cohort to provide monthly statistics to stakeholders to provide evidence of meeting KPIs
- Reports are also provided to the Health and Safety Board

The Influenza programme was very successful last year, the Trust having 63.7% uptake, changing the programme delivery was worth the investment and the aim for this year is to reach 70% uptake as recommended by the Department of Health.

Stress champion role

The Stress Group, consisting of a multidisciplinary group of staff from Human Resources, Learning and Development and Union Representatives, continues to support wards/ departments as they go through the process of completing the HSE questionnaire. Following analysis of results a stress action meeting is held and an action plan developed. The findings are then taken to the Health and Safety Board.

The Stress survey was also carried out last year incorporated in the Staff survey, with an increased response rate from 24% to 67.1%. The results indicate an increase in stress in the workplace.

A joint action plan is to be developed between Human Resources, Learning and Development and the Occupational Health and Wellbeing service. Working as a team it is proposed the information/education/support will be taken to staff, linked in with Trust's policies such as Sickness Absence, Trust Values, how to access support from Occupational Health and Wellbeing such as Cognitive Behavioural Therapies (CBT), Eye Movements Desensitisation and Reprocessing (EMDR), sign posting to external services for example, alcohol and drug advice, debt advice, food distribution agencies and domestic abuse.

Manual handling

As requested, extra sessions have been delivered to meet training compliance.

Head count of training attendance 1 April 2012–31 March 2013

- Theory loads - 1691 staff trained
- Practical patient handling -1853 staff trained
- E-learning - 567 staff trained

Compliance 93% for no patient handling
71% for patient handling

99 key trainers in place who have trained 340 staff.

15 Managers have taken up the Risk Assessment training.

Audit of risk assessments on-going and action plan in place. Taken to Health and Safety Board.

Manual Handling steering group takes place on a quarterly basis (sub group of Health and Safety Board).

Manual Handling Specialist continues to run sickness absence referral clinics for musculoskeletal referrals and at this time is the gateway for physiotherapy referrals for staff.

Next year Barnsley Occupational Health and Wellbeing Service aim to:

- Gain SEQOHS accreditation and continue working to maintain and build on the current standards
- Have an achievable action plan to work as part of a team in reducing stress in the workplace, enabling all staff to have a better understanding of mental health issues in the workplace and how they can support themselves and others
- To meet all our KPIs so we maintain and increase our Service Level Agreements and continue to income generate
- Continue and build our collaborative working

Countering fraud

Barnsley Hospital fully subscribes to mandatory requirements on countering fraud and corruption across the NHS and is committed to the elimination of fraud within the Trust. Where fraud is proven, it is investigated and we ensure that wrongdoers are appropriately dealt with and steps are taken to recover any assets lost due to fraud.

The Trust has a nominated Local Counter Fraud Specialist responsible for carrying out a range of activities that are overseen by the Audit Committee. Fraud risk assessments are undertaken throughout the year and used to inform counter fraud work. Where fraud is identified or suspected it is formally investigated in accordance with the Trust's Fraud Policy and Response Plan.

During the reporting year, activity in the counter fraud arena has concentrated on the prevention of key fraud risks and raising the fraud awareness culture of new and existing staff. There is understanding and support throughout the Trust to raising awareness of staff, contractors and users of the organisation's services to the threat of fraud and to ensuring robust counter fraud measures are in place. The efforts of the Director of Finance and Information together with the Audit Committee in this process contributes to an embedded anti-fraud culture throughout the Trust.

Previously, NHS Protect has evaluated the Trust's counter fraud work through an annual Qualitative Assessment process as 'Performing Well'. This process was suspended in 2011/12 due to NHS organisational changes and is to be reintroduced for 2012/13 counter fraud activity.

Better Payment Practice Code

As part of our efforts to help local businesses and be a fair trading partner in these difficult economic times, the Trust signed up to the Better Payment Practice Code whereby we agreed to pay invoices within 30 days of receipt and for small/medium sized enterprises and our local business partners we aim to pay bills within just ten days, thereby supporting improved cash flow for our local suppliers and businesses.

Our performance in the year is as follows:

Number of Bills Paid: 36121
Number of Bills paid within 30 days: 34368
Percentage of bills paid within 30 days: 95.15%

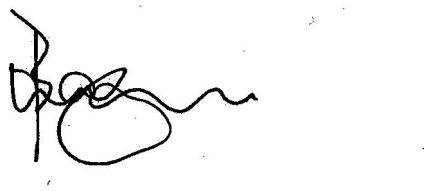
Cost allocation and charging requirements

The NHS foundation trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Serious incidents

Serious incidents and 'never events' are taken very seriously. When a serious incident or never event is identified it is escalated to a Director. It is then thoroughly investigated by an internal independent review team. A report and action plan is completed. The action plan is monitored by the SRG on a monthly basis.

The Trust had a total of 34 serious incidents and four never events during 2012/13.



Paul O'Connor
Chief Executive

Date: 28th May 2013

Statement of Accounting Officer's responsibilities

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

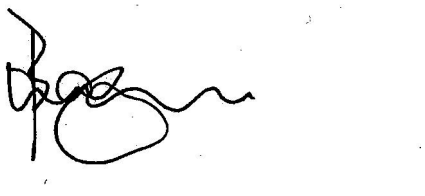
Under the NHS Act 2006, Monitor has directed Barnsley Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Barnsley Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



Paul O'Connor
Chief Executive

Date: 28th May 2013

Annual Governance Statement (AGS)

By Paul O'Connor, Chief Executive

ANNUAL GOVERNANCE STATEMENT (AGS) 2012/13

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Barnsley Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically. The system of internal control has been in place in Barnsley Hospital NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Accounts.

3. Capacity to handle risk

The overall responsibility for the management of risk lies with the Chief Executive as Accounting Officer. The Board of Directors, collectively and individually, ensures that robust systems of internal control and management are in place. This responsibility is supported through the assurance committees of the Board of Directors under the chairmanship of a Non-Executive Director, with appropriate membership or input from members of the Executive team.

As part of the Board's continuing commitment to risk management, the Trust reviews its governance arrangements on a regular basis, most recently in 2012/13, in order to appraise the implementation, effectiveness and outputs of the changes. The results of these reviews indicated that the revised arrangements were robust and operating effectively. The review did however recommend some changes to further enhance these arrangements. The recommendations included; revising the membership of the governance committees and aligning the agendas of these committees to directly correlate with the Board Assurance Framework, in order to ensure the relevance of assurance information received and reviewed at each of these Committees (which would in turn enhance the upward assurance provided to the Board of Directors).

The Trust has in place a Director of Quality and Performance function; the role's portfolio includes improving the Board Assurance processes by linking quality, business planning and performance reporting. The Trust also has in place a Head of Corporate Governance to support this function. The Board of Directors is satisfied that these arrangements are

robust and operating effectively.

The Trust continually reviews best practice advice as outlined in Monitor guidance, Healthcare Financial Management Association (HFMA) and other governance literature, to ensure that the Trust proactively develops progressive systems and processes that can deliver exemplary practice.

The Board of Directors has sought assurance through quarterly scrutiny of the full Board Assurance Framework and a monthly review of a Board Assurance Framework exception report. The Board also receives reports from the four Board/Assurance Committees, following each committee meeting. The assurance committees and in particular the Clinical Governance and Non-Clinical Governance and Risk Committees, receive exception reports from a number of sub-committees that closely monitor areas of risk including: the Quality and Safety Improvement and Effectiveness Board, Infection Prevention and Control Board, Safeguarding Adults and Children's Boards and the Health and Safety and Information Governance Boards. All these groups have a role to provide regular monitoring for best practice as well as to identify themes and trends for learning and sustained improvements.

The Risk and Governance Strategy for the Trust clearly outlines the leadership, responsibility and accountability arrangements. This document was updated in 2012 by the Head of Corporate Governance and the Trust's Risk Manager and was approved in December 2012. The updated document clearly differentiates between the Trust's risk management arrangements and the governance and assurance framework and also details the Clinical Service Unit and departmental governance infrastructure, which has been developed throughout 2012/13.

A strategic risk forum headed by the Director of Quality and Performance provides the leadership, supervision and monitoring of all serious incidents, complaints, claims and Coroner's inquests. This forum provides the overview, enquiry and challenge to ensure consistency, appropriate levels of investigation and root cause analysis and that key learning is delivered. This forum's functioning has been reviewed and strengthened during 2012/13 and now incorporates the newly appointed Associate Medical Director for Patient Safety to ensure wider clinical engagement. A Quality Assurance Officer and Governance Support Officer have also been included as part of this process in order to ensure that all actions and recommendations identified as part of the process are completed; this also provides an interface with the Clinical Effectiveness Department, which monitors on-going compliance. The lessons learnt from these processes are communicated Trust-wide through the risk management team's quarterly news publication 'Risky Business'. The annual review of the Corporate Curriculum has also been undertaken to ensure that the Trust's training programmes are aligned to statutory and mandatory requirements and that training continues to support the embedding of risk management policies and procedures throughout the organisation.

Capacity is developed across the Trust through a series of training events commensurate with staff's duties and responsibilities. This includes risk management training for all new staff and regular involvement in risk management practices and awareness through monthly risk reviews and their appraisal at clinical service unit and departmental governance forums.

The Trust procured and is currently commissioning a new governance and risk reporting system which will improve the triangulation of clinical incidents, complaints, litigation and patient experience contacts to better identify trends and learning.

Sharing the learning throughout the organisation from risk related issues, incidents, complaints, claims and significant events is key to maintaining the risk management culture within Barnsley Hospital NHS Foundation Trust. Learning is acquired from a variety of sources, including:

- Analysis of incidents, complaints and claims and acting on root cause analysis
- External inspections
- Health and safety issues
- National Patient Safety Agency data
- Assurance from Internal and External audit reports
- Clinical Audit
- Clinical Service Unit and departmental governance meetings
- Corporate governance committees

4. The risk and control framework

Governance Structure and Risk Management

The revised governance arrangements implemented in 2012 have led to improvements in Trust-wide engagement with the risk agenda and controls assurance.

These revised arrangements manage risk and provide assurance to the Board through four Board committees namely: Clinical Governance, Non-Clinical Governance and Risk, Finance and Audit. There is a fifth Board Committee, the Remuneration and Terms of Service Committee, which has specific responsibilities relating to appointment of the Executive Directors and overseeing their performance, including delivery of key responsibilities for management of governance and risk within the Trust. The Board Committee structures reporting through to the Board of Directors have been clearly defined following a comprehensive review of Terms of Reference and reporting arrangements, led by the committees.

The Risk and Governance Strategy and the updated Meeting and Assurance Reporting Framework were approved by the Board in July 2012 and December 2012 respectively, these documents clearly outline the strategic intent and the committee structures that support the Board of Directors and provide the framework for risk control.

The strategy covers risk identification, evaluation, recording risk, control, review and assurance. It also defines the structures for the management and ownership of risk and clearly identifies the Trust's attitude and appetite for risk and at what level a risk is tolerated.

The Board Assurance Framework, together with other reporting mechanisms provided to the Board, provides the evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle objectives have been reviewed. The Board of Directors has approved the Assurance Framework confirming that the risk control measures in place are reasonable and that action plans have been developed to improve the controls and assurance processes where appropriate.

The Assurance Framework is reported monthly to the Board of Directors, on an exception basis, with a full review being undertaken at Board meetings quarterly. The framework is subject to specific detailed review at each of the Board's assurance committees. The

framework is continually updated in order to ensure that it covers all areas on which the Board should be seeking assurance. This information is supplemented and enhanced by the other performance management tools presented, including the monthly Integrated Performance Report. This report provides a comprehensive performance overview to the Board on adherence with regulatory targets, quality indicators, financial delivery, workforce metrics and progress of the business plan objectives.

The Audit Committee performs the key role of reviewing and monitoring the systems of internal control. This committee receives regular reports on the work and findings of the internal and external auditors. This committee is chaired by a Non-Executive Director. An assurance report and minutes following each meeting, along with an annual report, are provided to the Board of Directors. The Committee reviews the establishment and maintenance of effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. The Audit Committee also reviews the effectiveness of the management of principal risks. In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work.

The Board of Directors takes an overarching role in assurance and monitoring of performance and has monitored the delivery of the 2012/13 Business Plan throughout the year. Further assurance is given through on-going Board committee reviews in relation to financial management, quality and governance through the assessment process for quarterly self declaration to Monitor.

The risk management function, risk registers and the Board Assurance Framework have all been continually developed throughout 2012/13 by managers within the Quality and Performance Directorate, led by the Director of Quality and Performance and the Board committees. These enhanced practices have all been robustly reviewed in-year by the Trust's Internal Audit team, the results of which have demonstrated improvements in the Trust's controls assurance processes.

All risk registers for the Trust have been centralised onto an electronic database. This system is supported through monthly risk review processes led by the risk management team; risk register reports are then scrutinised at both Clinical and Non-Clinical Governance meetings. Risks that are not being successfully mitigated and controlled are escalated and discussed at the Board of Directors' meetings in order to prioritise management action appropriately.

The Trust continues to use the National Patient Safety Agency (NPSA) risk matrix in order to assess the likelihood and consequences of identified risks. Risk awareness training on the use of this matrix is planned to be refreshed to all members of the Board and senior managers throughout the Trust. Additional training on the risk register database has also been cascaded throughout the organisation. A further training package on the management and investigation of serious incidents was developed during 2011/12 and has been delivered to a targeted group of senior managers who are responsible for this activity. An external review of Serious Incidents and Never Events was commissioned and further improvements made to the process of education, investigation and reporting. Education on risk management has also been provided to the Clinical Directors as part of their development programme.

In 2012 the Trust agreed to replace the existing incident reporting system to improve ease of reporting and analysis and management reporting. This will enable the Trust to further refine incident information, identify emerging risks, pinpoint trends, improve organisational

transparency and improve access to incident information. The implementation plan has focused on improving understanding of risks and risk management linked to encouraging improved reporting.

Our Major Risks

In 2012/13 the Board took a range of actions to support both on-going assurance and scrutiny and specific actions to reduce risks; examples being:

- Undertaking an annual review of the governance arrangements and evaluating the effectiveness of these arrangements
- Closely monitoring compliance with challenging national and local infection prevention and control targets
- Assurance on the delivery of the Business Plan objectives
- Monitoring performance through an integrated performance dashboard report to ensure reduction in risk and adherence with the Trust's quality priorities
- On-going review and testing of emergency preparedness and business resilience planning
- Review of the Information Governance Toolkit

The most significant Risks facing the Trust looking forward are:

Generic Risks

- Delivering the challenging cost improvement programme (CIP) which is predominantly being achieved through the Trust's quality, innovation productivity and prevention plans (QIPP) delivered through eight Transformation programmes. These savings are essential to meet the financial pressures faced across the NHS and public sector and the impact and challenge that the comprehensive spending review presents to the hospital's annual budget. The Trust has a programme management approach which includes risk assessment and risk register approach which are aligned to the Trust risk management arrangements. The Trust has adopted the West Midlands Quality Impact Assessment (QIA) approach to evaluating the impact of CIP schemes which are required to be agreed by the clinical Director and the Medical Director and Chief Nurse
- Channeling staff engagement to deliver the significant service changes required to deliver both the Trust's Business Plan and the wider NHS reform agenda
- As patient choice, qualitative performance measures and provider competition become more open, the Trust will be required to demonstrate to both patients and commissioners that it consistently delivers high quality services. The Trust has a clear project plan in place to deliver the Friends and Family Test requirement for acute providers by April 2013 and data collection was successfully piloted in March 2013
- The re-admission and intermediate care drivers that will impact significantly across the interfacing health care providers
- Changes to the commissioning landscape have had some impact on provider organisations during their development in 2012/13, although the full impact of these changes may become apparent in 2013/14

Specific Trust Risks include managing:

- The wider impact of the Trust's challenging capital expenditure programme, to deliver the hospital's Estates Strategy
- Maintaining workforce engagement during the significant organisational change required to deliver the Trust's Business Plan
- Delivering the Trust's eight Transformational Programme objectives
- Development of the IT capacity and capability to deliver a comprehensive new patient information system by 2014
- Failure to achieve Trust targets would impact on financial and operational performance
- The challenging infection prevention and control targets
- The variable, high levels of unscheduled care have continued to add risk to the delivery of the A&E 4 hour target

This list is not exhaustive and more details can be found on page 52 of the Annual Report and in the Quality Account.

Significant existing clinical risks

The Trust risk register includes the following significant clinical risks:

- The challenge of maintaining safe staffing levels during periods of additional escalation capacity
- The outlier position in relation to Hospital Standardised Mortality Ratio
- The risk of patients not being seen and assessed in a timely fashion of the A&E 4 hour target

All identified risks are assessed using the NPSA risk assessment matrix used by the Trust, they are then included as part of Trust Risk Registers, mitigation and control actions are identified and risk outcomes are closely monitored through the Clinical and Non-Clinical Governance and Risk Board Committees.

The challenges outlined will be managed through existing Governance and Assurance structures as outlined above.

Internal Audit programme is agreed each year by the audit Committee and has included a number of audits associated with risk processes; these include a review of CQC compliance, risk management, Board Assurance Framework and clinical audit.

Engagement with Stakeholders

The Trust's Assurance Framework has been informed by partnership working across the health care region and through working with other foundation trusts, giving independence and robustness to its assurance framework including:

- Consulting with the local community and engaging with members of the Foundation Trust, including active involvement in the Local Involvement Network (LINks), the community-wide Safeguarding Boards and other district-wide patient and public involvement initiatives
- Membership of the Foundation Trust Network
- Membership of the Foundation Trust Governors Association

- Undertaking consultation and meeting with NHS Barnsley, the local Overview and Scrutiny Committee, NHS Yorkshire and Humber Strategic Health Authority, the recently authorised local Clinical Commisioning Group (CCG), the local Area Team, the Council of Governors and Patient Partnership Initiative (PPI) and other interested bodies/organisations
- Collaborative working between the Council of Governors and the Board of Directors; and
- Membership of the local Health Community IM&T network.

The Trust informs and engages with the public and other key stakeholders in relation to managing risk through a number of forums which include; a regular joint contract/clinical quality review meeting with the Trust's lead commissioners; the sharing of performance reports including key risks and presentation of the Trust's Board Assurance Framework reports at public Board meetings. The Trust's Council of Governors are actively involved in monitoring of the Trust's risks and performance through reports and discussions at Council of Governors meetings, their involvement at public board meetings and through an annual joint board meeting.

Compliance with Standards

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust has reviewed the internal assessment of compliance with CQC standards process and has implemented a four stage approach to assurance, monitored and controlled through identified CQC outcome leads. This revised process has been reviewed by Clinical Governance Committee and internal audit have reviewed the process.

The Trust has received a number of unannounced inspections from the Care Quality Commission during 2012/13 these are detailed below:

Termination of Pregnancy

The Trust was visited on the 21 March 2012 as part of the CQC's national targeted programme assessing arrangements for termination of pregnancy across care providers. The Trust received an initial draft report in April 2012 and a final report at the end of May 2012. The final report highlighted a minor concern with regards to record keeping which the Trust immediately actioned.

The CQC revisited the Trust on the 4 October 2012 to re-assess record keeping compliance and found the Trust to be fully compliant. This was formally reported at the end of October 2012.

Ionising Radiation Medical Exposure Regulations 2000 IR (ME) R

The Trust was visited on the 1 May 2012 to assess the Trust's compliance with the IR (ME) R regulations; the CQC outlined a number of changes that they would like to see within the Trust's imaging departmental procedures. These changes were all made and submitted to the CQC and the Trust was declared compliant in December 2012.

Full Outcomes Inspection

The Trust was visited on the 28 January 2013 and assessed across four outcomes in four clinical ward areas and the Trust was found to be fully compliant against all outcomes in all clinical areas the final report was published at the end of February 2013.

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

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

Sustainability and Carbon Reduction

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and Adaptation Reporting requirements are complied with. Further information can be found on page 47 of this report.

5. Review of economy, efficiency and effective use of resources

The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. These plans incorporate the Trust's plan for improving productivity and efficiency in order to minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. Financial plans are approved by the Board of Directors, supported by the Finance Committee.

An Annual Plan is submitted to Monitor, reflecting finance and governance (including both service and quality aspects), each of which is ascribed a risk rating by Monitor. The plan incorporates projections for the following two years which facilitates forward planning in the Trust.

The in-year resource utilisation is monitored by the Board and its committees via a series of detailed reports covering finance, activity, capacity, human resource management and risk. This in turn forms the basis of the monthly integrated performance report to the Board of Directors. The Trust is committed to the use of service line reporting as a way to assess and measure effective utilisation of resources.

The Board is provided with assurance on the use of resources through a monthly report and the Finance Committee undertakes a detailed review on a quarterly basis. Reports are also submitted to Monitor on a quarterly basis from which a financial and governance risk rating is assigned. Any concerns on the economy, efficiency and effectiveness of the use of resources are well monitored and any identified issues are acted upon.

The Audit Committee's purpose specifically is to provide the Board of Directors with assurance on the effectiveness of processes around corporate objectives. This assurance is validated through the Annual Governance Statement. The Committee also provides the

Board with an independent commentary of the fitness for purpose of the Board Assurance Framework and the effectiveness of the governance, risk management and internal control mechanisms. It focuses on the work of the Internal Audit Annual Plan and liaises with external audit in relation to the findings.

6. Annual Quality Report

The Directors of Barnsley Hospital NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of the Annual Quality Reports which incorporate the legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The formulation of the Trust's Quality Report has been led by the Director of Quality and Performance and the Head of Corporate Governance with the full support of the Board of Directors and the Council of Governors. The formulation commenced in August 2012, with discussion and consultation with the Board, Directors, staff, patients, Governors and stakeholder groups to determine the Trust's priorities and areas for improvement. These quality metrics were refined and discussed and involved reviewing or introducing new policies involving aspects of patient care including: having a better understanding of patients' nutritional status through undertaking nutritional screening and the weighing of patients on admission to hospital; to reduce the incidence of pressure ulcers, by improved identification and management of all cases; to better meet our patient's expectations on their discharge from the Trust.

The Trust's strategy comprises of a number of Trust-wide 'Quality Goals', to address the three quality themes of patient safety, clinical outcomes and patient experience.

The Trust's priorities for 2012/13 were to:

- Improve our knowledge of individual patients nutritional status
- Reduce the incidence of hospital acquired pressure ulcers
- Ready to go no delays

These priorities were communicated through a number of Trust-wide working groups including the Quality, Safety Improvement and Effectiveness Board (QSIEB), the Executive Team, the Clinical Service Unit and departmental Governance Committees and through targeted communication articles in staff weekly news bulletins.

The Board tracks the performance of these priorities through review of the quality section of the integrated performance report that is presented monthly. In addition the quality agenda is integrated within the Board Assurance Framework, ensuring that control measures are in place to deliver the quality priorities.

The Trust's Annual Quality Report is prepared to ensure that it presents a balanced view of the risks to quality governance that has faced the Trust throughout the year. To deliver this perspective and understanding the Board of Directors and the Council of Governors receive regular quality reports and quality dashboard reports to track quality performance and the risk to achieving quality objectives are openly discussed at both Board and Council of Governors meetings. Key members of the Executive team also meet with NHS Barnsley/the CCG, the Trust's lead commissioners, monthly. Quality performance is a key agenda item together with exploring the risk to delivering quality initiatives.

The Board of Directors, Governors and NHS Barnsley are all asked to assess the final Quality Report to ensure that the content of the report on the Quality Account is consistent with the views and experience through the year. These comments are included in the report verbatim and the review occurs before final approval by the Board of Directors.

A number of additional quality initiatives have been introduced in order to improve quality in the widest sense; these improvements include the implementation of:

- The pressure area care patient pathway
- Refined best practice end of life care processes
- Enhanced recovery patient pathways
- Mental health care pathway within maternity services
- The World Health Organisation (WHO) surgical safety check list
- Implementation of the Safety Thermometer point prevalence report on harms
- Implementation of the Friends and Family Test

The nursing dashboard monitors and reviews the progress and performance against these wider quality programmes.

In order to ensure that all the Trust's quality priorities are delivered, work has been carried out with front line staff through the Quality and Performance Department. This has given staff a good knowledge and understanding of the Trust's quality agenda by providing a clear outline of the quality priorities, including how success and achievement against these initiatives will be measured. All staff involved have received training and instruction on the procedures, systems and processes being used to both collect the data and evidence the quality performance outputs. Achievements against these initiatives are monitored through QSIEB and the Quality Commissioning Group meetings. Detailed reports are then provided to the Board of Directors on a monthly basis to provide assurance.

The Board is actively engaged in quality improvement and has fully supported a number of new quality tools for clinical assessment, individual patient safety at a glance boards for all patients where magnets are used as visual symbols to highlight individual patient safety risks and enhanced care requirements.

The Board is assured that quality governance is subject to rigorous challenge through Non-Executive Director engagement and the chairmanship of the key governance committees.

Data Security

Barnsley Hospital NHS Foundation Trust has implemented the NHS Information Risk Management Guidelines by establishing a register of key information assets, allocating each one to an information asset owner who reports to the Senior Information Risk Owner. Information risk management is reviewed and monitored by the Information Governance Board. The Trust has implemented and rigorously enforced the Information Risk and Information Security Policy to control where personal information is stored and to protect personal information that is stored on all portable data storage devices from unauthorised access, through the encryption of all portable devices and remote access personal computers.

A failure to follow the Trust's robust internal processes for the delivery of a new system of work did however lead to a breach of patient confidentiality which was reported as a serious incident in May 2012.

The Trust adopted an open and honest approach to the incident and conducted a thorough investigation in accordance with the Trust's Information Governance and Serious Incident Policies and Procedures. The incident was escalated to the Trust's Commissioner's, the Strategic Health Authority and the Information Commissioner's Office.

Individuals that were potentially affected by the breach of confidentiality were all informed by the Trust and a telephone support line was operated through the Patient Advice and Liaison service to respond to any individuals' concerns.

The Information Commissioner's Office was satisfied that the Trust had the necessary internal processes in place and had they been followed correctly the breach may have been prevented recommending that the Trust ensures that all staff involved in projects involving personal data are fully trained in the requirements of the Data Protection Act and that they have received the relevant training in the roles that they are undertaking.

The Trust has taken this recommendation forward.

Fraud

The Trust has clear management processes with regard to fraud and internal control, laws, regulation, potential litigation and claims affecting the financial statements.

A risk assessment is carried out annually by the Director of Finance and Information in conjunction with the Local Counter Fraud Specialist which covers all potential areas of risk to the Trust. Proactive identification of fraud exercises are undertaken annually based on this risk assessment and in accordance with a comprehensive work plan agreed by the Trust's Audit Committee. Where any frauds are identified or suspected an investigation is carried out in accordance with the Trust's Fraud Policy and Response Plan.

A number of measures are used to increase staff awareness of fraud and encourage individuals to report any suspicions or concerns they may have. The Trust's Local Counter Fraud Specialist regularly gives presentations to members of staff to raise awareness of fraud issues and counter fraud information is provided to all new employees.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report incorporated within this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance Committee, the Clinical Governance Committee and the Non Clinical Governance and Risk Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Work has been commissioned from the Internal Audit service as noted within the statement to review the adequacy of the controls and assurance processes in place and to develop improvements within the governance processes. The Head of Internal Audit and the Chair of the Audit Committee have formally noted the improvements to the Trust's governance processes and infrastructure. The Trust is committed to the continuous improvement of its risk management and assurance systems and processes, to ensure improved effectiveness and efficiency.

I have drawn on the content of the Quality Report incorporated within the Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

My review is also informed by:

- Opinion and reports by Internal Audit, who work to a risk-based annual plan with topics that cover governance and risk management, service delivery and performance, financial management and control, human resources, operational and other reviews
- Opinion and reports from our external auditors
- Quarterly performance management reports to Monitor
- Department of Health performance requirements/indicators
- Full compliance with the Care Quality Commission essential standards for quality and safety for all regulated activities across all locations
- NHS Litigation Authority (NHSLA) assessments against risk managements standards and Clinical Negligence Scheme for Trusts (CNST) for maternity
- Information governance assurance framework including the Information Governance Toolkit
- Results of national patient and staff surveys
- Investigation reports and action plans following serious incidents
- Council of Governors reports and
- Clinical audit reports

The Trust has proactively recognised the need for on-going development of the robustness of its systems of control and assurance and the monitoring of its risk registers and Assurance Framework to ensure they identify the changing impact and likelihood of risk and better support the delivery of business objectives.

During 2012/13, the Trust's Assurance Framework and governance processes identified gaps in control in the following areas:

- Delivery of the A&E 4 hour target has proved extremely difficult in 2012/13 due to the variable, high levels of unscheduled care presenting at the Trust. The Trust failed to achieve this target in both Quarter three and Quarter four. An action plan has been developed and a number of meetings have been held health community wide to

support the whole system changes required to rapidly improve performance to deliver this target consistently in 2013/14.

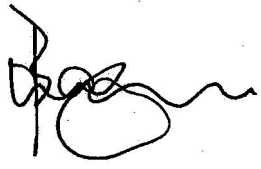
- An internal audit of infection prevention control procedures highlighted some gaps in controls assurance relating to mattress replacement at the Trust. The systems and processes to manage this process have been revised and strengthened and when re-checked the gaps in control had been fully addressed.
- An internal audit examined the Clinical Audit function at the Trust and identified a number of controls assurance weaknesses relating to the approval and monitoring of the Trust's Clinical Audit Plan. These weaknesses have been fully addressed and controls assurance processes are now in place and have been reassessed as robust.
- The Trust has had an excellent track record in delivering across the full range of cancer targets. The Trust did, however, fail to deliver the two week wait (breast symptoms) 93% target in quarter 3 and the 'all cancers' two week wait for quarter 4, due to patient choice. The Trust also only achieved 92.97% at quarter 4. The Trust is awaiting Monitor's decision in relation to rounding on this figure.

During 2012/13, the Trust's Assurance Framework and governance processes identified the following positive signficant assurance reports:

- Occupational Health
- Research Governance
- Payroll
- Infection Control Follow-up
- Medicines Management
- Training Expenditure
- Serious Incidents
- Equality and Diversity
- Patient Experience
- Clinical Audit Follow-up
- Medical Devices
- Information Governance
- Contract Management
- IT Procurement Follow-up

Conclusion

As Accounting Officer and based on the review process outlined above, the Trust has identified and is taking action on the control issues arising in-year which have been identified in detail in the body of the Annual Governance Statement (AGS) above.



Paul O'Connor
Chief Executive

Date: 28th May 2013

Financial Statements