Annual Report & Accounts

2011/12

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

Barnsley Hospital NHS Foundation Trust

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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 Hospitals 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.

The hospital was built in the 1970s, and covers a site of 8.2 hectares. It has c500 beds, and employs 3008 staff (at 31 March 2012). We serve a population of approximately 226,000 across an area which matches the same the 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, South West Yorkshire Partnership NHS Foundation Trust, the local authority and other private and public sector partners.

Chairman & Chief Executive overview

We knew that 2011/12 was going to be our toughest year ever. The sheer scale and pace of the NHS reforms, coupled with no inflationary uplift in our annual budget meant that we started the year facing unprecedented challenges.

We had exacting performance and quality targets to meet as well as needing to make yet more efficiency savings, but we were also faced with unpredictable events. In particular, an unanticipated surge in unplanned admissions, due to factors outside our control, tested our flexibility and responsiveness.

And so while our plans to meet our business objectives were largely on track, the unforeseen continued pressures on our unscheduled care services - such as the emergency department, medical admissions unit and diagnostics - placed incredible pressure on our teams and services.

On top of this, we also had a disappointing report early in the year from the Care Quality Commission on our nutritional standards.

So it is with a strong sense of pride and huge admiration for our staff that at the end of the year we are able to say we delivered on all our national and local targets and are in a stable financial position with a modest planned surplus. Given the challenges we faced, some anticipated, others unpredictable and outside our control - this is an incredible feat.

Our performance
Despite seeing the biggest rise in emergency department attendances in the whole of Yorkshire, we met our target to see and treat 95% of all patients within four hours. The stretch this placed on our staff - in both the emergency department and the teams across the hospital who help to diagnose conditions and admit and care for patients on wards - was very challenging at times.

It is a tribute to their professionalism and dedication to patients that they 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.

Already rigorous infection control standards were made even tougher when our C.Difficile target was more than halved – from 65 to 31. We had fewer cases than the target and also maintained our zero cases of MRSA bacteraemia for the second year in a row. This, too, is a phenomenal result, given the increased numbers of patients and the extra pressure that our staff were under.

We managed the increase in unplanned patient numbers by opening escalation wards, as and when needed. 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. And this is not ideal. Our plans for greater continuity of care and improving urgent care services in the year ahead will help us to tackle this.

The Chief Operating Officer, David Peverelle, talks about these plans in more detail in his performance report on pages 12 to 14, as well as illustrating just how tough the challenges have been and our response to them.

Quality
All the success of our staff's hard work to meet the many high standards we are set and set ourselves was overshadowed by a Care Quality Commission report into our nutrition standards.

The report followed an inspection into both nutrition and privacy and dignity. Although we met the privacy and dignity standards, we did not meet all those for nutrition. As a result, the CQC had moderate concerns around how we ensure people's individual dietary needs around food and drink are met.

We were extremely disappointed by the findings and immediately put in place a range of actions to tackle the shortcomings identified. In December we were reinspected and the final report praised the systems and processes we had introduced. You can read more about this and the many other quality standards we meet and work towards in both the quality account and the business review.

Transformation
Our biggest challenge last year lay not just in improving the efficiencies of our services but developing a wholesale approach to transforming how we work. We have reduced our costs two years in a row – and we can only cut back so much. As a district general hospital, our survival depends on coming together as a team to transform how we work.

We took some significant steps. We appointed 13 of 14 clinical directors in March – from within our existing clinical teams - who will be at the centre of our transformation plans in the coming year, we developed advanced nurse practitioners who are helping to diagnose patient conditions and prescribe their medicines and we took an altogether fresh approach to managing patients through surgery by building their strength and resilience before some procedures.

You can read about these developments in the business review.

While these were significant steps, we are still at the beginning of our journey. We need to do much more if we are to not just survive, but thrive in the years ahead.

Looking ahead
If we are to meet our patients' needs, if we are to put quality and safety first, if we are to flourish in the new NHS, then our wholesale transformation needs to start now.

The Health & Social Care Act reforms aim to improve patient outcomes, drive up quality and increase clinical leadership. Very soon, GPs will be our commissioners and later this year, competition for providing some NHS services will be opened up. In addition, the reforms will strengthen local accountability with increased powers for our governors.

The findings from the Mid Staffordshire NHS Foundation Trust public enquiry are also anticipated later in 2012 and while we cannot predict what recommendations they will make for the whole of the NHS, we are making preparations to ensure that our response ensures that we are providing safe and effective care.

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 need greater clinical leadership. This is why we have introduced 14 clinical service units (CSUs), each with a clinical director at the helm. The units will be the way we do business and all our staff will support them in ensuring 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 need to develop our clinical directors, governors and Board directors so that they are equipped to take on their enhanced roles.

To transform, we need to think differently and act differently.

In developing our plans, we involved our staff, governors, partners, patients and unions. These are their ideas, shaped through discussion, exploration and fine-tuning. Some of our plans are simple and straighforward, some are hugely ambitious.

They have been developed to help us meet the enormous challenges ahead. 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 Governing Council.

Chief Executive - Paul O'Connor

Medical Director - Dr Jugnu Mahajan
Director of Finance and Information - Dawn Hanwell
Chief Nurse - Juliette Greenwood, until 30th September 2011
Heather Mcnair from 5th December 2011

Chief Operating Officer - David Peverelle

Chairman - Stephen Wragg

Non-executive directors
Anne Arnold
Linda Christon
Francis Patton
Paul Spinks (to 31st December 2011)
Sarah Wildon (to 31st December 2011)

Stephen Houghton CBE (from 1st January 2012)
Suzy Brain England OBE (from 1st January 2012)

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.

In the last 12 months, there have been some changes to the team. The role of Director of Quality and Standards changed to Director of Quality and Performance. Following Sharon Linter's departure to a new job in Cornwall, Liz Libiszewski joined the team from Kettering General Hospital NHS Foundation Trust where she was Director of Nursing.

Heather Mcnair became our new Chief Nurse in December, following the departure of Juliette Greenwood, who had held the position for six years.

The Director of Strategy and Business Development role was dissolved and this important work was carried forward by the rest of the management team.

Our work throughout the year to introduce clinical directors was almost complete at the end of March, with 13 of the 14 posts filled. This new model of governance, which devolves responsibility and accountability to clinical service units, each led by a clinical director, meant an end to divisions. As such, our divisional director roles were also dissolved at the end of March 2012.

Paul O'Connor, Chief Executive
Hilary Brearley, Director of Human Resources and Organisational Development
David Bullimore, Divisional Director for Emergency and Integrated Medicine (until 9 December 2011)
Matthew Chobbah, Director of Strategy and Business Development (until 30 June 2011
Juliette Greenwood, Chief Nurse (until 30 September 2011)
Dawn Hanwell, Director of Finance and Information
David Hicks, Divisional Director for Women's, Children's and Diagnostics (until 31 March 2012)
Elaine Jeffers, Divisional Director for Surgery and Critical Care
Liz Libiszewski, Director of Quality and Performance (from 1 March 2012)

Sharon Linter Director of Quality and Performance (until 29 January 2012)
Dr Jugnu Mahajan Medical Director
Heather Mcnair, Chief Nurse (from 5th December 2011)
David Peverelle, Chief Operating Officer
Helen Stevens, Associate Director of Communications and Marketing

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: .....

Paul O'Connor .....
Chief Executive

Date: .....

Performance

Performance overview

In 2011/12 we cared for 61,193 patients in the hospital (over 3,000 more than the previous year), saw 268,025 in clinic appointments (3,600 more) and treated 78,217 in our emergency department (over 3,000 more).

As you will have read in Stephen and Paul's overview, the most significant challenge to our performance last year was an increase in unplanned admissions due to circumstances outside of our control. This related predominantly to changes in admissions to hospitals on our borders. As a result, we have seen the biggest rise in unplanned attendances at our hospital than any other in the whole of Yorkshire, in a year when we set a path to reduce our bed base.

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 immensely proud to work at this hospital with such dedicated teams.

Managing the extreme demand on our services has, at times, been testing. We cope by opening, and closing, escalation wards. These are wards without established teams, and while the staff who work on them do their absolute best to ensure high quality patient care at all times, they do so without the familiarity and understanding of our regular ward setup. And while this is safe and the standards are high, it is not ideal for our patients or the staff.

The turnaround time for patients who come to us by ambulance is the second fastest in Yorkshire. This is a fantastic service for our patients and we intend to keep it this way, but it too adds extra pressure to our services.

Our plans for the coming year include both an expansion to our medical admissions unit and the introduction of an 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 are also keen to develop our services beyond the routine Monday to Friday, nine to five pattern. Patients who are admitted outside of these times have a right to the same services and care. We have already started to look at the continuity of care of our patients, particularly around diagnostics, and this work programme will pick up pace in the year ahead.

Our overall performance against national and local standards given the extra pressures we faced has been exceptional. We have met them all (see page 15), including seeing and treating 95% of all patients within four hours in our emergency department. I am indebted to the teams who make this happen 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
In a year when headlines were being made about reducing workforce numbers, we bucked the trend and invested £1 million in nurses and midwives. We did so because quite simply we wanted to maximise the quality and safety of our care. A review of our nursing and midwifery staffing levels, set against the rising trend in unplanned admissions, had shown us this was necessary.

At the same time, we made great strides towards changing how we plan, run and monitor the performance of our services. At the end of March we had appointed 13 of 14 clinical directors who will each lead a clinical service units (CSUs). They will report to me, as will the assistant chief operating officers (currently assistant divisional directors), who will manage a team of service managers working within each clinical service unit.

The units will be the way we do business and all our staff will support them in ensuring that patients are always at the centre of our decision making.

We worked alongside our staff last year on several projects, all of which looked at making improvements in areas they said could be better. The "Together we will make it: better" programme involved teams of staff tackling areas around senior management communications, appraisals and improving staff perception of the priority of patients to the hospital to develop solutions. Not only did they come up with a raft of ideas, they put them into action and as a result our staff survey scores improved.

With the help of our staff, we developed a set of values and behaviours. The inclusive engagement approach that we took, which involved staff from all across the hospital, means that our values have truly been set by them.

The increasing continual involvement and communication with our staff is manifested in the outcomes we are seeing. At the end of the year, staff's training and appraisal rates had increased notably since the year before and the feedback from our Investor in People accreditation showed significant improvements in how staff feel about their working environment.

During the year we started to revise and improve our services for patients – and you can read about examples in the sections on providing high quality and services and designing healthcare around our patients needs. They include improvements for patients suffering from a stroke, patients undergoing breast screening and helping patients get better faster from their surgery.

Our work on carbon reduction & sustainability was recognised nationally and we were named as one of the leading hospitals in the country in this area. You can read more on this on pages 48 to 50.

Looking ahead
In Stephen and Paul's review, they refer to the impact that the Health and Social Care Act and the findings of a public enquiry into Mid Staffordshire NHS Foundation Trust will have 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 challenges 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 embark on a number of transformation programmes to radically review and re-shape 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

Signed

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David Peverelle
Chief Operating Officer

Performance against our plans
Key performance indicators

National targets

We met all our national targets

- 95% patients to be seen within four hours in the emergency department. **We achieved 95.6%**
- 90% patients treated within 18 weeks of referral for admitted patients. **We achieved 94.14%**
- 95% patients treated within 18 weeks of referral for non-admitted patients. **We achieved 98.6%**
- 95% patients to have a maximum waiting time of 31 days from diagnosis to treatment. **We achieved 99%**
- 85% of all patients to have a maximum waiting time of 62 days from urgent referral to treatment of all cancers. **We achieved 95%**
- 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 0.16%, which is within the target of less than 1%.**

Infection control

- There were no cases of MRSA in the year
- There were 28 cases of C.Difficile against a target of 31. Last year there were 49 cases of C.Difficile (against a target of 65).

Handling complaints

The Trust received 272 formal complaints during 2011/12. This represents a reduction of 13 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 twelve requests for information to support the stage two review by the Ombudsman in the past year, the outcome being that three have been assessed by the Ombudsman with a decision not to conduct an investigation and take no further action. Four are still being reviewed by the Ombudsman and the Trust is awaiting notification of those reviews, three

were closed following intervention by the Ombudsman, 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 just some of the improvements we have made in 2011/12:

- Work with Weston Park Hospital to ensure a streamlined pathway of returning test results to correct location and consultant within Barnsley hospital.

- Refresher training has been offered to staff where required for inputting data onto PAS (electronic Patient Administration System) to improve accuracy of information.

- A small number of staff 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 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.

- 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.

- Security team to receive customer care training.

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.

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 airway diseases
- 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.

Providing high quality and safe services

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.

Investing in more nurses and midwives
This year we invested £1 million employing more nurses and midwives to help improve patient care .

The recruitment of nurses to our medical wards – the equivalent of almost 15 full-time nurses – was to ensure the highest standards in patient care and safety. Having the correct staffing levels and skill mix is vital to ensuring we deliver quality patient care and patient safety though during the year our nursing workforce fluctuates due to turnover.

And in a separate move, investment in more midwives was made, helping the hospital to deliver nationally recommended midwife-to-woman staffing ratios. Ten were approved to be appointed by the end of the year, and another eight by 2013 to enable the hospital to meet the recommended midwife-to-woman ratio of 1:28.

Breast screening age extension
After meeting strict criteria from the National Office, we were approved to introduce an extended age range for patients for breast screening in March 2011.

The age ranges we are now extending to are 47-49 and 71-73. To date we have screened both age ranges and the uptake of invitations has been good.

The unit also went fully digital in the year, after the installation of two more digital mammography machines. It was officially re-opened by Dan Jarvis MP, in February 2012.

Increased mandatory training compliance
In April 2011, the Trust introduced a package of measures to ensure that mandatory training compliance levels increased and to enable the Trust's target of 90% of staff receiving training to be achieved. We made signficant progress in year, with compliance levels at the end of March at 84.1%. This was an increase from 23.6% at 30th April 2011.

The measures included:

- Extra classroom training sessions

- Extensive promotion of e-learning and extra support for staff wanting to complete training using the e-learning system
- Statements sent out to all staff showing their individual training requirements
- Launch of a dedicated intranet site, providing a one-stop-shop for staff and managers wanting to access information and guidance regarding training requirements.

Qualified nursing staff in the imaging department
We introduced qualified nursing staff into our imaging department in the year, helping to enhance our patients' experience and developing closer communication and understanding with wards over the needs of patients for imaging investigations.

By introducing pathways for interventional procedures, documentation for monitoring during procedures, checklists for interventions and enhanced infection control procedures, we have increased the safety of our patients.

We have improved the quality and standards as well, with the introduction of controlled drugs into the department, increasing the scope of our interventional services and participating in quality monitoring processes.

Improved communication with wards has helped us to ensure the service is fully integrated with the teams working on them and we are continually listening to and acting on patient feedback.

Care Quality Commission inspection
Following a disappointing report at the beginning of the year after a Care Quality Commission (CQC) inspection on our nutritional standards, we ended the calendar year having met all the essential standards of quality and safety.

The final report found that the hospital was fully compliant following a re-inspection to check it was meeting nutritional standards.

Inspectors spoke to patients who said they were very satisfied with the quality and choice of food available, and the care and treatment they receive from staff.

The report praised the systems and processes that had been put into place to ensure that patient's individual dietary needs around food and drink were being met. These included:

- Protected meal times – where patients are not disturbed during their meals by clinical and non-clinical interruptions, allowing meals to be served and eaten in a better environment.
- Introducing meal monitors - an identified member of nursing staff whose specific job it is to ensure patients are getting the right meals and that mealtimes run smoothly on the wards.

The initial report found that throughout their observations the CQC saw staff treat patients with respect and courtesy and patients told them that overall they were very happy with the treatment and support they were receiving at Barnsley Hospital.

Chief nurse and chief executive on wards to support nutrition message
Our chief nurse and chief executive joined other senior hospital staff during 'nutrition and hydration week' by helping out during meal times on the wards.

They offered extra help at meal times on the wards throughout the week to emphasise the trusts commitment to nutrition.

The awareness week in January was part of the National Patient Safety First campaign.

GUM accreditation
Our Genito Urinary Medicine (GUM) team successfully met the *You're Welcome* accreditation – the quality criteria for young people friendly health services.

The quality criteria covers ten areas – each with detailed sub-criteria. *You're Welcome* aims to improve acceptability, accessibility and quality of service provision to young people aged 11-19 years inclusive.

Out of hours thrombolysis for stroke patients
As part of the South Yorkshire and Humber Stroke Network, we joined the launch of a telemedicine pilot in January to provide a network-wide solution to providing out of hour thrombolysis.

As part of the out of hours service, our physicians work alongside all other hospitals in the network rota to ensure that thrombolysis is available to its local population 24/7.

As part of our committment to deliver high quality stroke services at Barnsley Hospital, Dr Ahmed will be joining Dr Al Bazzaz as the second full time physician specialising in Stroke.

Nurses on the acute stroke unit have been trained and are highly skilled to care for patients pre and post thrombolysis.

Raising the profile of patient safety
We raised the profile of patient safety by asking all our staff to pledge to help keep patients safe during national Patient Safety Week.

Staff and visitors were encouraged sign up to the pledge and find out about how we are improving patient safety by introducing *'patient safety at a glance'* across the Trust.

A stand was on show in the main entrance, the outpatients' entrance, the restaurant and at the Annual General Meeting to demonstrate how *'patient*

safety at a glance' will reduce incidence of errors and disruptions to the patient, improve communications across disciplines and result in more face-to-face patient care time.

The 'Patient safety at a glance' initiative is the introduction of magnetic boards on all wards and clinical areas. The boards show important patient safety information that can be updated regularly and seen 'at a glance'. Magnets are used as visual symbols to highlight individual patient safety risks such as infections or falls, or enhanced care requirements.

The aim is to make patient information clear and easily understandable for all relevant disciplines within 3 seconds.

Patient safety remains one of the Trust's key priorities. Some of the other initiatives to improve patient safety in recent times include:

- Improved and modified early warning systems and alert tools across the Trust
- World Health organisation (WHO) safety checklists introduced in operating theatres
- Improved training across a range of clinical staff involving a range of clinical procedures
- Real patient stories at all Trust Board meetings
- Board member patient safety visits throughout the year
- Measured reductions in patients falling whilst in hospital
- Evidenced reductions in Hospital Acquired infection rates

Promoting normal birth
Our midwives were shortlisted for a Royal Collage of Midwifes (RCM) Award in the category of 'promoting normal birth'.

The team was shortlisted because they offer an antenatal drop in service which provides mums-to-be with evidence based information and free TENS machine hire, which is a device to help ease the pain in the early stages of labour.

Earlier this year the 'Friends of Barnsley Hospital' fundraising group donated 20 new obstetric TENS machines to the maternity unit.

The machines help to manage pain by generating mild electrical impulses through pads attached to a woman's back that stimulate nerve fibres under the skin and control pain. TENS is also believed to work by stimulating the body to produce more of its own natural painkillers.

Enhanced recovery
We launched and started to roll out the enhanced recovery programme – an evidence based process that helps patients get better sooner after surgery.

The programme has been developed by involving every member of the medical and nursing team that a patient comes into contact with before,

during and after surgery. A patient's GP starts the process by helping to ensure they are in optimum health ahead of the operation.

Thereafter, a series of measures are introduced during and after surgery that have the ultimate effect of getting a patient better sooner:

- Patients are no longer starved before surgery and instead they are given drinks loaded with carbohydrates to help build them up after surgery
- Bowel preparation is avoided – this prevents patients being dehydrated before surgery
- Less use of drains and nasogastric tubes – reducing complications including infections
- Early nutrition – patients are encouraged to eat and drink as soon as they feel able to after surgery
- Early mobilisation – patients are incentivised to get up and walk around soon after surgery.

We started the programme with patients who need bowel surgery and we are seeing real benefits with them. For those who have open surgery, the length of stay in hospital can be 10 to 14 days. If we can reduce that by even just a couple of days, it makes a significant difference to patients and to the hospital.

Designing healthcare around the needs of our patients

We 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 together in this way means the care and treatment patients receive is seamless and as convenient as possible for our patients.

Comfort care pack
Barnsley's End of Life team introduced a new 'Comfort Care Pack' with families whose relatives are in the last days of life and being treated at the hospital.

The pack, developed with £2,200 from hospital charity funds, is being trialled for nine months and was designed to improve communication, replicate some of the comfort measures found in hospice care, make a relative's stay more comfortable and improve psychological care.

The team will evaluate the impact of the pilot using a questionnaire and feedback from relatives.

New scanner to help detect osteoporosis
We invested in a new £100,000 bone density scanner to scan patients who have suffered fractures and are vulnerable to osteoporosis.

The new scanner means patients no longer have to travel to Sheffield or Mount Vernon Hospital for a bone density scan.

It enables our staff to detect the early signs of osteoporosis in patients and intervene early with treatment, whether that be medication or changes to a patient's diet to ensure they are getting sufficient calcium.

Feedback from our younger patients
A new touch screen system that enables young patients to rate their experience in the emergency department started during the year. The system uses smiley faces to help them give their views.

We have already been collecting information from adult patients about the quality of care, infection prevention and control and the hospital environment. This is done using an electronic system called CRT where the patients read a series of questions and respond appropriately using touch screen technology.

New minor injuries unit
A £240,000 Minor Injuries Unit, providing purpose-built facilities for the assessment and treatment of a wide range of urgent conditions, minor injuries and illnesses, opened in May.

Historically people with minor injuries or illness had longer waiting times in the emergency department as there was insufficient space for the number of patients wanting to be seen. The new Minor Injuries Unit has meant we can treat patients with less serious injuries more quickly helping to reduce patient waiting times.

The unit is staffed by highly experienced nurse practitioners and junior doctors within the Emergency Department and supported by consultant emergency physicians. The team has access to a comprehensive range of support services within the hospital and community, including x-ray, pharmacy, outpatient clinics, social work and Intermediate Care Teams.

Barnsley Mayor, Councillor Karen Dyson officially opened the unit.

Getting it Right charter
To show our commitment to ensuring that people with a learning disability get the healthcare they have a right to, we signed up to Mencap's *Getting it Right* charter.

The document, developed by the Barnsley Integrated Learning Disability Service, NHS Barnsley and Barnsley Hospital NHS Foundation Trust, is a healthcare passport for people with learning disabilities that records important information about them that a healthcare professional can use when they visit hospital.

The document is split into three areas 'things you must know about me', 'things that are important to me' and 'my likes and dislikes'. The information is designed to help hospital staff understands how to look after a person with complex and often specific communication needs.

State of the art surgical wards
Our refurbished surgical wards and Surgical High Dependency Unit (SHDU) for seriously ill patients were officially re-opened.

The refurbishment and investment of £775,000 on wards 31 and 32 and the SHDU formed part of the hospital's plans to improve surgical inpatient services.

The renovation included new anti-slip flooring, ventilation system, suspended ceilings, energy efficient lighting and a full redecoration.

The SHDU benefitted from new individual rooms, enhancing patients' privacy and dignity, air conditioning throughout and state of the art ceiling mounted equipment that allows for staff to access the patients from 360 degrees without having to move or disturb the patient.

Our surgical division looks after more than 19,000 surgical patients annually.

Porridge and toast the new breakfast choice for patients
We changed the breakfast menus offered to patients following a review carried out by our team of dieticians and catering staff.

The change means the hospital no longer routinely offers traditional cooked breakfast items across the board - though they are still be available for patients who need them.

The new menu – which started in August – was the result of a review which showed that the most popular breakfast choices for patients were porridge and cereal. The review also showed that the menu would reduce waste and save money.

Patients continue to have the option of a further two hot meals in the day.

Partnership approach for mums-to-be
A partnership approach that encourages mums-to-be to be healthier and fitter during pregnancy started during the year.

The exercise referral scheme is a joint venture between our maternity unit, NHS Barnsley, GP Practices and Barnsley Premier Leisure (BPL) - offering pregnant women 24 free sessions at Barnsley Metrodome. Expectant mothers can attend the gym, swim or join classes such as pilates or yoga.

Through the scheme BPL provide specialist advice and support for clients who have been referred by their community midwife.

New self management course for cancer patients and survivors
Our cancer services launched the Self Management to Improve Life Experience (or SMILE) course in February.

The six week rolling programme aims to enable cancer survivors to regain normality and to empower them to self manage their health and healthcare needs.

The course is the result of feedback from patients, who said there was a gap in services. Patients and survivors can attend the six week course or pick from the topics that are important or useful to the individual. The course topics cover subjects such as: how to cope with fatigue and stress and improve sleep patterns, general exercise, coping strategies, benefits and welfare advice, communication with family, friends and professionals, healthy eating and complementary and beauty therapies.

Patients have their say on outpatient experience
The findings from the national outpatient department survey 2011 were published by the Care Quality Commission (CQC) in February.

The survey, carried out by the Picker Institute, asked the views of adults in outpatients in May 2011 what they thought about different aspects of care and treatment they received at the hospital.

The hospital did better than most on the questions relating to cleanliness of the toilets, being able to find a place to park and confidence and trust in staff. Above average scores were also achieved for explaining test results and privacy while discussing their condition and treatment.

The survey also highlighted four areas where Barnsley Hospital had made significant improvements since the last survey (in 2009). These were - appointments starting within 15 minutes of stated time, understanding what would happen during an appointment, being told about danger signals regarding illness or treatment and feeling that the department was well organised.

Areas where the hospital rated worse than average were around not being given the name of the person the appointment was with, not being aware they would be having treatment and not receiving copies of all letters between hospital doctors and GPs.

We will be paying particular attention to making improvements in the areas where we didn't rate as highly as we could and continuing to listen and respond to the daily feedback our patients give us.

Results from the survey also showed that 98 per cent of patients said their overall rating of care was good, very good or excellent.

Patients have their say on inpatient experience
The results of the 2011 annual inpatient survey highlighted minimal differences between Barnsley Hospital and nearby hospitals.

In 13 questions, we scored in the highest 20% of Trusts and in three questions, we scored in the lowest 20% of Trusts.

Some of the areas where we scored highly were not having to wait long to be admitted, from the time the patient first talked with a health professional about being referred to hospital. They also rated highly us for their privacy for examination for being given enough privacy when being examined or treated.

Areas where we were in the lowest 20% of hospitals were around inadequate information about condition or treatment being given, not getting answers that patients could understand in relation to important questions and unsatisfactory explanation of what would be done during the operation or procedure.

Our response rate at 45% was 10% below the national average and translated into an overall total of 381 respondents.

Although the results were comparable with adjacent hospitals, we recognise that there is a significant opportunity to improve in this area and a clear

requirement linked to the ongoing national Commissioning for Quality and Innovation (CQUIN) in this area.

Audiology team out and about
Our audiology team were out and about in community locations offering advice and information during the year.

Awareness raising events took place at the Mall Alhambra shopping centre and the team also offered outreach community clinics, held at Enable Barnsley in the town centre and the health centre in Penistone, making it easier for patients with hearing aids to attend services closer to home for basic hearing aid repairs and maintenance.

Finger foods for dementia patients
We introduced finger foods menu for patients with dementia, to give them more choice.

The initiative was rolled out as part of our continued developments in dementia care and also as a result of feedback from carers who said that finger foods alternatives would be helpful for patients.

Patients with dementia can often experience difficulties eating or drinking due to a number of factors such as poor coordination making it difficult to use cutlery, becoming distracted in a strange environment or resistance to accepting help with eating.

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 just 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, the Trust employed 3008 employees. A breakdown of the Trust's workforce is shown below.

Employee profile table (age profile by staff group)

	Staff	%
Age		
16 - 20	107	4%
21-30	666	22%
31-40	716	24%
41-50	854	28%
51-60	564	19%
61+	101	3%
Ethnic Origin		
White	2765	92%
White - Other	45	1%
Mixed	22	1%
Asian and Asian British	93	3%
Black and Black British	39	1%
Other Ethnic	19	1%
Not Stated	25	1%
Gender		
Male	541	18%
Female	2467	82%
Disability		
Yes	100	3%
No	2711	90%
Not Stated/unknown	197	7%

Gender profile table

Staff Group	Female	Male
Add Prof Scientific and Technic	84	29
Additional Clinical Services	654	65
Administrative and Clerical	516	111
Allied Health Professionals	107	21
Estates and Ancillary	27	53
Healthcare Scientists	60	35
Medical and Dental	83	153
Nursing and Midwifery Registered	928	73
Students	8	1
	2,467	**541**

Staff survey 2010/2011 – 2011/12: key comparisons

	2010/11 Trust	2010/11 Nat Av	2011/12 Trust	2011/12 Nat Av	Trust improvement/ deterioration
Survey response rate	55%	54%	43%	55%	
Top four ranking scores (2011)					
Staff receiving health and safety training in the last 12 months	89%	80%	95%	81%	**6% improvement**
Staff experiencing physical violence from staff in the last 12 months	1%	1%	0%	1%	**1% improvement**
Staff having equality and diversity training in the last 12 months	53%	41%	82%	48%	**29% improvement**
Staff believing the trusts provides equal opportunities for career progression or promotion	93%	90%	94%	90%	**1% improvement**
Bottom four ranking scores (2011)					
Staff suffering work-related stress in last 12 months	30%	28%	34%	29%	**4% deterioration**
Impact of health and well-being on ability to perform work or daily activities	*	*	1.65%	1.56%	*
Staff motivation at work	3.73	3.83	3.72	3.82	**.01 deterioration**
Staff feeling satisfied with the quality of work and patient care they are able to deliver	72%	74%	69%	74%	**3% deterioration**

**Due to changes to the format or data collection, direct comparisons with the 2010/11 score are not possible*

Future priorities and targets

The key priority areas arising from the 2011 staff survey are to:

- Continue to improve staff perception of the priority of patients to the Trust
- Improve line management engagement with staff
- Increase quality of staff appraisals
- Decrease levels of work-related stress
- Increase survey return rates in line with NHS acute trust average
- Reduce errors which could hurt staff

The action plan outlining actions to address the key priority areas is outlined in the tables below:

Key priority areas and actions for improvement

Key priority area	Action/target	Monitoring	Measure of success
Improve staff perception of the priority of patients to the Trust	➢ Continuation and extension of current Focus Group to further develop solutions to address this theme in 2012/13 ➢ Continue dedicated agenda item during PPI Meetings in 2012/13	Launch event in June 2012 Focus Groups in July; Sept; Nov; Jan & March	➢ Feedback from staff via formal & informal methods ➢ Themes summarised & issues addressed in next focus group meeting ➢ Focus Group Suggestions - Status Chart ➢ Agreed suggestions implemented & incorporated into organisational processes ➢ Agreed suggestions communicated to staff via focus group, Intranet microsite & periodic communications ➢ Board to receive bi-annual summary report ➢ Measurable improvement in next year's survey relating to this area

Key priority area	Action/target	Monitoring	Measure of success
Improve line management engagement with staff	➢ Widening of last years' Enhancing Senior Management Communication Focus Group to further develop solutions to address themes now relating to line managers in 2012/13	Launch event in June 2012 Focus Groups in July; Sept; Nov; Jan & March	➢ Feedback from staff via formal & informal methods ➢ Themes summarised & issues addressed in next focus group meeting ➢ Focus Group Suggestions - Status Chart ➢ Agreed suggestions implemented & incorporated into organisational processes ➢ Agreed suggestions communicated to staff via focus group,Intranet microsite & periodic communications ➢ Board to receive bi-annual summary report ➢ Measurable improvement in next year's survey relating to this area ➢ Acknowledgement of improvement in this area in IIP Strategic Review June 2013

Key priority area	Action/target	Monitoring	Measure of success
Increase quality staff appraisals	➢ Continuation and extension of current Focus Group to further develop solutions to address this theme in 2012/13	Launch event in June 2012 Focus Groups in July; Sept; Nov; Jan & March	➢ Feedback from staff via formal & informal methods ➢ Themes summarised & issues addressed in next focus group meeting ➢ Focus Group Suggestions - Status Chart ➢ Agreed suggestions implemented & incorporated into organisational processes ➢ Agreed suggestions communicated to staff via focus group, Intranet microsite & periodic communications ➢ Board to receive bi-annual summary report ➢ Measurable improvement in next year's survey relating to this area ➢ Acknowledgement of improvement in this area in IIP Strategic Review June 2013

Key priority area	Action/target	Monitoring	Measure of success
Decrease levels of workplace stress	➢ Focus Group to be established and further develop solutions to address this theme in 2012/13	Launch event in June 2012 Focus Groups in July; Sept; Nov; Jan & March	➢ Feedback from staff via formal & informal methods ➢ Themes summarised & issues addressed in next focus group meeting ➢ Focus Group Suggestions - Status Chart ➢ Agreed suggestions implemented & incorporated into organisational processes ➢ Agreed suggestions communicated to staff via focus group, Intranet microsite & periodic communications ➢ Board to receive bi-annual summary report ➢ Measurable improvement in next year's survey relating to this area ➢ Acknowledgement of improvement in this area in IIP Strategic Review June 2013

Key priority area	Action/target	Monitoring	Measure of success
Increase survey return rates in line with NHS Acute Trust average	Raise the profile of the survey across the Trust and ensure maximum exposure through all available communication channels Ensure that distribution channels are formalised across CSU's through the use of champions. Promote the benefits of staff completing the survey and minimise concerns relating to confidentiality Incentivise completion of the survey to increase return rates Explore alternative methods of distribution by staff survey provider i.e. post to home address or email link	Jul & Aug 2012 Formalise distribution process & identify champions Set to Dec 2012 Publicise & distribute	➢ Monitor survey return rates via extranet ➢ Feedback from staff and champions ➢ Input from Clinical Service Units ➢ Staff Survey Working Group Meetings

Key priority area	Action/target	Monitoring	Measure of success
Reduce errors which could hurt staff	Share the findings of the staff survey with the Trust Risk Management Team and identify actions Monitoring and review of actions co-coordinated in Learning and Development	June 2012 – March 2013	➢ Feedback and suggestions from staff and managers via formal & informal methods ➢ Agreed suggestions implemented & incorporated into organisational processes ➢ Board to receive bi-annual summary report ➢ Measurable improvement in next year's survey relating to this area

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 blogs 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. We also introduced social media channels in the year, and opened up access to them from all computers for all staff.

In addition to the embedded methods of consultation, engagement and awareness, we last year introduced 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 also 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. In December 2011, the Trust completed a three year full assessment against the IiP standard. This involved two independent assessors interviewing 85 staff from across the hospital. The assessment report provided important feedback and contained an action plan to ensure ongoing continuous improvements. We are committed to continuous improvement and to using the Investors in People standard to drive cultural change and good practice.

As a result of the assessment, we successfully returned to meeting the IiP Standard.

New initiative helps staff back to work
We were recognised for our innovative idea for helping clinical staff to return from long-term absence.

We featured as a case good example study on the NHS Institute of Innovation and Improvement's website for inviting clinical staff who are ready to come back to work, but not able to return to their normal clinical duties, to take up the role of productive ward facilitators. By taking up this role, staff support ward teams to increase the pace of the implementation of the productive ward programme.

BRILLIANT staff awards
We introduced a new way of 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. The awards were introduced in November and all individual winners receive automatic entry into the annual staff HEART awards.

Our values
The 'Your Values are Our Values' programme involved more than ten per cent of all hospital staff, resulting in a *Values and Behaviours Statement*.

Staff had the opportunity to feedback their thoughts about what the Trust's values should include – through postcards, twitter, email and in focus groups. The programme ended in a workshop with a wide range of staff, including representatives from the Board, Governing Council, volunteers, clinicians, managers and staff side. All the feedback was brought together, analysed and in partnership, the themes developed.

The values and behaviours statement will be launched alongside the hospital's business plan and will soon be displayed in all work areas from May 2012.

Employees congratulated for their dedication
Forty-two staff were congratulated for more than 1,000 years service to the hospital in the annual long service awards.

The employees picked up certificates, presented to them by the Chairman, for their dedication to the hospital for either 20 years, 25 years, 30 years or 35 years service.

Employees picking up awards included healthcare assistants, nurses, community midwives, radiographers, maintenance technicians and estates managers.

Nurse trainer recognised by students
Student mentor, Sister Amy Marshall received one of only six awards regionally for her 'outstanding contribution to mentoring students in clinical practice'.

The award, from Sheffield Hallam University, was presented at the annual mentor conference and covers all of the health trusts in South Yorkshire, where student nurses can be placed as part of their learning experience.

Nursing students across the region nominated mentors who had made an impact on them and Amy, the Learning Environment Manager for ward 34 at Barnsley Hospital, was one of the few to receive the accolade.

Award winning domestic staff
Domestic staff based at the hospital picked up two national awards for their services.

The 'Initial Facilities' Extra Mile Awards saw Initial staff walk away with two of the eighteen award categories.

Dawn Pickering, the general manager of domestic services picked up the award for Excellence in Health & Safety thanks to the systems she introduced at Barnsley that ensure health and safety is the number one priority.

Barbara Lunn, the assistant manager for Initial at the hospital, received the Lifetime Achievement Award. She started work in 1969 when the site was still Becketts Hospital.

Healthy workplace scheme recognised
Our healthy workplace scheme was granted the Inspire mark by the London 2012 Inspire programme. The hospital's healthy workplace scheme motivates and supports physical health, healthy eating, mental health and smoking prevention for all its employees.

The London 2012 Inspire programme recognises innovative and exceptional projects that are directly inspired by the 2012 Olympic and Paralympic Games.

Our programme offered a range of 2012 themed activities based on getting more physically active in the run up to the 2012 Games.

Sickness absence data

The table below shows the sickness absence rates for 2011/12. Overall performance shows a trend of continual improvement. From 4.65 % in 2009/10 to 4.46% in 2010/11 to 4.26% in 2011/12, although further improvement is still a key focus for the Trust.

	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Cumulative % Abs Rate (FTE)
	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	
Barnsley Hospital NHS Foundation Trust	3.96%	4.30%	4.48%	4.75%	4.25%	4.22%	3.91%	3.91%	4.25%	4.40%	4.22%	4.43%	4.26%
Corporate Functions & Operational Support Division	1.37%	1.75%	3.05%	3.51%	3.25%	3.68%	3.82%	4.09%	2.95%	4.06%	3.93%	4.12%	3.29%
Integrated Medicine and A&E Division	4.58%	5.64%	5.01%	5.06%	4.71%	5.10%	4.78%	4.36%	4.31%	4.14%	4.83%	4.10%	4.71%
Surgery & Critical Care Division	4.41%	4.24%	4.74%	4.96%	4.57%	3.75%	2.87%	2.73%	4.08%	3.83%	4.05%	4.56%	4.07%
Women's & Children's and DCSO Division	4.30%	4.46%	4.53%	4.92%	4.15%	4.14%	3.99%	4.29%	4.84%	5.10%	4.00%	4.72%	4.46%

Learning and Development

Simplified KSF

We completed an extensive review of the Knowledge and Skills Framework (KSF) appraisal system to simplify the process and paperwork for staff and appraisers. The review involved input from managers and staff side representatives and contributed to our achievement of high levels of appraisals - 87% at the year end. The roll-out of the new system included briefing sessions for all appraisers and the work on simplified KSF has been nationally recognised, appearing as a case study on the NHS Employers website.

New induction training
We reviewed the way we deliver induction training for new starters as part of a package of measures to raise overall mandatory training compliance. The new induction programme ensures that all new starters receive their core mandatory training in the first two weeks of their employment. The programme is delivered twice a month and has been running now for several months. Delegates said that they appreciated the opportunity to receive corporate information and their mandatory training early on in their employment.

Together we will make it: better
The Together we will make it: better organisational development programme was launched in June 2011 to address areas of improvement highlighted in the 2010 annual NHS staff survey.

Staff nominations were invited from Directors to propose their staff members who had strong influence across the organisation, who were positive about organisational change and making a personal contribution to addressing the issues identified in the survey. These staff members acted as Agents for Change and attended a series of focus group meetings held throughout the last business year. This was a staff driven process empowering staff to make suggestions, rather than a management-led approach to addressing the staff survey action plan.

The programme focussed on three areas of concern arising from the staff survey results and by the end of the year, the particpants had achieved success with streamlining appraisal forms, influencing staff access to social media, ensuring Team Brief was more patient focused and developing plans for a patient excellence week. In all cases, the areas of concern they addressed achieved higher scores in the 2011 survey.

This way of tackling the issues raised by staff in the national staff survey has proved valuable and the Board agreed a continuation of the programme for the year ahead.

Library Review
During 2011, we completed a review and re-launch of our library service, including re-naming the service as Library and Resource Centre (LRC). The main achievements included:

- 85% score on the 2011/12 LQAF report (Libraries Qualified Assurance Framework). This was a 25% increase on the 2010/11 LQAF report.
- The Library and Resource Centre established a readers group, which meets on a monthly basis and has been very popular with staff.
- A commendation was received from the Strategic Health Authority for Innovation for the partnership working which has been established with the Barnsley Public Library.
- New in 2011 was the availability of computers for staff to complete e-learning. All Library and Resource Centre staff have been trained to help with queries with e-learning.

- The membership and footfall in the LRC for Trust staff has increased significantly during 2011/12.

Partnership Working with Barnsley College
In August we established a learning partnership agreement with Barnsley College. The partnership allows us to continue to deliver apprenticeships and vocational training qualifications to our employees and at the same time access government funding to support the vocational training delivery.

Barnsley College is a major provider of apprenticeships and vocational training in the Barnsley area and in 2012 the partnership working will be further developed to ensure that our employees can access a wider variety of vocational training opportunities.

Equality & 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 tick 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.

We have now adopted the Equality Delivery System. Last year we made some notable developments in equality and diversity:

Diversity champions
Diversity champions are self nominated staff from across the hospital with a real passion and commitment to the equality and diversity agenda. The diversity champions receive training through action learning sets and ongoing development sessions, facilitated by our Equality and Diversity Advisor.

More recently the champions have undergone Hate Crime training, provided in partnership with South Yorkshire Police, and also gender identity awareness training.

The initiative was launched and is supported by our Director of Human Resources and Organisational Development. Diversity training and equality workshops form an ongoing part of development, on a quarterly basis.

Their role is to keep their areas informed of recent developments in current equality and diversity matters via their team meetings and team briefs. As well as providing information to their fellow team members, they also identify areas of good practice and areas for improvement to share with other champions as peer support. They make their own suggestions as to service improvement

for their respective areas and always share good practice amongst other champions.

This work is supported with the development of an internal intranet equality webpage which hosts many useful current training resources, reports, presentations and web links. The Equality and Diversity Advisor is always on hand to provide any further strategic leadership and direction and operational lead for the initiative.

Progress from the Diversity Champions' Forum is fed back to the equality anddiversity strategy group as a regular agenda item. This also feeds into the Non Clinical Governance and Risk Group as part of our governance structures. This work not only supports staff and patients but assures the hospital that it is meeting the requirements in the NHS Equality Delivery System.

A key outcome from this group has been the development of a gender identity guidance booklet, as it was identified there was a knowledge gap in this area.

Hate Crime
We hosted a Hate Crime workshop event in October, delivered by South Yorkshire Police (SYP). It was attended by a wide range of our staff and some members of the community.

Borough-wide Hate Crime training has been made available for all staff members unable to attend the workshop to help ensure that all areas are aware of what Hate Crime is and how they can report it. We have amended our internal security reporting mechanisms, and managers are now encouraging their staff to attend the SYP Hate Crime training.

A number of Hate Crimes against staff have been successfully reported and progressed through to the Magistrate courts. Victim Support has also proved very supportive in the provision of support for staff who have been a victim of Hate Crime .

Gender identity awareness
We hosted two workshop days to help raise awareness of gender identity. The training was delivered by an equality specialist.

We were represented on an NHS regional wide task and finish group, which involved local equality leads. The group, with specialist advice, has now developed a gender identity guidance tool kit. This will support our staff in the equality of patient care and equality of patient experience. This area of equality work is ongoing with the support of senior leadership.

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 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
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.

Specialised Commissioning Group
The Trust is a member of a number of Specialised Commissioning Group committees that cover the South Yorkshire region. Collectively, the committees are where major South Yorkshire service planning and commissioning decisions are made. These affect the pattern of health service provision across the region.

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 Barnsley 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 is headed by a professor from the 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 2011/12, 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 commissioners to understand their new landscape during the transition of the Health and Social Care Bill and will continue to do so as Clinical Commissioning Groups 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.

In the year, a shadow Health and Wellbeing Board was launched. Both our chief nurse and chief executive are members of the Board and 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 130 research projects, including 50 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.

Professor Parker recently completed a European-wide project, led by Sheffield University, which will inform the European Commission about future research into ageing.

A new study within the hospital, looking at how the built or physical environment impacts on older people receiving acute care is also underway. The scope of the project includes Mount Vernon Hospital and residential care settings where researchers will undertake an architectural evaluation of the environment.

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 58 to 119.

GORD study

One of our research areas is in an international study looking to find a new treatment for gastro-oesophageal reflux disease (GORD) in children.

The study focuses on a treatment for children under the age of one who suffer from the condition. Parents in Barnsley have been signing up children to a trial of Rabeprazole, a medicine that aims to control the condition, which previously had not been offered to treat small children as it was not available in a soluble format.

The Trust is one of only three in the UK taking part in the international study, and the only hospital that is not a large teaching and research facility. It has already successfully met its recruitment target ahead of schedule.

Making more time for patients

Nurses have been at the forefront of an innovative scheme which enables them to spend more time with patients as we stepped up our drive to deliver the 'Productive Ward' scheme – a national project established by the NHS Institute for Innovation and Improvement.

Our nurses introduced more new ways of working on their wards to release more time to care for their charges. In a matter of months, the scheme has proved successful: nurses have increased the time they spent with patients and cut the time they spend on 'wasteful' activities.

Simple but effective measures have included a new colour coding system in stock rooms to make it easier for nurses to find supplies, releasing extra time to spend with patients. A major time saver has been the introduction of magnetic boards on wards which give an accurate and up-to-date report on the status of each patient.

Implementing the productive ward scheme has also enabled five members of staff to return to work from sick leave, helping with the project before resuming their previous activities.

Volunteers
There are approximately 200 active volunteers operating in different roles both within the hospital, and externally at The Well (cancer services based in The Core building in town); monthly outreach clinics for audiology and in Barnsley Hospital radio (in the Trust and outside broadcasts from Barnsley Football Club)

In the last year there have been the following developments:

- Nutritional Support Volunteers - lead nurse Maria Cooper identified a need for 'nutritional support volunteers' and nine current hospital volunteers and one member of staff have been recruited to take part in a four week pilot (started 12 March) on wards 19 & 33. There is also the potential to recruit more staff as volunteers to provide support for this and other initiatives planned within the Trust. Feedback on the pilot will help to shape the way forward.

- Matron Debby Horbury and her team are supporting the expansion of two British Red Cross volunteers' work in providing therapeutic hand and neck massage to patients. The two volunteers, based on ward 19, are hoping to offer hand and neck massage to suitable patients on ward 33. The British Red Cross is keen to expand this service and is hoping to train more volunteers in the future.

- In addition, Karen Sharman and Marion Page in dermatology are looking to recruit volunteers to assist with planned changes to the dermatology service as does Louise Wall and Joanne Bray of the pre-assessment unit.

- Nurse advisor for children and young people, Melanie Kinsman, is exploring the possibility of volunteers having a role within her department and she is currently consulting with colleagues.

- The intensive care unit team has also indicated an interest in using former patients as volunteers to support current patients and families.

Anticoagulant technology system
We are putting a new anticoagulant information technology system in place to improve the reliability and quality of the service we offer to our anticoagulant

patients who are managed by the anticoagulant team. The system implementation started at the end of March.

Website revamped
We launched a revamped website to aid patients, visitor and staff in January.

The new website, designed in-house, has an improved structure making it easier for patients to find the information they need before a visit to the hospital - such as parking, what to bring or a leaflet on a specific health condition. The new design was put together using patient and user feedback.

The aim of the new website is to answer the many questions patients, public and staff may have in the run-up to a hospital appointment, visit or working at the hospital. The website is very often the starting point to a patient's visit and we wanted to minimise anxiety, making it easy to find the information they need to make their overall experience of the hospital a more positive one.

A new 'news' section is interactive to encourage more people to feedback to the hospital about their experiences, whether positive or negative. The site promotes feedback from patients about their experiences so that we can constantly look to make improvements.

The website also includes a comprehensive guide to all the services offered at the hospital and provides key practical information such as public transport details, ward telephone numbers and visiting times across the hospital.

Widening options for fundraising
We widened the options for people to fundraise and make donations.

Since September, people have been able to use the Just Giving website, a well used and trusted method for giving money to charities.

People are still be able to donate in the usual way by using the *Donation Gift Aid* envelopes and taking the funds to the cashier's office in the hospital or by post to the cashier's office.

The Just Giving page is simple and straightforward and enables all the money raised to go direct to the hospital's Just Giving account, which then goes into the Hospital Charity General Fund. The site also makes it easier for people donating to use Gift Aid.

Last year around £101,500 was raised in donations and legacies to go towards helping staff and patients.

Some of the bids made to the Trustees in the last year for use of the charitable funds included:

- £20,000 to buy silent closing bins, recognised as integral to the ongoing work to reduce avoidable noise at night on wards and patient areas

- £1495 for bladeless fans for the intensive care unit
- £800 for TENS machines for mums-to-be on the maternity unit
- £3,000 to buy sensory equipment for children with special needs
- £620 for presents and activity materials for children in hospital at Christmas
- £400 (donation from Friends of Barnsley Hospital) to buy toys and art materials for children attending day surgery
- £330 for comfort packs, these are packs for relatives of patients on end of life care pathways
- £9,800 for datascope duos for each cubicle in the emergency department
- £55,000 to support the continuing appointment of a hospital chaplain

Sustainability
We work towards our Sustainable Development Management Plan, agreed by the Board at the end of 2010/11.

As well as reinforcing the link between sustainability and public health, the plan gives us a clear focus on sustainable development and environmental policies, enabling us to embark on a range of financial and non-financial benefits as well as a reduction in our carbon footprint.

Although the plan identifies the need to reduce CO_2 emissions other harmful greenhouse gases (GHG) are increased due to the way in which we deliver services. We need to be mindful that these also contribute to the environment we live in today and the Trust has a responsibility to reduce these other gases where possible.

The plan focuses on key priorities:

- energy and carbon management
- procurement & food
- low carbon travel, transport & access
- water
- waste
- designing the built environment
- organisational and workforce development
- role of partnerships and networks
- governance
- finance

The development of the management plan demonstrates our commitment to carbon reduction through a range of practical but ambitious measures, sharing of good practice and active engagement and support of its staff. The plan is monitored by the Sustainability Group, which is chaired by the Chief Operating Officer.

We also have a sustainability mission statement, which underpins the Trust's Sustainable Development 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".

Energy Accreditation
Following our investment in a range of projects last year (such as new roof coverings, corridor lighting, a refurbished energy efficient ventilation system and energy efficient plate heat exchangers), we achieved Energy Accreditation with the Carbon Trust.

We registered with the Carbon Reduction Commitment Energy Efficiency Scheme (CRC) as a participant and submitted our annual report and footprint (required by 29 July 2011). We were subsequently awarded 100% achievement – one of only four hospitals in the country and the only one in the North to gain this accolade.

We are on course to reducing our emissions by 10% by 2015, which was pledged in the NHS Carbon Reduction Strategy.

Work on reducing the Trust's carbon footprint continues. This includes our desire to remove printers from individual offices and to use centralised printing and also automated screen shutdowns to non-essential PCs if left unattended for more than 10 minutes.

This year we will again invest in critical backlog maintenance refurbishments that will add to energy efficiency drives, investment will be aimed at:

1. Continuation of the window replacement to medical and surgical blocks.
2. Pathology roof covering replacement.
3. Insulation to high energy loss pipework.
4. New lifts to maternity block, Outpatients department and CSSD (sterile services).

We will also look to provide a new ventilation plant in the maternity block to replace the original 1968 system.

The Trust is hoping to employ a sustainability manager in the future whose sole function will be to reduce the Trust's carbon footprint even further.

Area		Non-financial data (applicable metric)	Non-financial data (applicable metric)		Financial data (£K)	Financial data (£K)
Year		**20010/1**	**2011/12**		**2010/11**	**2011/12**
Waste minimisation & management	Absolute values for total amount of waste produced by the Trust	906.91 tonnes	1026 tonnes	Expenditure on waste disposal	£215,658.70	£151,474
Finite resources	Water	98,796m^3	90,468m^3	Water	£91,151	£85,012
	Electricity	9,329,002 KWhr	9,296,826 KWhr	Electricity	£712,796	£834,372
	Gas	22,000,445 KWhr	21,327,975	Gas	£525,544	£610,555
	Other energy consumed (gas oil)	8,691 litres	27,213 Litres	Other energy consumed (gas oil)	£6,057	£18,765

At the year end we were at a point of signing contracts for the Combined Heat and Power unit to be fitted, this will save approximately 22% of our energy carbon footprint once running and will save us around £300,000 a year on energy costs.

Financial Review

Summary of In Year Performance

2011/12 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 achieved this, ending the year with £0.46 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 between 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 2011/12 and has clear financial plans going forward to maintain this in 2012/13 and beyond. (see table for 2011/12 performance below)

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 budget)	100	85	70	50	<50	97.09%	4	0.40
Underlying Peformance	25%	EBITDA Margin (%)	11	9	5	1	<1	5.29%	3	0.75
Financial	20%	Return on Assets excluding dividend (%)	6	5	3	-2	<-2	3.59%	3	0.60
Efficiency	20%	I & E Surplus margin net of dividend (%)	3	2	1	-2	<-2	0.46%	2	0.40
Liquidity	25%	Liquidity ratio** (days)	60	25	15	10	<10	43	4	1.00
		Financial risk rating weighted average of financial criteria scores								**3.15**

The main factors that 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 should be agreed during early 2012/13 and the capital investment for this development has been set aside.

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 PCT 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 2011/12 we began in earnest to really start to look at the patient adminstration system and how we should replace that with a more modern electronic patient record system. This will be a key focus for the Trust in the next two years.

Income from Activities

The income from our core patient related activities was £ 140.3 million in 2011/12, a 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	**2010/11**	**2011/12**	%age Change
Elective inpatients	4,773	4,708	-1.4%
Day cases	19,666	21,790	10.8%
Non elective inpatients	33,490	34,695	3.6%
Outpatients	264,343	268,025	1.4%
A&E	75,099	78,217	4.2%
Other non PBR (payment by results)	2,480,468	2,605,315	5.0%

The biggest areas of activity increase related to non elective care (emergency admissions) and attendances at A&E. At the beginning of 2011/12 we agreed a significant contract increase with NHS Wakefield to match the increasing flow of patients attending our A&E and subsequently being admitted. In addition, whilst we are working really well with our main commissioner to address the scale of non elective admissions to hospital we are continuing to see increases locally.

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, commissioners, local authority and South West Yorkshire Partnership Foundation Trust.

As in the previous year we were eligible for a payment under CQUINs (Commissioning for Quality and Innovation) where we were eligible for 1.5% of our total contract. We slightly underachieved some of these quality stretch targets but achieved the majority of this income. Increasingly, income will be linked to quality and achieving best practice standards. In 2012/13 a lot more of our income will be received in this way rather than just on the volumes of patients we see. This means we really have to continue our focus on quality.

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. Year on year there were no material changes. Some non recurrent income received from NHS Barnsley in relation to supporting developments for changes to A&E was included here.

A change in accounting policy in relation to the treatment of government grants and donated assets has required us to restate last year's comparatives. This has resulted in a reduction in other income (which previously was released to match deprecation) of £291,000 in 2011 and £300,000 in 2012.

Expenditure
Year on year expenditure (our operating costs) did increase overall by 4.3% (over £6.5 million) 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 had a pay freeze in 2011/12, but largely predominantly the impact of the high volume of agency staffing we engaged during the year. Agency costs almost doubled from £3.3 million the previous year to £6.2 million in 2011/12. This expenditure links to the increase in demand and operational pressure in the hospital. We spent almost a £1 million on nurse staffing agency compared to the previous year, when we spent very little. The biggest pressure on agency however was medical staffing and in particular vacancies and gaps in junior medical grades as well as additional cover required to meet clinical demand. A detailed medical workforce review is being 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 some of the plans we intended to generate efficiency were not achievable, but the vast majority were and we saved £5.3 million against our own target of £7.3m. A large proportion of the savings in 2011/12 came from administration and management reorganisation and procurement and non pay savings. 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 2011/12 the Trust invested £4.7 million in new capital. Broadly this was split into our main three categories of spend as:

- Estate upgrades and backlog maintenance - £ 2.4 million
- Information Management and Technology - £ 0.6 million
- Medical and Surgical Equipment - £1.7 million

We did not spend quite as much as we had originally intended . The principle reason for this was we could not progress as quickly as we had hoped with procuring our new patient flow system, but this will now go live in June 2012. We also intentionally expanded the scope of work to look at the strategic options for our estate which we are continuing to progress.

At the end of the financial year we have revalued our estate. After obtaining an indication of the change in building indices and location factor (the benchmark of the relative preferred location to live) from the District Valuer, it was decided that a full revaluation should be undertaken in compliance with audit requirements. This exercise was undertaken on 20th February 2012 to be effective from 31st March 2012. This resulted in an increase in value of £8 million, predominantly as a result of increase in location factor, which moved from 93% (March 2010) to 98% (March 2012).

Forward Look

Establishing the contract baseline for activity was a key issue for us given the increases and volatility we had seen in 2011/12. 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 in patient 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 2012/13 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 ley challenge. The tariff for 2012/13 is 1.8% 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 generates a significant efficiency challenge over the next few years and this is undoubtedly the biggest financial risk not only for 2012/13 but over the medium term. To

address this we have set out a fundamentally different approach based on eight transformational programmes which are linked to sustainable efficiency. We recognise that to deliver the scale of financial savings that are required we need to look at radically different and innovative ways of working and delivering care. Supporting some of this will be our approach to how we use technology and our estate to underpin the efficiency changes we need to make. Linked to this are potential significant capital investment requirements. A key risk to the Trust will be generating the scale of funding required to make such investments. We are exploring a range of options around this and of course will continue to strive to make surpluses to contribute to future investment.

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 require 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. Key to how the changing healthcare environment unfolds will be the emergence of clinical commissioning groups, which is some way from being fully developed locally.. This generates a level of potential uncertainty with regard to establishing robust commissioning relationships going forward. The Trust is fully cognisant of this and is working within the current commissioning framework to ensure ongoing contracts for our services are managed effectively. We therefore do not anticipate any significant financial instability as a consequence of the changing commissioning landscape.

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 2011/12 and 2012/13 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
National Programme for IT Failure to maintain and develop IT infrastructure impacts on operational and financial performance	- Project management in place - Business analyst in place - Regular updates on investment portfolio - Weekly performance reports - Steering Committee in place
Imaging Failure to deliver 24 hour imaging target for stroke patients	- Imaging plan in place to extend service hours - 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 - Divisional performance meetings - Daily performance reporting
Clinical quality & governance	
EWTR Failure to comply with the European Working Time Regulation impacts on patient safety and financial performance	- Regular audits and monthly reviews - Roll out of 'hospital at night' programme & nurse practitioner model Out of hours on call arrangements

Infection prevention & control Failure to meet healthcare acquired infection standards impacts on patient safety	- Ongoing 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 - Divisional dashboards
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 Trust's future	- Detailed business cases - Monthly monitoring
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

QUALITY REPORT

2011 - 2012

INTRODUCTION

Welcome to the Quality Report for 2011/12 for Barnsley Hospital NHS Foundation Trust.

Quality Accounts are an annual accountability report to the public from providers of NHS Healthcare Services about the quality of their services. They provide the public with information about the quality of the services which this Trust delivers.

We hope that the public, patients and others with an interest in their hospital will use this report to help them understand:

- Where the Trust is doing well and what improvements we have made in the last year
- What our priorities for improvement are for the coming year
- How we have involved people who use our services, our staff, and others with an interest in the Trust in determining these priorities for improvement

You can also read more about the hospital and our work on our website
www.barnsleyhospital.nhs.net

This Quality Report is available to read at the national NHS Choices website
www.nhs.uk

PART 1*: CHIEF EXECUTIVE'S STATEMENT*

At Barnsley Hospital NHS Foundation Trust our vision is to:

"Provide the best healthcare for all"

We aim to do this by:

- Providing high quality and safe services
- Designing healthcare around the needs of our patients
- Investing in our workforce and continuing to develop them to provide high quality services
- Making the best use of our resources
- Maintaining financial viability and sustainability

Last year the Trust made significant progress and improvements on the quality and safety of our services in 2010/11. 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 C.Difficile 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.Difficile by only having 28 actual cases this year.

The Trust 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 Directors and other members of staff, and has resulted in changes to the environment and practice which have positively impacted both on patients' and staff's experience.

The Trust held another patient safety week in November 2011, focusing on "the visualisation of patient safety risks", this initiative was delivered through the Productive Ward, Patient Safety at a Glance Boards on all wards and clinical areas. Magnets are used as visual symbols to highlight individual patient safety risks and their enhanced care requirements.

The visualisation of risk will be further enhanced by providing patient boards above each patient's bed using the same magnetic symbols to improve staff communication and clearly highlight all patient needs. This visual method of communication will be used as part of the nursing handover and at the "Patient Safety briefings" that are undertaken at changeover of staff. The magnetic symbols include indicators associated with patients who are at risk of falling and patients with additional nutritional and hydration needs. This is just one example of how we are taking different approaches to reduce the risk of harm to our patients.

Making sure all our patients are supported with their nutritional needs is essential and continues to be a priority for the Trust. In order to achieve a better understanding of our patients' nutritional requirements we aim to weigh 90% of all eligible patients on admission and will continue to assess all patients on admission with a nutritional screening tool.

2011/12 saw 75% of patients weighed on admission, recognising the further improvement required to reach the Trust's target of 90%.

This was further supported through the Trust's involvement in the Patient Safety First Nutrition and Hydration Week held in January 2012. The Trust demonstrated its commitment with senior managers supporting front line staff to ensure that all patients were appropriately assisted at meal times.

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 Trust is able to compare and benchmark its performance with other similar sized hospitals. To support this approach in 2011/12 the Trust participated in 37 national clinical audits and two 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 Trust for the last three years, we have introduced 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. This year the Trust celebrated the achievement of the re-accreditation of the Investors in People Award which recognises the Trust's commitment and investment to our staff.

The Board of Directors has reviewed the overall vision and strategic aims and objectives of the Trust 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 2011/12 particularly in:

- Reducing the number of hospital acquired infections
- Reducing the number of in-patient falls
- Achieving the Investors in People award for our workforce support
- Being accredited with the Baby Friendly Initiative at Level 2
- Improving patient experience through responding to our "real time" collection systems
- Achieving a clear improvement in our staff survey results

We are not complacent, however, and recognise that we still have much more to do. Our patients have told us they want to see further improvements in:

- Knowledge of individual patient's nutritional status
- The incidence of hospital acquired pressure ulcers
- Reducing delays in discharge processes

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

The information contained within the Quality Report 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.

Signature: …… *Date:*……..

Paul O'Connor Chief Executive

PART 2: *PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD*

The primary purpose of the Quality Report is to encourage hospital boards to assess quality across the totality of services they offer with an eye to continuous improvement. If designed well, with the engagement of all interested parties, the Quality Report should provide assurance to commissioners, patients and the public that Trust Boards are scrutinising each and every one of the health services a hospital provides.

Key within the report is to identify three to four priorities where key achievements can be demonstrated to all partners within health and social care and more importantly patients. These priorities are required to be within three domains:

- Safety
- Effectiveness
- Patient experience

This section of the report revisits the priorities that the hospital set for this year across these three areas and shows how we have performed against the targets we set for ourselves.

The second section then examines what our priorities will be for the coming year and the targets we will strive to achieve.

How did we do in 2011/12 against our priorities?

Priority 1: To improve our knowledge of individual patient's nutritional status

Significant progress has been made against this priority.

Indicator 1: Establish criteria for the weighing of our patients

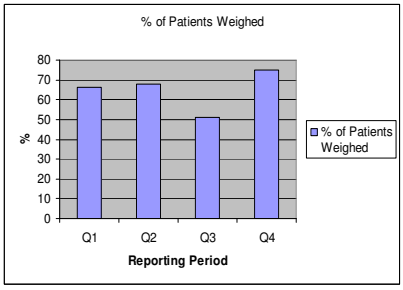
Performance: The standards that would be used to weigh patients and record the information were established in quarter 1.

Indicator 2: Weighing of patients

Performance: 75% of patients were weighed on admission.
Evidenced through clinical audits undertaken across all inpatient areas, unfortunately we have not achieved the 90% aspiration we set at the start of the year but we have definitely seen an improvement towards reaching this figure as our performance across the year indicates.

This year's performance shown at each quarter in the table and graph below:-

Reporting Period	% of Patients Weighed
Q1 (April to June 2011)	66%
Q2 (July to September 2011)	68%
Q3 (October to December 2011)	51%
Q4 (January to March 2012)	75%



The Trust also indicated it would measure this priority by continuing to assess all patients on admission with the malnutrition screening tool.

So how have we done?

Indicator 3: Nutritional Screening on Admission

Performance: The Trust continues to improve performance in this area with particular emphasis on vulnerable elderly patients.

The Trust's performance was evidenced by an audit that was undertaken for a full week in November 2011 on all patients 65 years and older who were in hospital for more than two days.

The results indicated that:-

1. **83%** of patients audited had been nutritionally assessed using the Trust's malnutrition tool.

2. **97%** of these patients, who scored over 10 (needing support) on the screening tool, were cared for using the hospital's red tray pathway and procedure - a system used to identify and assist patients who require additional nutritional support.

3. This audit also showed that a further nutritional assessment was undertaken on **94%** of patients over 65 years old prior to their discharge from hospital.

4. **93%** of these patients requiring further support were referred to community dieticians before going home to ensure continued care.

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

- The development and implementation of the Trust's nutritional policy providing a position statement and strategy to deliver high quality nutritional support to all our patients.

- A re-launch of the Red Tray and Red Beaker Pathways; the procedural tools to deliver the Trust's goals, ensuring that all staff fully understood how best to support patients requiring nutritional assistance.

- A schedule of nutritional inspections by the senior team supported by Governors across all clinical areas in order to both emphasise the importance of nutrition for all our patients as well as ensure that the standards that we have set are being met.

- The establishment of a Nutritional Steering Group led by the Medical Director, supported by senior nurses and dieticians across the hospital.

Priority 2: Reduce the incidence of hospital acquired pressure ulcers

The goal of this priority for 2011/12 was to 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.

Indicator 1:
The incidence of people who have developed one or more new pressure areas after 24 hours of admission with a target to achieve an 8% reduction from the baseline by the end of the year.

Indicator 2:
The number of incident forms completed for grade 2 ulcers and above which have developed during an episode of care. A target of 100% achievement was identified.

Indicator 3:
The numbers of root cause analysis investigations undertaken for patients with National Institute for Clinical Excellence (NICE) grade 3 pressure ulcers and above. A target of 100% achievement was identified.

The Trust has performed extremely well against this priority meeting and exceeding the goals that we set at the start of the year.

Achievements against each indicator are shown below:-

Reporting Period	Targets for the 3 Indicators	Performance
Q1 (April to June2011)	An **8%** reduction on baseline (BL) of people who develop one or more new pressure ulcers after 24 hours of admission.	BL = **58** cases
Q2 (July to Sept 2011)		= **33** cases or a **40%** reduction on (BL)
Q3 (Oct to Dec 2011)		= **25** cases or a **57%** reduction on (BL)
Q4 (Jan to March 2012)		= **20** cases Or a **65.5 %** reduction on (BL)
Q1 (April to June2011)	Incident reports completed for **all/100%** of patients who develop a grade 2 and above pressure ulcer during an episode of care.	46%
Q2 (July to Sept 2011)		100%
Q3 (Oct to Dec 2011)		100%
Q4 (Jan to March 2012)		100%
Q1 (April to June2011)	A root cause analysis (RCA) investigation will be undertaken for **all/100%** patients with NICE grade 3 and above pressure ulcer.	100%
Q2 (July to Sept 2011)		100%
Q3 (Oct to Dec 2011)		100%
Q4 (Jan to March 2012)		100%

Priority 3: Ready to go no delays

Our patients clearly stated within our Quality Survey, conducted in 2010/11, that timely discharge was amongst their highest criticism of quality of care within the Trust, with a perception that delays were caused due to delays in discharge drugs. This is also seen as a recurrent theme within complaints and contacts made to our Patient Advice and Liaison Service (PALS).

The Trust's goal is to deliver a seamless approach to discharge and will be progressed through a number of workstreams to engage clinicians and review and improve discharge planning and discharge pathways. Improvements to the quality of discharge processes have been measured by improving performance against the Care Quality Commission (CQC) inpatient survey, aligned to two composite questions relating to discharge, these are:

Indicator 1: Patients not fully told of side effects of medication on discharge

Indicator 2: Patients not being told who to contact if worried on discharge

Our achievements against this priority and the Trust target to achieve a 1% decrease in these areas are:

Year	**Indicator 1 Q64**		**Indicator 2 Q69**	
	Told	Not Told	Told	Not Told
2009	42.5%	57.5%*	68.9%	31.1%*
2010	45.5%	54.5%*	81.4%	18.6%
2011	36.6%	63.4%	73.3%	26.7%

* Please note that due to a transposing error the figures included in last year's report were incorrect. This has been updated and the information provided in this year's report is accurate.

The Trust did see some improvements in 2010 against these indicators but despite our focus on discharge, our patients are telling us that we need to do more. Further work will be undertaken to review all the discharge information we provide for our patients, and the way in which we communicate this information. We will continue to measure our performance in this area until our performance improves.

Indicator 3: Additionally the Trust said it would reduce complaints relating to discharge so how have we done?

We have performed exceptionally well on both aspects of indicator 3 as achieving both targets that we set for ourselves in this area, as shown in the table below:

Reporting Period	Target	Performance
Q1 (April to June 2011)	**4% reduction in discharge focussed complaints** Baseline for 2010/11 was 14 complaints out of the total 285 complaints received or 4.9% of all complaints received 2011/12 performance was 11 complaints out of a total 272 complaints received or 4.04% of all complaints received This equates to a **21.4%** reduction in the actual number of discharge focussed complaints received	1
Q2 (July to Sept 2011)		1
Q3 (Oct to Dec 2011)		5
Q4 (Jan to March 2012)		4 Total =11
Q1 (April to June 2011)	**Reduction in all complaints mentioning discharge.** Baseline for 2010/11 = 128 out of the total 285 complaints received or 45% of all complaints received 2011/12 performance was 71 out of the total 272 complaints received or 26% of all complaints received This equates to a **44.5%** reduction in the actual number of discharge mentioned complaints received	19
Q2 (July to Sept 2011)		13
Q3 (Oct to Dec 2011)		15
Q4 (Jan to March 2012)		24 Total = 71

What are we going to do? Our three priorities for 2012/13

For 2012/13 the Trust will maintain the same three priorities to ensure that they are all fully achieved and that performance is maintained and further improved.

The consultation to reach this decision was conducted in much the same way as in previous years however no public responses were received, the details of the consultation have been provided below. The lack of public response has meant that the Trust has therefore had to make these decisions through consultation with the Trust Governors, the elected representatives of our Foundation Trust's patient, public and staff members.

For 2012/13, this year, the consultation was conducted via a number of routes:

- The Trust's magazine "Hospital Matters" (September 2011) where members and staff were invited to email issues. Regrettably from this no responses were received.
- A survey was distributed at the Trust's Annual General meeting on 14th September 2011. This meeting included staff, Governors and members of the general public. However no responses were received.
- The Trust's Governing Council was consulted at their meeting on 10th August 2011 following a presentation on the Quality Accounts 2010/11 by the External Auditors, future proposals were discussed with Governors. Following lengthy discussion it was agreed that the key existing priorities would be carried forward into 2011/12. This would demonstrate that improvements in quality of care are continuous, and as these were thought to be important to patients (as they had been derived from extensive consultation in 2010/11) that real benefits could be achieved through stretching performance targets.
- We will commencing a consultation exercise shortly in order to define the priorities for 2013/14 and would encourage everyone to be involved in developing our future quality priorities.

Each of the priorities reflects the three quality themes of:

- Safety
- Effectiveness
- Experience

In matching these themes, we can provide our patients with a comprehensive quality improvement in areas that impact on all aspects of care. All of these priorities have been agreed by the Board of Directors.

The three priorities and the three indicators we will use to measure our performance are fully detailed in the following pages.

Priority 1 - *To improve our knowledge of individual patient's nutritional status*

Why this priority?

Currently, 40% of patients admitted to hospital are undernourished (British Nutrition Foundation 2009). Malnutrition is associated with poor recovery from illness and surgery (Stratton et al 2003). NICE (2003) found that only about 1/3 patients were screened for malnutrition on admission to hospital. Subsequently, patients at risk of malnutrition are not recognised and referred for treatment (Elia et al 2005). The Trust has been screening patients on admission for the past three years, and on a point prevalence audit scores 100%.

But, we still recognise that we could improve further, and 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.

What's our aim/goal?

To ensure all eligible patients are weighed on admission.

How are we going to do this?

1. Refresh the criteria for which patients will be weighed.
2. Be clear about where on the patient's records weight is documented.
3. Documentation will clearly explain why patient weight is not recorded for those clinically excluded.
4. Continue to assess all patients on admission with the malnutrition screening tool.

Target 2012/13

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

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

Indicator 3: Ensure that 100% of admitted patients on inpatient wards will be nutritionally screened within 24 hours.

What does this mean for you?

If you are admitted as a patient, you are likely to be weighed. We have a variety of weighing equipment available to ward staff, so if you require specific weighing equipment this will happen during your stay, and not necessarily on admission.

How will you know we are improving and monitoring?

We will be reporting on and monitoring our progress to the Board of Directors on a quarterly basis within the Integrated Performance Report. This will be discussed during the public part of the Board meeting and regularly posted on the Trust's website.

Priority 2 – *Reduce the incidence of hospital acquired pressure ulcers*

Why this priority?

It was estimated in 2004 that the NHS in the UK spent £1.4-£2.1billion treating pressure ulcers. These figures are a conservative estimate. 90% of this cost is nursing time. Evidence suggests that between 4% and 10% of patients admitted to UK district hospitals develop a pressure ulcer. In 2008/09 there were just over 51,000 pressure ulcers in England.

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

What's our aim/goal?

To reduce the number of people who develop a newly acquired pressure ulcer (by category of ulcer) following admission.

How are we going to do this?

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

1. Incidence of people who have developed one or more new pressure ulcers after 24 hours of admission which develop in service.
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 NICE Grade 3 pressure ulcers and above.

Target 2012/13

Indicator 1: A 10% reduction from baseline at end of year – recognising that the baseline will be much lower as a result of the excellent performance achieved in 2011/12.

Indicator 2: 100% achievement

Indicator 3: 100% achievement

What does this mean for you?

On admission you will be:

1. Screened and assessed.
2. Given information on pressure ulcer prevention and management.
3. Your care will be planned, implemented, continuously evaluated and revised to your individual needs and preferences concerning pressure ulcer prevention and management.
4. You will be repositioned to reduce the risk, and manage the care, of pressure ulcers.
5. You will be cared for on pressure redistributing support surfaces to reduce the risk, and manage the care, of pressure ulcers.
6. You will have the resources and equipment required to reduce the risk, and manage the care, of pressure ulcers.

How will you know we are improving and monitoring?

We will be reporting on and monitoring our progress to the Board of Directors on a quarterly basis within the Integrated Performance Report. This will be discussed during the public part of the Board meeting and regularly posted on the Trust's website.

Priority 3 – *Ready to go – no delays*

Why this priority?

Our patients clearly stated within the Quality Survey that timely discharge was amongst their highest criticism of quality care within the Trust. This also incorporated that their perceived delay was due to drugs.

This is also one of the top themes within our complaints.

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.

By getting our processes right, we can improve our patients' experience.

What's our aim/goal?

To create a seamless approach to discharge.

How are we going to do this?

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

1. Engagement of clinicians.
2. Evaluation of present discharge pathways.
3. Introduction of "progressive" discharge planning.
4. Timely prescribing and dispensing of medications.

These measures are the first stage of measurement to improve our discharge process.

What does this mean for you?

You will be provided with accurate and timely information regarding your discharge. This may occur at your pre-admission visit (for surgery) or during your first few hours in hospital.

How will you know we are improving and monitoring?

We will be reporting on and monitoring our progress to the Board of Directors on a quarterly basis within the Integrated Performance Report. This will be discussed during the public part of the Board meeting and regularly posted on the Trust's website.

How will this be achieved?

Three indicators have been established each of which has an associated target.

2012/13 Indicators and Targets

Indicator 1: To achieve an improvement on two key composite questions from the CQC Inpatient Survey. These are:

(a) Discharge: not fully told of side effects of medication

(b) Discharge: not told who to contact if worried

2010/11 & 2011/12 results were:
Question 1 54.5%, 63.4%
Question 2 18.6%, 26.7%
(lower scores are better)

Target: to improve score, decrease by 1%.

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

Priority 3 – *Ready to go – no delays – continued*

Cont/…

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.

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.

Indicator 3:

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.

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

Statements of Assurance from the Board

Review of Services

During 2011/12 Barnsley Hospital NHS Foundation Trust provided no sub-contracted NHS service.

Barnsley Hospital NHS Foundation Trust has reviewed all the relevant data available on the quality of care in the 43 services (see list below). This has been considered as part of the monthly Integrated Performance Report which is considered by the Trust Board of Directors monthly.

Direct access endoscopy	Accident and Emergency
Low vision	ITU
Retinal screening	Paediatrics (Diabetes; Trauma & Orthopaedics; ENT; Cardiology & Dermatology)
General surgery	General medicine
Urology	Gastroenterology
Breast surgery	Endocrinology
Trauma & Orthopaedics	Clinical Haematology
ENT	Diabetic medicine
Oral surgery	Audiology
Orthodontics	Palliative medicine
Cardiology	Stroke
Anticoagulant	Neonatology
Dermatology	Geriatric medicine
Respiratory medicine	Obstetrics
Genitourinary medicine	Gynaecology
Radiology	Midwifery
Rheumatology	Vascular Surgery
Chemical pathology	Medical microbiology
Haematology	Cystic fibrosis
Histopathology	Hepatology
Immunology	Therapy Services
Specialist nursing	

The income generated by the NHS Services reviewed in April 2011-March 2012 represents 100 per cent of the total income generated from the provision of NHS services by Barnsley Hospital NHS Foundation Trust for April 2011-March 2012.

Patient Safety

The Trust 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 Trust's business plan and nursing strategy each year in order that the Trust can deliver its vision of "providing the best healthcare for all".

The Trust committed to the National Safety First Campaign when it was introduced in 2010 and continues to perform well across all the focus areas to improve patient safety, taking part in the Annual Patient Safety First – 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 Trust each year, supporting staff to improve environments and procure equipment to continually improve all our services and reduce patient safety incidents.

Preventing and Controlling Infection

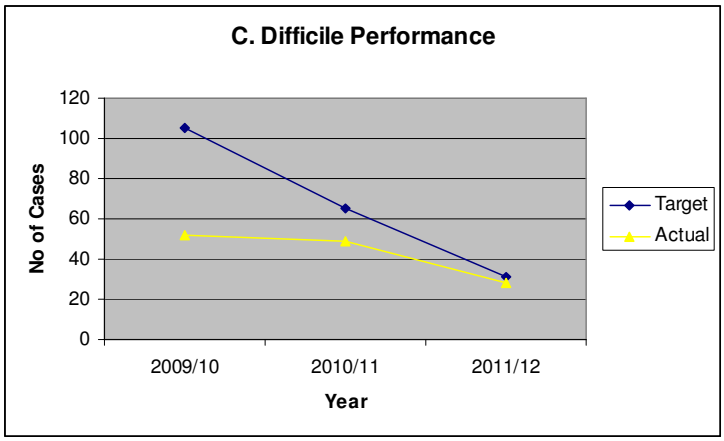
Preventing and reducing infection in hospitals has been a national priority since 2009, with challenging year on year improvement targets across the country. The aim being to:

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

Barnsley Hospital 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 incidence to zero by 2010 and continues to perform well to reduce C.Difficile over performing against targets year on year (shown below):

Year	Target	Actual	Comments
2009/10	105	52	53 better than the target
2010/11	65	49	16 better than the target
2011/12	31	28	3 better than the target



How are we doing in comparison to other Trusts within our Strategic Health Authority in reducing C.Difficile?

The following table shows the reduction in targets for each Trust across the Strategic Health Authority. Hospitals are set a new target each year based on how they have performed in reducing their incidence of C.Difficile. The bed day rate column is based on performance rather than a target.

Hospital Trust	2009/10 Target	2010/11 Target	2011/12 Target	2012/13 Target	Year to date *Bed Day Rate Nov 2011
Airedale NHS Trust	108	83	18	9	1.25
Barnsley Hospital NHS Foundation Trust	105	65	31	31	1.71
Bradford teaching Hospitals NHS Foundation Trust	222	186	69	60	3.35
Calderdale and Huddersfield NHS Foundation Trust	180	151	58	33	1.29
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	146	141	57	48	1.14
Harrogate and District NHS Foundation Trust	37	51	19	11	0.75
Hull and East Yorkshire Hospital NHS Trust	294	256	60	60	2.27
Leeds Teaching Hospitals NHS Trust	584	392	159	159	2.97
Mid Yorkshire Hospitals NHS Trust	240	233	101	78	2.69
North Lincolnshire and Goole Hospitals NHS Foundation Trust	180	161	34	34	1.79
Scarborough and North East Yorkshire NHS Trust	81	66	46	24	2.95
Sheffield Children's NHS Foundation Trust	12	10	3	3	0.86
Sheffield Teaching Hospitals NHS Foundation Trust	375	304	134	134	2.80
The Rotherham NHS Foundation Trust	133	113	42	31	1.62
York Hospitals NHS Foundation Trust	116	112	27	27	1.33

The targets are based on hospital size but also on actual performance each year. The hospital has performed well in reducing the actual numbers of cases, but also now needs to focus on the * bed day rate of infection which is calculated on the actual number of cases per 100,000 bed days.

At the end of the year the Trust has had 0 cases of MRSA against a target of 0 and has had 28 cases of C.Difficile against a target of 31 cases. The bed day rate at the end of March was 1.88. No target was actually set but this indicator will be used more to assess variation across different hospitals.

Utilising feedback from 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 99.6%, a marginal underachievement of the 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 Safety Walkabouts

During 2011/12 these have continued on a monthly basis. Directors and Senior Managers have visited a wide range of clinical areas to discuss their incidents, complaints and compliments and talk to staff about their issues. This initiative has also helped to increase the visibility of senior staff in the Trust.

These visits have taken place throughout the 24 hour period, and have resulted in changes to the environment and practice which have impacted both on patients' and staff's experience.

2011/12 also saw the introduction of weekly CQC "mini and full" inspections being undertaken across all areas of the Trust led by Senior Nurses, members of the Board and input from the Clinical Audit Department. This initiative is being developed in 2012 to incorporate Governors as a regular part of the inspection team. Their focus will be to help us understand what our patients really think and say about the care we provide.

In order to drive the Productive Ward and Productive Theatre Initiatives the project lead has introduced monthly visits to clinical areas. These visits include a member of the Board so that staff can discuss the improvements they have made through the implementation of this programme.

"Listening NEDs"

"Listening NEDs" (Non-Executive Directors). This provides the Chairman and NEDs with the opportunity at least once a month to visit areas across the hospital and talk to staff and patients, and to discuss issues in relation to all aspects of care delivery which they can then feedback to the Board of Directors.

Throughout the year the NEDs have visited 10 different teams across the hospital. Their visits include the Emergency Department, Pharmacy, Infection Prevention and Control, Clinical Audit and they have also spent a session with the hospital's volunteers.

These visits have not only helped to make the Board more visible to front line staff, these interactions have enabled our staff to show case and present developments that they are really proud off whilst being able to discuss issues that are slow to progress but could be achieved with Board level support. Our staff have said that these visits make them feel valued and supported by the Board whilst giving them an opportunity to impart their expertise through sharing knowledge and experience.

Quality Accounts for 2011/12 – Clinical Audit Requirements

Information on participation in Clinical Audits and National Confidential Enquiries

During 2011/12, there were 37 national clinical audits and two national confidential enquiries which covered NHS services that Barnsley Hospital NHS Foundation Trust provides.

In 2011/12 Barnsley Hospital participated in:-

- 26 (70%) out of a possible 37 national clinical audits
- 2 (100%) of the national confidential enquiries

Of the 11 national audits that the hospital did not participate in, 10 of these were not part of the national mandatory audits defined by National Clinical Audit and Patient Outcomes Programme (NCPOP), which is overseen by the Health Quality Improvement Partnership (HQI). The one mandatory audit that the Trust did not participate in was the Acute stroke (SINAP) audit as this programme does not start until later this year.

In addition to national audits, the Trust also participated in 203 local audits, these audits included local initiative audits, but also included audits undertaken to provide evidence for other regulators for example; the National Health Service Litigation Authority (NHSLA) the National Institute for Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) etc.

The national clinical audits and national confidential enquiries that Barnsley Hospital participated in during 2010/11 are as follows:

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/ reporting details
Peri- and Neonatal				
Perinatal mortality (MBRRACE-UK)	✓	✓		Participate via Sheffield.
Neonatal intensive and special care (NNAP)	✓	✓	100%	Current report not yet available.
Children				
Paediatric pneumonia (British Thoracic Society)	✓	×		Not part of NCAPOP.
Paediatric asthma (British Thoracic Society)	✓	×		Not part of NCAPOP.

[1] Applicable to BHNFT
[2] Participated in

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/ reporting details
Pain management (College of Emergency Medicine)	✓	✓	50 cases submitted	Awaiting report.
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✓	✓	100% cases submitted	Report not yet available.
Paediatric intensive care (PICANet)	×	NA		Undertaken at specialist paediatric hospitals.
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	×	NA		Not applicable.
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	100%	Data collection complete. Report due shortly.
Acute care				
Emergency use of oxygen (British Thoracic Society)	✓	×		Not part of NCAPOP.
Adult community acquired pneumonia (British Thoracic Society)	✓	×		Not part of NCAPOP.
Non invasive ventilation (NIV) - adults (British Thoracic Society)	✓	✓	100% (30/30)	Not part of NCAPOP.
Pleural procedures (British Thoracic Society)	✓	×		Not part of NCAPOP.
Cardiac arrest (National Cardiac Arrest Audit)	✓	✓	100%	
Severe sepsis and septic shock (College of Emergency Medicine)	✓	✓	100%	Data has been submitted and the report is due to be published late April / early May.
Adult critical care (ICNARC CMPD)	✓	✓	100%	Reported quarterly.
Seizure management (National Audit of Seizure Management)	✓	×		The Trust did not participate in this study.
Long term conditions				
Diabetes (National Adult Diabetes Audit)	✓	✓		
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	✓	100%	Awaiting report.

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/ reporting details
Chronic pain (National Pain Audit)	×	NA		Submitted by Doncaster and Bassetlaw.
Ulcerative colitis & Crohn's disease (UK IBD Audit)	✓	✓	90% (36/40) (20/20 Crohn's, 16/20 Ulcerative colitis)	Awaiting report.
Parkinson's disease (National Parkinson's Audit)	✓	×		Not part of NCAPOP.
Adult asthma (British Thoracic Society)	✓	×		Not part of NCAPOP.
Bronchiectasis (British Thoracic Society)	✓	×		Not part of NCAPOP.
Elective procedures				
Hip, knee and ankle replacements (National Joint Registry)	✓	✓	100% hips and knees	Number of cases too low to do ankles.
Elective surgery (National PROMs Programme)	✓	✓	100%	Reported Quarterly. Reported to Q2 to date.
Intrathoracic transplantation (NHSBT UK Transplant Registry)	×	NA		
Liver transplantation (NHSBT UK Transplant Registry)	×	NA		
Coronary angioplasty (NICOR Adult cardiac interventions audit)	×	NA		
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	×	NA		
Carotid interventions (Carotid Intervention Audit)	×	NA		
CABG and valvular surgery (Adult cardiac surgery audit)	×	NA		
Cardiovascular disease				
Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	100% of CCU patients	Yearly validation exercise just taken place. Report not yet presented.
Heart failure (Heart Failure Audit)	✓	✓	100% (20 cases per month)	Ongoing data collection.

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/ reporting details
Acute stroke (SINAP)	✓	×		Due to start 2012.
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	✓	✓	100%	
Renal disease				
Renal replacement therapy (Renal Registry)	×	NA		
Renal transplantation (NHSBT UK Transplant Registry)	×	NA		
Cancer				
Lung cancer (National Lung Cancer Audit)	✓	✓	100%	
Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	100%	
Head & neck cancer (DAHNO)	✓	✓	100%	
Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	100%	
Trauma				
Hip fracture (National Hip Fracture Database)	✓	✓	100%	
Severe trauma (Trauma Audit & Research Network)	✓	✓		Reported at Clinical Governance.
Psychological conditions				
Prescribing in mental health services (POMH)	×	NA		
Schizophrenia (National Schizophrenia Audit)	×	NA		
Blood transfusion				
Bedside transfusion (National Comparative Audit of Blood	✓	✓	100% (50/50)	

Area/national audit title	A[1]	P[2]	% cases submitted	Comments/actions/ reporting details
Transfusion)				
Medical use of blood (National Comparative Audit of Blood Transfusion)	✓	✓	Part 1 - 100% (44/44)	Part 2 - to start Jan / Feb 2012
Health Promotion				
Risk factors (National Health Promotion in Hospitals Audit)	✓	×		Not part of NCAPOP. Plan to participate on 2012/13 study
End of Life				
Care of dying in hospital (NCDAH)	✓	✓	100%	Report received December 2011

National Confidential Enquiries (NCEPOD)

Peri-operative Care - Knowing the Risks

Action taken

Quality and Safety Improvement and Effectiveness Board (QSIEB) received and reviewed the report. The National Confidential Enquiry of Patient Outcomes & Death (NCEPOD) self-assessment tool was considered by QSIEB for implementation.

Surgery in Children: Are We There Yet?

Action taken

QSIEB received the report. Key stakeholders contacted to attend a Task and Finish Group, to use the NCEPOD self-assessment tool for implementing the recommendations

Examples of Outcomes from Completed Audits – National and Local

NICE CG94 Angina & Non-ST-segment-elevation myocardial infarction (NSTEMI)

The audit results showed poor overall compliance to NICE Guidance with regards to formal assessments of patients using an established scoring system ie Thrombolysis in Myocardial Infarction (TIMI)/Global Registry of Acute Coronary Events (GRACE) which predicts six month mortality and categorises the risk of future adverse cardiovascular events. To improve compliance, the TIMI/GRACE scoring system are to be included in the Medical Assessment Unit (MAU) pathway and a presentation/training to be provided for all junior medical staff working on MAU on how to use the scoring system and understand the importance of risk stratification.

2285 - NICE TA195 Adalimumab, etanercept, infliximab, rituximab, and abatacept for the treatment of Rheumatoid Arthritis (RA) after the failure of a Tumour necrosis factor inhibitor (TNF)

Overall report shows good compliance with NICE guidelines when prescribing anti TNF drugs for RA. However monitoring needs to improve. Disease activity score (DAS) scores should be measured at least every six months, and should be recorded in a way that makes them easily accessible. To improve compliance the Rheumatology Team has introduced relevant training sessions to ensure all junior medical staff are instructed how to calculate the DAS score. The Senior House Officer (SHO) who undertook the audit also designed a table to be included in the notes so that the DAS scoring can be recorded. This is to be discussed at the Health Records Group for approval for inclusion in the patients' notes.

Essence of Care Privacy and Dignity on the Neonatal Unit

The audit identified that the white boards and computer screens with confidential patient information on are sometimes visible to patients. Staff have been made aware that the door to the ward office needs to be closed at all times as patient details are visible on the white boards located in there and the computer screens need to be turned away from parents view. This has been discussed in their team meeting and written in the communication book.

2204 – Blood Transfusion audit for breast surgery

The audit identified that only 1.8% patients required a blood transfusion in the peri-operative period during this six-month study. Of those, none occurred during the operation itself or when it was vital that the blood be available urgently. As a result of the findings, a new protocol is in place to reduce costs of unnecessary cross matching or group and save sampling for breast surgery patients.

Essence of Care

Overall, five benchmarks have been audited during the time period, and these benchmarks generally show improvement across all areas. There has been a much greater participation from the outpatient and imaging areas and they have organised sessions in line with benchmarks using nurse specialists across the Trust to talk to staff about topics. The nutrition audits have supplemented other audits with patient and staff feedback and the Essence of Care Working Group has been able to share ideas to help others achieve better standards with simple ideas like using bull dog clips on curtains to help maintain patients privacy and deter people from walking into a bed bay or treatment area.

CRT® – Is the tool we use to collect immediate information from our patients on their experience of our services and treatment. This is done through hand held minicomputers and stand alone terminals in outpatient departments. This system asks a number of questions in order to elicit and measure feedback.

The use of the CRT® patient survey software has grown in popularity and we are now capturing data from patients in Pharmacy, Day Surgery, Endoscopy, the Planned

Investigation Unit and Accident and Emergency Department in addition to the Matron's questionnaire and the freestanding data collection points at the main entrances. The feedback is reported each month.

CRT® is the trade name for the company the hospital contracted for the patient experience software.

Research & Development

The number of patients receiving NHS services, provided or sub-contracted by Barnsley Hospital during the year January 2011 - January 2012, that were recruited during that period to participate in research approved by a research ethics committee was 552.

Participation in clinical research demonstrates Barnsley Hospital's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Clinical research supports our clinical staff to stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Barnsley Hospital NHSFT was involved in conducting 118 clinical research studies across the whole of the hospital during January 2011 – January 2012.

55 of our clinical staff participated in the research projects approved by research ethics committees during January 2011 – January 2012. These staff participated in research covering 22 different medical specialties within the Trust.

144 publications (in the last three years) have resulted from our involvement in the National Institute of Health Care Research (NIHR), which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

The following impacts based upon Barnsley Hospital research demonstrate the hospital's commitment to testing and offering the latest medical treatments and techniques.

Barnsley Hospital research has had the following impacts within the Trust and in the wider health environment both nationally and internationally:

- Seeking to identify ways of measuring patient and public involvement in research is informing national policy and outcome measure development

- Patient education is empowering patients and leading to better musculoskeletal health quality and outcomes

- Development of new treatments for arthritis is transforming the morbidity as well as the mortality for patients with arthritis

- Development of biomarkers for arthritis which is helping to develop targeted and personalised medicine.

- Participation in the RATPAC/Accident and Emergency trial has enabled us to develop a Point of Care testing pathway for patient with low risk chest pain in the Emergency Department. This prevents admission to hospital and is better for patient care and satisfaction.

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

CLAHRC research work of which Barnsley is a leading member, will impact in the way that obesity services and long term conditions services are commissioned in the future. Local data will be used by the Department of Public Health to justify further investment in obesity prevention and treatment from the Central Commissioning Group, in order to prevent and reduce long term conditions.

The Advanced Nurse Practitioner project service evaluation is also part of CLAHRC. Possible impacts are the way in which the Trust will staff the medical, surgery and orthopaedic junior medical teams. This study may have impacts on staffing costs and the quality of care provided.

The NIHR Age and Ageing Group has adopted the published ageing ROADMAP priorities into national practice. The ROADMAP was commissioned by the European Union Framework 7 Programme to formulate a statement of priorities. The ROADMAP priorities will benchmark age and ageing care for the next 10 years.

The hospital's work in Testosterone therapy has led to an 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 probably 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. This resulted in Barnsley stroke services being among the best in country, first in Yorkshire and Humber and third best in England. (Care Quality Commission Report 2011).

Commissioning for Quality and Innovation (CQUIN)

A proportion (1.5%) of Barnsley Hospital NHS Foundation Trust income in 2011/12 was conditional upon achieving quality improvement. Innovation goals were agreed between; Barnsley Hospital NHS Foundation Trust, NHS Barnsley and other associated Commissioners. This was then included as part of the contract for the provision of NHS services, in accordance with the CQUIN.

The CQUINS for 2011/12 covered a range of national and local goals. The monetary total for the amount of income in 2010/11, conditional upon achieving quality improvement and innovation goals, was £1.875 million.

There were two national and eight local targets. The national schemes were:

- Venous Thrombo-embolism (VTE) - Ensure that 90% of all patients are VTE risk assessed each month

- Patient experience – ensure that scores in the annual CQC inpatient survey are at least 1% better in five questions.

The local schemes were:-

- Patient Experience – a local target of a further 1% on CQC national patient satisfaction survey.
- Tissue Viability - Pressure Ulcers - to reduce the number of hospital acquired pressure ulcers, fully report and investigate all incidences.
- Nutrition - based on Essence of Care standards, four areas, 90% screened on admission and discharge and action exceptions. High risk patients at discharge have a specialist referral.
- Workforce - safeguarding training – 91% of all staff are appropriately trained for adult and children safeguarding.
- Dementia – patients aged 65+ have an Abbreviated Mental Test (AMT) on admission (target = 75% @ Q4) and 40 staff trained in dementia mapping.
- Catheter Associated Urinary Tract Infections – to reduce incidence.
- Falls - to reduce repeat falls based on 2010/11 outturn.
- Colorectal Enhanced Recovery Programme – to reduce patients length of stay in hospital following colorectal surgery.

Performance

The Trust achieved 68% of the additional income available to the hospital for delivering national and local quality targets. The failure to deliver the patient experience national and local targets and the loss of the associated additional income aligned to these targets, make it very clear that we need to learn from what our patients are telling us as part of the CQC national patient survey, as these targets are directly aligned to questions designed to understand patients' perceptions of their care experiences in hospital.

The hospital is currently developing a patient experience strategy which will respond to what our patients are telling us. This document will identify clear patient experience objectives and the workstreams that will be delivered in order to meet these objectives.

The achievement against the individual CQUIN income targets is detailed below:

CQUIN Income Summary

National & Local Targets	Indicator	Performance		
		Target	**Achieved**	**Received**
National 1	VTE	£187,589	Yes	£187,589
National 2	Patient Experience	£187,589	No	no payment
Local 1	Tissue Viability Pressure Ulcers	£187,589	Partially	£171,957 (one indicator in Q1 not achieved)
Local 2	Patient Experience	£187,589	No	no payment
Local 3	Nutrition	£187,589	Partially	£140,691 (Did not meet target for number of patients being screened on admission)
Local 4	Workforce Safeguarding Training	£187,589	Yes	£187,589
Local 5	Dementia	£187,589	Partially	£112,553 (Achieved the target for staff training but did not achieve the stretch target for risk assessing patients on admission in Q4)
Local 6	Catheter Associated Urinary Tract Infections	£187,589	Partially	£150,072 (There were issues with data collection in Q3)
Local 7	Repeat Falls	£187,589	No	£187,589
The Trust has achieved a reduction in repeat falls from 2010/11. The Trust's Commissioner has recognised this, whilst also recognising that the 2011/12 CQUIN target had been set on an incorrect basis.				
Local 8	Colorectal - Enhanced Recovery	£187,589	Partially	£140,692 (Q3 target not met)
		£1,875,890		**£1,278,731**

2012/13 will see 2.5% in addition to contract income paid as CQUIN in order to further incentivise quality. This has increased from the previous 1.5% paid in 2011/12. This increase equates to approximately **£3.23 million** for Barnsley hospital and will be paid against quarterly performance.

20% (£646,000) of this will be allocated to the **four national CQUINs:**

1. Dementia – Screening and Risk Assessment
2. Patient Experience based on 5 questions - CQC Inpatient Survey
3. NHS Safety Thermometer (improving collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and VTE)
4. Venous Thromboembolism (VTE) 90% of admissions risk assessed

NHS Barnsley has indicated these will be financially weighted as shown in accordance with their priorities.

80% (£2.58m) will be allocated across **six local CQUINs**:

1. Paediatric Safeguarding – Developing systems for:
    a. Alerting GPs to patients who did not attend (DNAs) their appointment.
    b. Alerting Health Visitors to frequent Emergency Department attendances.
2. Achieve a staged approach to deliver a 97% local stretch target by quarter 4 against the four hour A&E target.
3. Clinical Communication – GPs to receive within five days communication from the hospital following outpatient appointments incorporating clear treatment requirements and associated information to be included.
4. Implementation of Modified Early Warning Score (MEWS – a method of assessing patient care needs) in clinical areas.
5. Reduce the Incidence of Catheter Associated Urinary Tract Infections (CAUTIs).

Further details of the agreed goals for 2011/12 and for the following 12 month period are available from the Trust's Chief Nurse at hmcnair@nhs.net.

Regulation and Compliance

Care Quality Commission (CQC)

Barnsley Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status as of 31st March 2012 is without conditions.

The Trust uses the CQC quality risk profile information provided monthly in order to monitor and control risks to maintaining full registration.

The Trust did have an unannounced visit from the CQC on the 31st March 2011. This was as part of their national assessment programme assessing dignity and nutrition. This inspection was part of a targeted inspection programme of NHS hospitals looking at whether older people were treated with respect and how they were helped with food and drink should they need assistance.

The Trust received an initial draft report in May 2011 and then received a final report at the end of May 2011. The CQC report confirmed that the Trust was fully compliant against outcome 1; respecting and involving people who use services. The Trust did however, receive an improvement action highlighting moderate concerns in terms of outcome 5; meeting nutritional needs.

As a consequence of these findings the Trust developed a comprehensive action plan incorporating all the compliance requirements identified, but also included a number of enhancement or best practice actions to further improve patient outcomes. These workstreams and all the associated actions have been delivered and the Trust were revisited in December 2011 by the CQC and the subsequent report confirmed the Trust's compliance with all the essential standards.

The CQC visited the hospital on the 21st March 2012 as part of a National Responsive Review, to examine records associated with termination of pregnancy. At the time of producing the report the Trust was still awaiting the outcome of this latest visit.

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.

It is important to note the following caveats around PROMs data:

The procedures summarised in the health gain charts published to date only represent 25-30% of those procedures carried out in the timeframe under consideration. There are a number of reasons for this:

- Low participation rates - in 2010/11 the participation rates (pre-op questionnaire) was 70% on average across all Trusts and procedures
- Linkage with Hospital Episode Statistics (HES) - it is not possible to link all questionnaires to HES data for verification and thus in 2010/11 the average linkage rate was 74%
- Low response rates - on average in 2010/11 the response rate (post-op questionnaires) was around 72%

It is recognised that the collection and publication of PROMs data is relatively new and still considered to be “experimental” by HES.

PROMs Performance

For Yorkshire and Humber 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. For Barnsley Hospital these rates are slightly above the Yorkshire and Humber average. 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 and knee replacement scores.

The latest published data as at April 2012 is detailed below:-

		BHNFT			National		
Procedure	**Measure**	**2009/10 (Finalised)**	**2010/11 (Provisional)**	**2011/12 (Provisional)**	**2009/10 (Finalised)**	**2010/11 (Provisional)**	**2011/12 (Provisional)**
Hip Replacement	EQ-5D	0.337	0.335	0.321	0.411	0.405	0.423
	EQ-VAS	5.797	6.185	10.680	8.955	9.182	10.129
	Oxford Hip	16.560	15.942	15.497	19.655	19.717	20.270
	Participation Rate	84.5%	94.0%	78.8%	76.3%	78.8%	80.8%
	Completed Q1	175	188	104	48,515	54,991	42,848
Knee Replacement	EQ-5D	0.245	0.266	0.339	0.295	0.299	0.313
	EQ-VAS	-0.121	2.575	3.749	3.043	3.110	5.056
	Oxford Knee	12.846	13.862	16.304	14.624	14.873	15.369
	Participation Rate	90.4%	100.0%	67.5%	78.4%	83.7%	85.4%
	Completed Q1	328	335	187	56,925	63,023	48,575
Groin Hernia Repair	EQ-5D	0.082	0.089	0.123	0.082	0.085	0.089
	EQ-VAS	-3.277	-2.930	-0.943	-0.932	0.538	-0.256
	Participation Rate	50.5%	43.6%	40.3%	55.0%	55.7%	59.0%
	Completed Q1	148	115	91	37,765	37,939	30,482
Varicose Veins	EQ-5D	*	*	*	0.094	0.091	0.094
	EQ-VAS	1.195	*	*	-0.366	-0.091	0.298
	Aberdeen	-4.462	*	*	-7.930	-7.518	-8.173
	Participation Rate	45.1%	46.2%	47.4%	43.4%	47.7%	48.3%
	Completed Q1	55	43	45	15,137	15,394	9,498

= 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

This information shows that for 2011/12, we continued to be an outlier for the ED-5D knee replacements and both Oxford Knee and Hip Replacements. It also shows some deterioration in our participation rate in all areas except Varicose Veins.

It has been recognised that further work is required to support patients who are required to complete both the pre and post-op questionnaires. Improved support and information for patients on how to: 1) complete the questionnaires and 2) what to expect following this type of surgical procedure.

A revised questionnaire is now in use and the pre-assessment team fully explain the importance of completing the questionnaires accurately and in such a way that their true health benefits, whether they be good or bad are reflected appropriately. Nursing staff support patients and their families in completing the pre-operative questionnaire during their pre-assessment appointment and patients are encouraged to contact the department following surgery when they have received the post-operative questionnaire for help in completing the questions.

Patient feedback from the Enhanced Recovery Programme for elective hip and knee replacement surgery is now well established and has involved the patient much more closely in all aspects of their care, particularly in relation to their health and general wellbeing. Patients feel much more in control of their recovery and are much more in tune with the progress they should be making and by when.

It is envisaged that by adopting a much more focussed, patient-centred approach to the accurate and timely submission of this important information will have a positive impact on assessing the perceived health benefit scores as determined by patients of the outcome of the procedure they have undergone and the expected improvement of their quality of life and health gain.

Monitor Risk Ratings

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

Barnsley Hospital is a Foundation Trust and as such performance is checked by Monitor, the independent regulator of Foundation Trusts. Monitor uses a risk based approach to determining 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. The Trust is currently rated at a financial risk rating of 3 and a governance risk rating of green.

The National Health Service Litigation Authority (NHSLA)

Overview
The NHSLA handles negligence claims and is established to indemnify NHS Trusts in respect of both clinical negligence and non-clinical risks. It manages both claims and litigation and has established risk management programs against which NHS Trusts are assessed in order to improve risk management practices in the NHS.

The promotion of good risk management and governance are integral components of the NHSLA schemes. There is now a single set of risk management standards for each type of NHS healthcare organisation: acute, ambulance, mental health and learning disability, and primary care trusts.

There is a different process for maternity services within Trusts which is the Clinical Negligence Scheme for Trusts (CNST).

There are three levels of Risk Management Standards with five standards for each and ten criterion; these standards cover different aspects of healthcare.

1. Governance
2. Competent and Capable Workforce
3. Safe Environment
4. Clinical Care
5. Learning from Experience

Trusts are accredited at different levels against these standards ranging from level 0-3, level 0 being considered higher risk and level 3 lower risk. The NHSLA scheme is essentially an insurance type scheme with annual premiums.

Barnsley Hospital currently pays approximately £4.5 million each year to receive indemnity. The scheme offers 10% discount for higher levels of accreditation against their standards as this indicates that the hospital has systems in place to reduce risk.

The risk management standards have been significantly updated and changed and consequently the hospital has needed to be reassessed against the new standards prior to being able to increase our accreditation level and reduce the corresponding level of premium.

The hospital was assessed by NHSLA in March 2012, and achieved level 1 accreditation against the new standards; this will be maintained whilst working towards delivering level 2 standards in readiness for re-assessment in 2013.

The Trust was also assessed by CNST in September 2010, and achieved level 1. A re-assessment against this level with the updated standards will be undertaken in September 2012 whilst working towards delivering the updated level 2 standards.

Information on the Quality of Data

Secondary Uses

BHNFT submitted records during 2011/12 to Secondary Uses Service (SUS) for inclusion in hospital episode statistics which are included in the latest published data of April 2011 – January 2012.

The percentage of records in the published data:

- which included the patient's valid NHS number was: 99.5% for admitted patient care; 99.7% for out patient care; and 98.5% for accident and emergency care.

- which included 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.

Information Governance (IG)

Barnsley Hospital Information Governance Assessment Report overall score for 2011/12 was 82% and was graded as satisfactory.

Data Quality

In 2011/12, progress has continued with the action plan relating to data quality following the "dry run" of the External Assurance of our Quality Account 2009/10 in August 2010. Out of the 44 actions, 41 are now completed, giving a compliance of 93%. Further internal and external audits have been completed this year including a Quality Account audit, a Clinical Coding audit, IG Toolkit compliance of the Data Quality requirements and an audit of all previous external audit recommendations. All have shown very good compliance with only minor recommendations which have been addressed immediately.

The Trust is taking the following actions to improve data quality:

- Roles and responsibilities have now been assigned to all managers of information assets/systems. This ensures that they are accountable for the quality of information held within their designated asset whether this is paper or electronic.
- Training programmes and materials for all information assets/systems need to be quality assured by the Learning and Development Department.
- An internal audit programme of data quality and clinical coding has commenced in line with the requirements of the Audit Commission and NHS Connecting for Health. The Head of Clinical Coding will be accredited to complete this work once Connecting for Health have released dates for this training.
- Work is in progress to ensure that the Clinical Coding department has a designated work space within the main hospital and access to the Trust's patient administration system (PAS) to enable them to code outside of the department.
- Implement a data quality spot check audit programme, of all information assets/systems, that is carried out regularly during the year.
- A patient flow management system has now been procured which once implemented will improve the current issues relating to batch inputting.
- Raise awareness of data quality issues by producing a data quality dashboard at departmental level. Work alongside Clinical Directors with a view to improving data quality and to encourage their involvement in the validation of coding data.

Clinical Coding

A Payment by Results (PbR) audit covering data from quarter one was carried out in October 2011 and an Information Governance (IG) audit covering quarter three information was carried out in March 2012.

The audits undertaken covered a random sample of 100 episodes of care across the whole range of services covered by a mandatory PBR tariff, additionally a random sample of 100 episodes of paediatric care across the whole range of paediatric activity undertaken at the Trust was included as part of the audits. The results of the audit should not be extrapolated further than the actual sample audited. However the results of the audits showed that an improvement in the quality of clinical coding was achieved in these areas over the months between the two audits:

	Quarter 1 Results		Quarter 3 Results	
	Primary Diagnosis correct	Secondary Diagnoses correct	Primary Procedures correct	Secondary Procedures correct
Target for Clinical Coding Accuracy	90%	80%	90%	80%
PbR Audit October 2011	87.5%	83.1%	93.3%	97.3%
IG Audit March 2011	95.5%	86.2%	94%	96%

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

- Monitoring, spot checking and auditing of clinical coding by senior clinical coding staff, together with feedback to coders;

- Continuous internal and external training of coders to ensure clinical coding skills are kept up to date.

What everyone is saying about us

The information provided on the NHS Choices Website in March 2012 states that 82% of respondents would recommend our hospital to a friend.

Our average ratings from patients/ respondents showed that:

The environment where I was treated was…

 Very clean

The hospital staff worked well together…

 All of the time

I was treated with dignity and respect by the hospital staff…

 All of the time

I was involved with decisions about my care…

 Most of the time

NHS hospitals must provide same-sex accommodation. How satisfied were you that this hospital did so?

 Satisfied

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 the CRT system (data collection tool) described on page 96.

CQC In-Patient Survey 2011

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 (eg 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 ninth survey of adult inpatients and involved 161 acute and specialist NHS trusts. A total of 70,000 patients responded providing a national response rate of 53%.

The hospital's response rate was 42% which is 10% below the national average and translates into an overall total of 347 respondents. Currently the Matrons, through their regular report to the Board, 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 2011, 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 2011 and completed the postal survey questionnaire later in the autumn. Thus, whilst clearly a valuable source of information, the report findings have been be viewed by the hospital in conjunction with messages from the Matrons' workstreams.

The full CQC report was published on the CQC website on the 24th April 2012

On reviewing the Trust's scores against the thresholds for each of the 77 questions the following picture emerges:

Achieves or surpasses the threshold for the highest scoring 20% of NHS Trusts - **Green**	0
Within the remaining 60% of Trusts – **Amber**	73 questions
Is within or below the threshold for the lowest scoring 20% of NHS Trusts - **Red**	4 questions

The four questions that the Trust scored in the lowest 20% of trusts were:

<u>Your care and treatment</u>

Q41: Were you involved as much as you wanted to be in decisions about your care and treatment?

<u>Leaving hospital</u>

Q64: Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

Q65: Did a member of staff tell you about medication side effects to watch for when you went home?

Q66: Were you told how to take your medication in a way you could understand?

Overall the Trust position was much the same as 2011 with deterioration in a small number of areas which can be targeted to introduce improvements.

The challenge is how we make the move to become one of the top 20% performing hospitals. Staff engagement is key and their empowerment to effect change at the front line to deliver service improvement and improved patient experience.

As previously stated on page 85 the Trust did not achieve the national or local CQUIN target in relation to the five composite questions included as part of this survey. The Trust is currently developing a clear action plan in order address the areas covered by these questions, this action plan will also address the four additional areas outlined above where we scored in the lowest 20% of Trusts.

To further support this work as described early the Trust is developing a patient experience strategy which will identify clear improvement objectives.

The action plan to address the key issues identified, and the patient experience strategy will be monitored through our Patient Experience Board which has staff, Governor and patient involvement.

CRT (Real time) Patient Experience Collection System

The Matrons within the Trust routinely ask a sample of patients from across adult ward areas a number of questions. These relate to the quality of care, nutrition, infection, prevention and control and communication.

The outcomes of these and the free standing devices are reported to the Trust's Board of Directors regularly to provide the Board with ongoing assurance of improvement in patient experience.

Patient Stories to Board

During 2010/11, the Trust introduced patient stories at the start of the Board meetings. These have been sourced from patient and user complaints; experiences and associated responses and on some occasions by patients talking to the Trust Board.

The intention is to ensure that a patient's voice is heard at Trust Board in order that it can provide a connection between the Trust's leaders and our primary purpose of proving high quality, safe care for patients.

This beneficial practice has been continued throughout 2011/12, and the intention is to maintain this practice in the future as it provides a quality context at the start of each Board meeting.

Complaints & Patient Liaison Service (PALS)

The following information gives an overview of the formal complaints received by Barnsley Hospital between April 2011 and March 2012, along with the informal complaints and concerns dealt with by the PALS Team in the same period.

	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	
Mortuary/PM arrangements	1	
Support/Advice (PALS only)	0	614
Total	**272**	**1484**

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 here are just some of the improvements we have made in 2011/12;

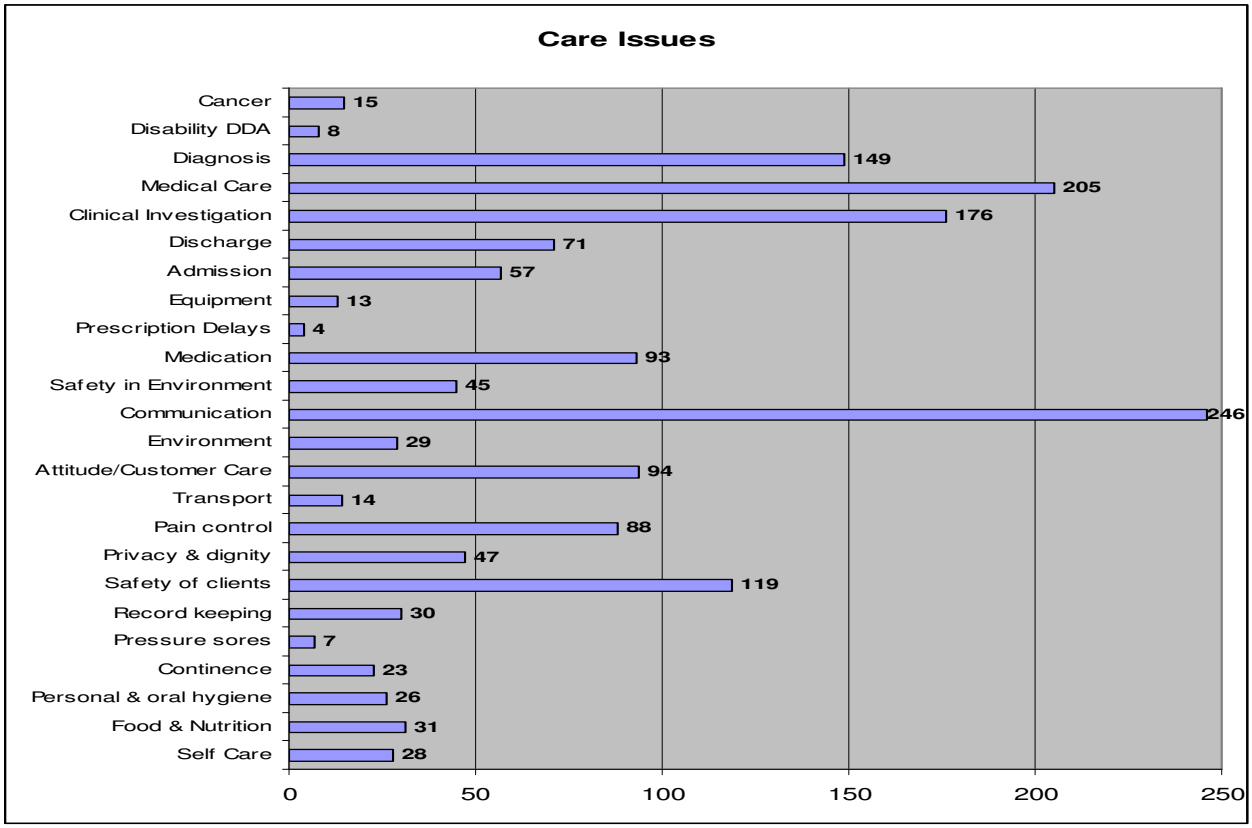
- Liaison with Weston Park to identify a streamlined pathway of returning test results to correct location and consultant within Barnsley Hospital.

- 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 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.
- 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 reviewed protocol.
- Security team to receive customer care training.

The following graph provides further detail behind the complaint categories and relates only to the formal complaints received.



Staff survey

In order to deliver high quality services throughout the hospital we recognise that our staff are our most valuable asset and ensuring that they are trained, happy and motivated is essential to 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 Trust uses the valuable annual information collected as part of the national NHS staff survey to identify key themes.

The 2011 staff survey results show how the hospital scored across 10 areas compared to 2009/10.

Scores improved for the areas of:

- Training, learning and development
- Staff who had been appraised
- Staff saw care of patients as the Trust's top priority
- Senior managers act on staff feedback

Scores remained about the same for:

- Work life balance
- A worthwhile job and the chance to develop
- Communication with senior managers
- Harassment, bullying and violence

Areas where improvements are needed are:-

- Occupational Health support to staff in dealing with work related stress
- Encouraging all staff to record and report all non patient related incidents

To this end the Trust will continue with the project launched in 2011; "Together we will make it better". A new and 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 managers and staff nominations 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.

PART 3: OTHER INFORMATION

How are we performing?

Performance Improvement 2011/12

We have chosen our areas for performance improvement through engagement with patients, staff 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 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.

<table>
<tr><th rowspan="2">We have chosen to measure our performance against the following metrics:</th><th>2010/11</th><th>2011/12</th><th rowspan="2">Target 2011/12</th><th rowspan="2">Comments</th></tr>
<tr><th colspan="2">Performance</th></tr>
<tr><td colspan="5">Patient Safety</td></tr>
<tr><td>Patients with MRSA bacteraemia</td><td>0</td><td>0</td><td>0</td><td>Target set by SHA</td></tr>
<tr><td>Patients with C.Difficile infection</td><td>49</td><td>28</td><td>31</td><td>Target set by SHA</td></tr>
<tr><td rowspan="2">Serious Incidents (SIs) that occur within the Trust</td><td colspan="3">No target but wish to monitor</td><td rowspan="2">Board wish to monitor as an indicator of Quality of Care</td></tr>
<tr><td>27</td><td>17</td><td>NA</td></tr>
<tr><td>Medication errors</td><td>137</td><td>168*</td><td>126</td><td>Target 5% decrease</td></tr>
<tr><td colspan="5">* We encourage all staff to report incidents in order to increase learning and reduce adverse outcomes. Future targets should be based on reducing adverse outcomes rather than discouraging reporting.</td></tr>
<tr><td rowspan="2">Hospital in-patient falls (patients who have fallen more than once)</td><td>185</td><td>164</td><td rowspan="2">133</td><td rowspan="2">Local CQUIN</td></tr>
<tr><td colspan="2">A reduction of 11.35%</td></tr>
<tr><td colspan="5">In the Governors meeting on the 28.02.12 they selected Hospital in-patient repeat falls (where patients had fallen more than once during a hospital admission) as the local indicator to be reviewed by external audit for the 2011/12 Quality report.
As part of the 2011/12 audit process there were control weaknesses identified in the capture and validation of the repeat fall data. These weaknesses meant that when the KPI was validated the recalculated repeat falls data moved from 81 to 164.
Because of the control weaknesses identified the Trust have taken the opportunity to recalculate the 2010/11 repeat falls balance to show a like for like comparison against the</td></tr>
</table>

164 repeat falls identified above. This exercise has meant that the 2010/11 KPI performance has moved from 158 to 185. The reason for this movement is due to incomplete data capture in the Sentinel risk reporting system. The Trust have taken the control weaknesses seriously and are in the process of reviewing the existing controls following the audit review to ensure that they are strengthened, improving the robustness and consistency of future reporting.				
Hospital in-patient falls (previous priority in 2009/10 and 2010/11) measured in number of falls and fall rate per 10,000 bed days	54.8	46.81	No Target	Board wish to monitor indicator of Quality of Care
VTE Assessment Compliance	88.39%	92.69%	90%	Achievement of National indicator value of CQUIN
Clinical Effectiveness				
	2011/12 Performance		**Target 2011/12**	**Comments**
To reduce the incidence of Catheter Associated Urinary Tract Infections (CAUTIs)	Partially achieved year 1 of this 2 year target.		To set up a monitoring tool	Local CQUIN
Improvement in numbers of staff who are eligible receive safeguarding training (adult and child)	Achieved		91% (Adult & Children)	Local CQUIN
Patients will be able to expect early diagnosis of dementia to facilitate access to and provision of a seamless service that is patient centred, delivered safely with privacy and dignity, and with appropriate sedation	55.29% Achieved		75% of all eligible patients have had score completed 40 staff have completed training	Local CQUIN
2009/10 Indicators	**2011/12**	**2010/11**	**Target 2011/12**	**Comments**
	Performance			
Delayed discharges (measured % of occupied bed days)	222 Achieved a 37.1% reduction	353	Target 10% reduction	Performance 2010/11 n = 114 Achieved
To reduce the number of patients readmitted as an emergency admission within 14 days of a previous discharge	4.59%	4.76%	4.40%	Part of Operating Framework on re-admissions

Increase participation rates in Patient Reported Outcome Measures (PROMS) for the following: • Varicose veins • Hernia repair • Hip replacement • Knee replacement	47.4% 40.3% 78.8% 67.5%	53.2% 75.0% 83.8% 81.4%	Increase to 70% in all areas	Figures provided are for 2010 Quarter 3 and 2011 Quarter 3
These have been changed completely from the 2009/10 Quality Account, this is to reflect the Trusts' locally agreed CQUINs, based on local needs of the population and performance achieved in 2010/11.				
Patient Experience				
	2011/12 Performance		**Target 2011/12**	**Comments**
Was your sleep disturbed by avoidable noise at night?	59%	72%	Increase average of No to 64%	Monitored via Trust's real time patient experience tracking system
Staffing levels (in your opinion , were there enough nurses on duty to care for you in hospital)		74%	Increase average of Yes to 80%	
To improve responsiveness to personal needs of patients, will be a composite, calculated from five survey questions: • Involved in decisions about treatment/care • Hospital staff available to talk about worries/concerns • Privacy when discussing condition/treatment • Informed about medication side effects • Informed who to contact if worried about condition after leaving hospital	Not achieved only scored 61.3% Not achieved only scored 61.3%		69% (National CQUIN) 72% (Local CQUIN)	CQC In-patient Survey

Planned changes for Quality Accounts 2012/13

Now in their third year, Quality Accounts are becoming an increasingly important tool for strengthening accountability for quality within hospitals.

To date there has been considerable flexibility in the content of Quality Accounts in order to foster the local ownership, some trusts have included comparative data within their reports in order to provide context to their performance. The National Quality Board, the steering group in the development of the Quality Account and the associated annual Quality Report, has been considering how to advance the readers understanding of comparative performance data. In order to do this they have recommended that all

healthcare providers will present information across a number of mandated indicators. All trusts will be expected to show their own performance against these indicators, the national average for the indicator and provide an explanation on any variation from the national average detailing what steps they have taken or are planned to improve quality.

The mandated indicators for acute hospitals will be:

1. Summary Hospital Level Mortality Indicator (SHMI)
2. PROMs
3. Emergency readmissions within 28 days of discharge
4. Responsiveness to patients needs
5. Percentage of staff who would recommend hospital to friends or family needing care
6. Percentages of patients risk assessed for Venous Thrombo-embolism (VTE)
7. Rate of C.Difficile
8. Rate of patient safety incidents and percentage resulting in severe harm

Many of these indicators have been included within this year's report, but not necessarily providing the full context of our hospital's performance, against the national picture. The Trust is currently undertaking a full comparative analysis, to understand our relative performance against these specific measures. We will then develop clear action plans for any significant variations in our performance so that we can proactively address any areas of weakness and further improve the quality of our services.

The full position against these indicators will be provided in next year's report.

Overview of Performance in 2011/12 against the key national priorities from the Department of Health's Operating Framework and against the Department of Health's National Core Standards

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

- Reducing Health Care Associated Infections (MRSA and C.Difficile)
- Patient Experience Survey
- Patient Access - Referral to Treatment Times
- Eliminating Mixed Sex Accommodation
- Delivering the A&E Quality Indicators
- Delivering Cancer Targets
- Reducing Emergency Readmissions

Our Performance

Reducing Health Care Associated Infections (MRSA and C. Difficile)

This year we have had zero MRSA and 28 C.Difficile 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 99.6% 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 Survey

Refer to pages 94-96.

The hospital continues to implement initiatives to improve the quality of care provided to our patients. Some examples are provided below but also refer to the patient access section to understand how we support vulnerable patients.

<u>"Red jug and beaker" scheme</u>

A scheme that helps to ensure patients at risk of dehydration get enough fluids was put in place in the year.

Following a successful pilot scheme, the "red jug and beaker" project was rolled out across the hospital. The bright red jugs and beakers are assigned to patients who, after monitoring, are not taking enough fluids into their bodies. These then provide a visual prompt to staff and relatives to encourage the patients to drink, and to make sure that the jug and beaker are within easy reach.

The inspiration for the scheme follows the "red tray pathway" – introduced several years ago for patients who may have problems eating their meal.

<u>Real time information</u>

We continue to use the 'real time' collection of patient experiences, helping our Matrons to collect and theme the feedback from across the wards.

Feedback on areas such as the quality of care, infection prevention and control and the hospital environment is gathered using an electronic system called CRT where the patients read a series of questions and respond appropriately using touch screen technology.

Younger patients are also being encouraged to give their view in the Emergency department with the help of a touch screen using smiley faces.

The result is monthly reports and action plans which the Matrons use to understand where they need to place greater focus in the coming weeks. This development was part of our actions to improve responsiveness to the personal needs of patients. The touch screen system enables them to rate hospital services with, for example, a smiley face indicates a short wait in the Emergency department; a glum face suggests too long a wait.

Patient Access

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

Additionally the Trust 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 Trust 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 Trust. 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 Trust continues to make progress in the work on improving the experience of patients within the Trust who have learning disabilities. Progress continues in the development of a 'Hospital Passport' that patients carry so that their care, treatment and preferences are known. Work has also being 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 and 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 Trust to the Mencap charter 'Getting it Right'. This has been endorsed by the Board of Directors

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.

As a hospital we have signed up to the National Dementia Declaration, a national pledge with clear standards to support patients with dementia. We have also agreed to implement the butterfly initiative within the hospital to ensure that patients suffering from dementia are identified to all staff groups providing their care.

Ethnicity Needs

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

Eliminating Mixed Sex Accommodation

The hospital has organised its facilities to eliminate mixed sex accommodation.

There were some difficulties in delivering this requirement within our Day Surgery and Endoscopy unit in the early part of last year, whilst making adjustments to accommodate a patient with learning disabilities.

The hospital has been fully compliant with all the standards associated with delivering this requirement from June 2011 onwards.

Delivering the A&E Quality Indicators

2010/11 saw the Accident and Emergency less than four hours to treatment target reduced from 98% of all patients to 95% but a number of developmental measures were introduced to ensure that high quality care was delivered.

Despite an above average increase in numbers of patients attending, the hospital has ensured that 95% of patients are seen and treated within four hours achieving the national quarterly and annual target. The hospital has published data covering the other developmental measures introduced.

Delivering Cancer Targets

There are a number of cancer targets that need to be delivered to ensure that our patients get rapid access to care and treatment. These include delivering a less than two week appointment system, and ensuring that diagnosis of cancer is confirmed within 31 days of referral, we also must ensure that patients receive their treatment within 62 days from their referral or from a screening process. The hospital continues to work with our patients to provide a full range of high quality services that can deliver these exacting standards. The hospital was pleased to conclude the year having achieved all of these standards and targets.

As well as delivering traditional treatment to our patients a number of complimentary therapies have also been developed to enhance the patient experience for our cancer patients.

The Well for Wellbeing – a centre offering complementary therapies for cancer patients – was opened at The Core in Barnsley town centre in July 2010 and continues to provide excellent facilities for our patients.

With two confidential treatment areas, a reception, and waiting area, the centre offers therapies and is used for group classes and patient support groups. Complementary therapies include oriental massage, reiki, and beauty therapies, including brow and lash enhancements and a tailor-made service to teach people how to tie scarves and fit hats and wigs. The Well also offers advice on how to look after your scalp and hair during and after treatment for cancer.

Reducing Emergency Readmissions

This was a new standard introduced this year. The hospital has therefore had to take a number of actions to address this requirement. These include:

- Undertaking a root cause analysis of all emergency readmissions to fully understand the reason, to learn and adapt services to eliminate the causes identified.
- The implementation of an enhanced recovery programme across a number of pathways to improve recovery processes and prevent the need for readmissions.
- The development of a virtual ward concept that will support progress monitoring of patients in their own home.
- Working with other health and social care partners to meet patient's care needs.

The Trust has also continued to ensure that it is able to **respond in a state of emergency.** The Trust has, in conjunction with the health community, reviewed all of its business continuity and emergency resilience plans, and has undertaken a number of live exercises throughout the year to demonstrate the strength of its business continuity and resilience plans.

Monitor Targets 2011/12

As described earlier in this report as a Foundation Trust Hospital we are also regulated by Monitor, an independent regulator. Monitor as part of its regulatory arrangements produces an annual Compliance Framework which encompasses a list of key targets that are used to measure if hospitals are delivering high quality outputs for their patients.

The table below shows the hospital's performance against these targets.
(Please note: figures in this table could be subject to minor variation following full validation. The figures in the final version of this report will be fully validated).

Indicator	Performance			
	2011/12		2010/11	
	Target	Actual	Target	Actual
C. Difficile	31	28	65	49
MRSA	0	0	1	0
All Cancers 31 Days - subsequent treatments (Surgery)	94%	100%	94%	100%
All Cancers 31 Days - subsequent treatments (Drug Treatments)	98%	100%	98%	100%
All Cancers 31 Days - Radiotherapy	N/A	N/A	N/A	N/A
All Cancers 62-day GP urgent referral to treatment	85%	95.5%	85%	91.3%
All Cancers 62 Days - Consultant upgrades	80%	94.9%	85%	88.5%
18-week referral-to-treatment target: Admitted patients treated	90%	95.7%	90%	96.73%
18-week referral-to-treatment target: Non-admitted patients treated	95%	98.1%	95%	98.72%
All Cancers: 31-day diagnosis to treatment	96%	99.8%	96%	99.3%
All Cancers: two week wait	93%	96.5%	93%	96.5%
Symptomatic Breast Patients - two week wait (non cancer referrals)	93%	94.3%	93%	95.3%
Screening all elective in-patients for MRSA	100%	100%	100%	100%
Total time in A&E: four hours or less	95.%	95.6%	95%	95.54%
People suffering heart attack to receive thrombolysis within 60 minutes of call	68%	N/A	N/A	N/A
Other Indicators that are monitored:				
Audiology patients treated within 18 weeks	95%	100%	95%	100%
Delayed Transfer of Care - as %age of bed occupancy	< = 3.5%	0.16%	0	0.09%
All Cancers 62 Days - Screening Programme Upgrades	90%	91.3%	90%	94.7%
Two week Rapid Access Chest Pain Waits	100%	100%	100%	100%
Operations cancelled for non- clinical reasons		181	162	
1) Number of cancelled operations as a percentage of FFCEs	< = 0.8%	0.68%	0	0.67%
2) Percentage not given a binding date within 28 days	0%	0%	0	0%
48 Hour Access to GUM clinics	100%	100%	100%	100%

The external auditors have reviewed the returns submitted by the FT for three indicators. Two of the indicators selected were mandated by Monitor and the third indicator (falls) was selected by the Governing Council. The criteria for the three indicators are 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 date that the referral is received to first being seen by a consultant;
- The indicator only includes GP referrals for suspected cancer (ie 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 Trust; and
- 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.

MRSA

- An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review).
- Reports of MRSA cases include all MRSA positive blood cultures detected in the laboratories, whether clinically significant or not, whether treated or not.
- The indicator excludes specimens taken on the day of admission or on the day following the day of admission.
- Specimens from admitted patients where an admission date has not been recorded, or where it cannot be determined if the patient was admitted, are also attributed to the Trust.
- Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

Local Indicator: Hospital in-patient repeat falls

- For the purpose of the indicator, a fall is taken as an inpatient fall recorded as such by clinical staff on 'Sentinel', the FT's incident reporting system.
- A repeat fall is categorised as a second or subsequent inpatient fall recorded within the same admission.

ANNEX 1

Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees and Governing Council

Governing Council Comments – Received 10th May 2012

The Governing Council welcomed the opportunity to submit a comment on the draft 2011/12 Quality Account and other aspects of care delivered by the Trust. 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 Governing Council. The QA was discussed at the sub-group meeting and this collective response subsequently drafted and agreed following circulation to all governors.

The Governors appreciate that the document has been drafted within strict guidelines and also value the opportunities they have had throughout the year to contribute to identifying and agreeing key priorities for the 2012/13 Quality Account.

The Governors have also reflected on comments and discussions raised at their meetings throughout 2011/12 in order to provide a reflective view on the quality of the Trust's services over the past year, not just at this present moment, and would like to comment as follows:

- As one of our governors stated at our sub-group meeting, "on the general question as to whether the content of the report [the Quality Account] is consistent with the views and experience of the Governors, my answer is an unqualified yes." This statement was fully endorsed by everyone present.

- We believe that the Trust continues to provide and strives to continuously improve high quality, safe and efficient services for patients as evidenced to us by the Board reports shared with us regularly and good progress against the Trust's key priorities from the 2011/12 Quality Account and Business Plan. This is not something which goes unchallenged by the Governors and the information provided to us is regularly reviewed at our General and sub-group meetings as part of our role of holding the Board to account. In addition the Governors observe all public Board meetings, which enables us to see the Board's own challenge and response to these important issues.

  In terms of your request for comments specifically under the headings of safety, effectiveness and experience, we would advise:

  - <u>Patient Safety</u>:

    This is clearly an important issue for the Board of Directors and the Trust as a whole and we have been pleased to note the improvements aimed for and progressed through some of the key priorities identified in the 2011/12 Quality Account as well

as the other reports and information provided to us throughout the year. Examples include:

- the continuing reduction of inpatient falls (work on which is being carried forward into 2012/13)
- zero incidence of MRSA and the further reductions in the incidence of C.Difficile (nearly 50% reduction on 2010/11)
- the Trust's pro-active approach to encouraging reporting (eg incidents, medication errors, patients' complaints) and ensuring that all reports are scrutinised and any learning is swiftly acted upon
- closer scrutiny and challenge by the Board of the Trust's Hospital Standardised Mortality Ratio (HSMR), and further Governors' awareness of this important indicator following a useful sub-group briefing from the Medical Director and agreement to share copies of the Board reports.

With regard to infection prevention and control, we do appreciate that the Trust's monitoring and active approach is not limited solely to MRSA and C.Difficile, but also encompasses other infection risks, including Norovirus (which was also managed well within 2011/12) and the more recent monitoring of MSSA. We also appreciate the Trust's readiness to respond to further changes, such as the measurement of C.Difficile moving towards bed-day rates, etc.

Our and the Board's focus on patient safety was emphasised during the search for a new Chief Nurse in 2011, and Governors were very pleased to be invited to be part of the appointment process.

- Clinical Effectiveness:

The Trust's continuing drive towards improved efficiency and the delivery of high standards was again demonstrated in the reports provided to and scrutinised by the Governors throughout the year as well as the Quality Account. It was particularly encouraging to note the constant drive for effectiveness in all aspects of the Trust's work – from the front line services (eg further roll out of the productive ward programme and year end achievement of the "<4 hours" target for A&E despite huge demands on the service throughout the year) to the 'back room' services, eg the Trust's successful registration with the Carbon Reduction Commitment Energy Efficiency Scheme (CRC) and recognition as one of only four trusts in the country awarded 100% achievement, and full Investors in People accreditation achieved again in December 2011. This last point is a welcome reflection of the Trust's support for its staff, whose contribution to the hospital's services for patients is invaluable. Similarly the reduction in sickness absence and superb increase in staff appraisals and training is to be commended.

- Patient Experience:

The Quality Account, reports received and feedback we receive directly from members of the public have, again, been largely positive and reinforced our view of the Trust's drive to put patients first and to improve services for patients wherever possible. This was demonstrated at the beginning of the year, when the Trust "breached" the target for single sex accommodation (SSA) when, following careful discussions with the patient/their family, it was judged necessary on this one

occasion to ensure that the patient was on the right ward, getting the right care, at the right time. The Board affirmed its full support for this decision, nevertheless it did not detract from their commitment to privacy and dignity, as evidenced by a swift return to full SSA compliance, which was maintained for the rest of the year.

It is disappointing to note that the Trust did not achieve the 2011/12 CQUIN indicator for patient experience, which is linked to a national survey carried out with a relatively small number of patients and seeking their feedback retrospectively. Patient experience is clearly very important and we appreciated the assurance gained via the range of internal monitoring, carried out on site by the Matrons each month and through several freestanding units in public areas, enabling the Trust to gather feedback from a much higher number of patients before they leave the hospital. Additionally the Trust also continues to encourage patient feedback via complaints and compliments, and the review, learning and actions taken in response to every one of the letters or less formal comments received from patients. Collectively, this larger and more current data gives a more positive picture of patients' experiences at Barnsley hospital. The internal reports shared with Governors also identify where actions are needed and are implemented to ensure further improvements to patient services.

We were also able to hear first hand experience from patients when Governors were involved in the ad hoc internal "CQC" inspections that the Trust started in 2011/12 as part of its response plan to the external CQC inspection on nutrition and dignity. This allowed us to observe the Trust's quick and thorough response to the CQC's findings and also to speak to patients about their views of the hospital's services, the feedback from which was very positive. Several of us have continued to be involved in the internal PEAT inspections throughout the year too and, where time allows, used these to speak to patients: again the feedback was largely complimentary about the care provided to our patients and particularly about the staff. Governors' involvement in these two initiatives has given birth to our own programme of "Governor's visits" on the wards, which we will be progressing further in 2012/13.

Health & Adult Service Scrutiny Commission (Barnsley Metropolitan Borough Council) Comments –

The Health and Adult Services Scrutiny Commission responded on the 17th May 2012 to say that they were hoping to discuss the report on the 4th June 2012. The Trust responded to them saying that they would still like to receive a response but unfortunately the response provided would not be included in the published document which would be finalised by the end of May 2012

Barnsley Local Involvement Network (LINk) Comments –

The Barnsley LINk responded on the 14th May 2012 to say although the report had been distributed as part of the consultation exercise on the 4th April 2012, they had not received any comments from members of LINk, by the 9th May 2012 deadline.

NHS Barnsley Comments – Received 14th May 2012

NHS Barnsley welcomes the opportunity to comment on Barnsley Hospital NHS Foundation Trust's Quality Report 2011/2012.

As the Commissioner of services on behalf of the local population, we believe this Quality Report demonstrates the Trust's general commitment to quality Improvement and delivery of high quality services. To the best of our knowledge the information contained within the Quality Report, which is also provided to NHS Barnsley as part of the Contractual Agreement is accurate.

The Operating Framework for the NHS in England requires Quality to span three areas; Safety, Clinical Effectiveness and Patient Experience. The Quality Report provides an overview of these areas and overall demonstrates a fair reflection of the Trust's achievement against delivery of Quality against priorities in a changing NHS.

Delivering Health Care services in an organisation with a wide range of services requires strong commitment to continuously monitor and deliver Quality Care.

The Trust has made progress over the last 12 months in placing Quality at the heart of services it provides. NHS Barnsley as Commissioner welcomes the approach of collaborative working with us as Commissioners to deal with Performance and Quality Issues as they arise in the spirit of openness and transparency.

We are pleased to note the following achievements.

- Patient Safety:

  In terms of improving knowledge of an individual patient's nutritional status, whilst it is disappointing that the Trust did not reach its aspirational target in relation to the weighing of patients, we have noted the improvements that were achieved within the year as well as the number of initiatives there were also introduced to support this priority. It is particularly encouraging to see the Trust's commitment to continued improvement in 2012/13.

  The work that the Trust has undertaken which has shown a significant reduction in patients who have developed a hospital acquired pressure ulcers is welcomed.

  The Trust should be congratulated on the continued sustained performance in relation to preventing and controlling Hospital Acquired Infections, particularly in ensuring there were no reported MRSA Bacteraemia this year.

- Clinical Effectiveness:

  The inclusion of outcomes of Clinical Audit within the report is welcomed, which demonstrates the Trust's commitment to learning and taking action to improve the quality across its services.

- Patient Experience:

  It is noted that the Trust still has work to do in relation to listening and acting on patient experiences. We would look for an improvement during 2012/13, which we will be monitored through our Quality Assurance Process.

  In reviewing the Quality Report priorities, NHS Barnsley would ask that the Trust consider the following in relation to the following priority -

  - Priority 3 – Ready to Go – No Delays

    The Trust should consider the development of specific indicators to ensure the effectiveness of their planned workstreams in particular the timely prescribing and dispensing of medications to improve patient experience.

Author :- Vicky Peverelle - Head of Corporate Governance May 2012

ANNEX 2

2011/12 Statement of Directors' Responsibilities in Respect of the Quality Report

The Directors 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 annual Quality Reports (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*;
- 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 2011 to June 2012**;**
    - Papers relating to Quality reported to the Board over the period April 2011 to June 2012**;**
    - Feedback from the Commissioners 14th May 2012
    - Feedback from Governors 10th May 2012
    - Feedback from LINks 14th May 2012 – confirming that they had no comments
    - Feedback from Health & Adult Services Scrutiny Commission expected June
    - The Trust's complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in July 2011 taking into account the quarterly complaints reports from April - June 2011, July – September 2011; October – December 2011; January – March 2012.
    - The CQC national patient survey 24.04.12
    - The CQC national staff survey 19.03.12
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2012;
    - Care Quality Commission quality and risk profiles dated April 2012;
- 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

.....Date.....Chairman

.....Date.....Chief Executive

This is the survey that was used in 2011 to consult on the 2012/13 Quality Priorities.

APPENDIX 1

Quality Survey 2012-13

Barnsley Hospital NHS
NHS Foundation Trust

Quality of care and patient safety are part of the Trust's highest priorities. Our Quality priorities for 2011-12 are:

- To improve our knowledge of individual patient's Nutritional status; with the goal to ensure all eligible patients are weighed on admission.
- Reduce the incidence of hospital acquired pressure ulcers; with the goal of reducing the number of people who develop a newly acquired pressure ulcer following admission.
- Ready to go – no delays; with the goal of creating a seamless approach to discharge.

The Quality Account outlines the quality of service the Trust has to offer, our priorities for improvement and actions we intend to take to secure these improvements. Full report for 2011/12 can be found at http://www.barnsleyhospital.nhs.uk/annual-report/quality-report/

To continue to drive improvements and as part of this process, it is important to listen to our members, the Council of Governors, patients, staff, members of the public and other healthcare providers about the quality of services we provide.

After consultation with the Council of Governors, they felt it was right to keep the above priorities for the following year so that we can make further improvements on the quality we are delivering in these areas.

However, we do want your opinion, so we are asking:

Are there any other Quality improvements you would wish the Trust to consider?

You can email us at: quality.barnsley@nhs.net, let us know through the feedback form on our website – www.barnsleyhospital.nhs.uk, or write to us.

Address for correspondence:

Glossary of Terms

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
CRT	Trade name of company contracted for patient experience software
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
MAU	Medical Assessment Unit
MEWS	Modified Early Warning Score
MINAP	Myocardial Ischaemia 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
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
SUS	Secondary Uses Service
TED	Thrombo Embolus Deterrent
VSGBI	Vascular Society of Great Britain & Ireland
VTE	Venous Thrombo-Embolism

Our approach to governance

Corporate governance

Our governance structure

The Trust is managed by the Board of Directors, which is accountable to the Governing Council. 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 Governing Council 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 137 highlights the number of Governing Council general and sub-group meetings attended by members of the Board, to enable more and more opportunities for listening to governors, sharing of information and responding to challenges. In addition, we welcome our governors among the public attendants at every public meeting of the Board of Directors. This is in addition to the annual invitation to join a private meeting of the Board.

But these are not the only routes of engagement: the Board fosters an "open door" approach with governors and is pleased to respond to their questions and requests for information on any subject. Governors' views and those they feedback from the members they represent, are welcomed - about the hospital's services, patient experience and plans for the future, etc. Several governors have also taken up seats on behalf of the wider Governing Council on a number of committees and forums within the Trust (eg Patients Experience Group, Equality & Diversity Steering Group, Learning Disabilities working group) and also take part in internal inspections (see page 127), helping them to have a growing understanding of the Trust's work – and giving the Board the benefit of questions about "what, why – and why not?" through the eyes of governors and members. Just some examples of where the hospital has benefitted from their insight includes their work on the 'noise at night' campaign, equality of access and in the membership engagement activities.

Governance code

The Trust complied fully with the provisions of the Code throughout 2011/12. It applies 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 Governing Council.

We have an integrated approach to governance. You can read more about our committee structure on pages 139 to 144.

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 58 to 119.

The Governing Council

The Governing Council is made up of 20 public governors elected by members of the Trust, and six staff governors elected by hospital staff. 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.

The Governing Council has dealt with a range of issues charged to it under legislation (eg appointment of the Chairman, Non Executive Directors and auditors) and supports the Trust in its strategic development (business plan, etc). 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. The Governing Council lost one partner organisation towards the end of 2011, when Barnsley Arena ceased operating. Governors were also conscious of the huge changes expected within the NHS as a result of the Health & Social Care Act. As the Act was not passed until the end of March 2012, the annual review of the composition of the Governing Council was deferred. With the Act now established, governors will be reviewing the options for partner organisations going forward, to ensure the Trust continues to benefit from the knowledge, shared interests and support from partners across the region.

It is timely to record our 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.

In 2011/12, the Governing Council 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 ends 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 2012 (first term).
Eric Livesey. First appointed 1 January 2009. Term ended 31 December 2011 (first 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

Ann Frost. First appointed 1 September 2010. Resigned March 2012 for personal reasons (health and/or family).
Sharon Hodgson. First appointed 1 January 2005. Term ends 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. Term ends 31 December 2014 (first term).
Michael Dunlavey. First appointed 1 January 2010. Terms ends 31 December 2012 (first term).
Glyn Etherington. First appointed 1 January 2008. Term ends 31 December 2013 (second term).
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).

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

Denis Gent. First appointed 1 January 2005. Term ends 31 December 2013 (third term).
Wayne Kerr. First appointed 1 January 2005. Terms ends 31 December 2012 (third term).
Trevor Smith. First appointed 1 September 2010. Term ends 31 December 2012 (first term).

Constituency O
Covering out of area/England & Wales

Bill Joice. First Appointed 1 January 2005. Resigned December 2011 for personal reasons (health and/or family)

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 2012 (first term).
Jill Marshall. Non clinical support. First appointed 1 January 2007. Term ends 31 December 2012. (second 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).

Joyce Rhodes. Volunteers. First appointed 1 January 2009. Term ends 31 December 2014 (second term).

Partner governors
Pauline Acklam, MBE. NHS Barnsley (from October 2006).
Professor Nigel Bax. University of Sheffield (from January 2005).
David Brannan. Voluntary Action Barnsley (from January 2005).
Councillor Jenny Platts. Barnsley Metropolitan Borough Council (from October 2009).
Jim Holliday. Barnsley Arena (from March 2010 until 30 April 2011).
Steve Kirk. Barnsley Arena (from July 2011 to September 2011)
Kay Philips. Sheffield Hallam University (from June 2007).
Martin Jackson. Joint Trade Unions Committee (from January 2008).
Harshad Patel. Barnsley Black & Ethnic Minority Initiative (BBEMI) (from September 2010 to October 2011)
Alex Whitely. Barnsley College (from September 2010).

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 2011 (for appointment from 1st January 2012), eight public and three staff governor seats were put forward for election; the elections were supported by the Electoral Reform Services, as independent scrutineers.

There are currently vacancies for three public governors, which will be carried forward to the next elections (commencing September 2012).

While appointed by nomination rather than election, partner governors are subject to reappointment at three year intervals.

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.

Governing Council and Board member attendance at Governing Council is noted in the table on pages 135-137.

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 Governing Council considers reasonable
b) Directors' attendance at the Annual General Meeting is recorded separately in the table of Board Meetings and Attendance.

Governing Council – meetings

For the joint meeting between the Governing Council and Board of Directors in November 2011, 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 137). 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 Governing Council. It comprises the Chairman, three public governors, two partner governors and a staff governor (see above) to consider and make recommendations to the Governing Council for the appointment and terms of service of non-executive directors, including the Trust's Chairman. The Lead Governor (as elected by the Governing Council) holds one of the seats for public governors.

Membership in 2011/12 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 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.

The Committee led the appointment of two new non-executive directors in 2011/12 (for terms starting 1st January 2012). Both appointments were progressed by open competition. With much care and consultation, it also led the reappointment process for the Chairman, Stephen Wragg, whose appointment for a second term of office was unanimously approved by the Governing Council in April 2011.

The Committee also started the process for consideration of appointments in 2012/13, in readiness for the terms of office of three Non Executive Directors due to expire in 2012 (see pages 131-133).

During the year, the Committee, working closely with the Senior Independent Director, assisted with the further development and completion of the comprehensive appraisal process for the Chairman. This includes inviting feedback from all members of the Board of Directors and Governing Council, 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 Governing Council. The introduction of the bi-annual appraisals (at mid year and year end) for the Chair and Non Executive Directors was completed in 2011/12, to provide a more supportive approach to the process.

Sub-groups
The sub-groups are informal groups of the Governing Council (rather than formal committees) and are open to all governors. They are often frequently attended by executive and non-executive directors, managers, staff and external speakers, to provide briefings on key issues and to respond to governors' questions. 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 Board to account directly.

The structure of the sub-groups enables the Governing Council to develop a more proactive approach to its role. Governors continue to hold the Board to account and challenge them against delivery of the identified objectives in the Trust's business plan. Additionally in 2012/13 the governors:

- Supported the Trust's development of its annual plan for 2012-15
- Hosted a Governors' development event at Barnsley in October 2011; this was attended by representatives from 15 trusts across the region
- Successfully held three membership engagement events within the community. Two of these were held with partners – Barnsley College and the women's forum of the Barnsley Black and Ethnic Minority Initiative (BBEMI); one was a "stand alone" event held in Cudworth.
- Continued their role as members in a number of Trust-wide committees and groups, including – but not limited to - the Patient Experience Group, Learning Disabilities group, Clinical Excellence Awards panel and the Equality & Diversity Committee.

Further progress of each of the sub-groups in 2011/12 is highlighted below:

Patients & Access
This sub-group has continued to focus on a number of key issues that affect our patients when they come to hospital or try to access our services: from the food provided to them on the wards and in the restaurant, to the comments and complaints registered through a range of routes. Its Chair regularly attends and provides feedback from the Trust's Patient Experience Group; the group reviews the quarterly reports from the matrons alongside the complaints report. It also continues to monitor and challenge the Trust's progress on a number of issues that affect patients' stay in hospital, including noise at night and discharge arrangements. In 2011/12 it also gave particular attention to a number of issues, including seeking more assurance about equality of access for people with any form of disability, making enquiries for members about specific services and facilities (eg gall bladder surgery, pain clinic, car parking, lost property). In order to be able to represent members' view on the hospital's services, this group has also led work to launch a programme of 'governors' visits' to wards and clinical areas, enabling them to speak to patients on site and invite their views and comments on the care and services provided to them. When the CQC inspection findings were released, this group also provided further scrutiny on the findings and the Trust's response. Governors from the group - and the wider Governing Council – took part in internal "spot" inspections, to help ensure that improvements and continuing good practice around nutrition were being maintained .

Staff & Environment
This group continues to have a challenging agenda, addressing issues that matter to patients, public and staff such as single sex facilities, car parking and cleanliness. With its strong links with the estates, facilities and HR teams, the group continues to keep a keen focus on developments around sustainability (it was particularly pleased to note the Trust's CRC accreditation, as reported earlier), staff issues (including improvements in communications, mandatory training, appraisals and management of sickness absence, and the Trust's response to staff surveys, etc), the estate (always a topical subject, particular so with plans for development around facilities such as the urgent care centre), and cleanliness/infection control throughout the hospital. The group also leads on the governors' involvement in the internal and annual PEAT (Patient Environment and Action Team) inspections.

Strategy & Performance
This sub-group is mandated by the Governing Council to lead on a number of mechanisms to help the governors to deliver some of their core responsibilities:

- around holding the Board to account – 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, which it was able to do this year through a series of briefings from both the External and the Internal Auditors; by considering proposals for additional work to be undertaken by the external auditors and submitting a recommendation to the wider Governing Council, and through the appointment of an audit liaison governor, who acts as the first point of contact between the Trust's Audit Committee Chair and the Governors
- ensuring governors have the opportunity to provide input to the Trust's future planning, often by receiving and commenting on briefings and progress reports at its meetings
- 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.

As mentioned earlier in this report, the Governing Council also led two important projects in 2011/12: a pilot series of membership engagement events and the regional governors event hosted at Barnsley. Whilst these were initiated through the Strategy & Performance group, the detailed work for each event was driven through governors' "task and finish" groups, with representation from each sub-group.

Additionally the sub-group Chairs, together with the Lead Governor and the Associate Director of Communications & Marketing comprise the editorial board for the members' newsletter. This gives the governors more opportunity to really contribute to the newsletter and engage with the members they represent.

Funding & Finance Committee
This is a small group, chaired by the Lead Governor. Its terms of reference were revised in 2011 to include the Lead Governor plus 3 other governors and the Chairman as its membership. The remit of this group is to control a small dedicated budget and consider funding requests to support the work of the governors. In 2011/12 the Committee gave its full support to the regional governors' event and the membership engagement events and this approach was fully endorsed by the wider Governing Council.

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 Board to account. 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. The groundwork was laid in 2011/12 to build on the Board's successes and develop new ways of working in 2012/13, to promote even more strategic leadership, more challenge amongst its members and a more formal evaluation mechanism.

The following were the executive and non-executive directors for the year 2011/12:

Chairman	Stephen Wragg
Chief Executive	Paul O'Connor

Medical Director	Dr Jugnu Mahajan
Director of Finance and Information	Dawn Hanwell
Chief Nurse	Juliette Greenwood (until 30th September 2011) Heather Mcnair (from 5th December 2011)
Chief Operating Officer	David Peverelle
Non-executive directors	Anne Arnold Linda Christon Francis Patton (Deputy Chairman) Paul Spinks (until 31 December 2011) Sarah Wildon (until 31 December 2011) Stephen Houghton CBE (from 1 January 2012) Suzy Brain England OBE (from 1 January 2012)

Non-executive director appointments
Non-executive directors are appointed for a term of up to three years by the Governing Council, based on a recommendation from the Nominations Committee.

The Nominations Committee is a formal committee of the Governing Council and comprises the Chairman, three public governors, two partner governors and a staff governor to consider and make recommendations to the Governing Council for the appointment and terms of service of non executive directors, including the Trust's Chairman. See pages124 and 125 for further details.

The terms of office of two non-executive directors expired in 2011/12: Mr Paul Spinks, on 31 December 2011 and Ms Sarah Wildon on 31 December 2011. Following an appointment process through open competition, Mr Stephen Houghton CBE and Ms Suzy Brain England OBE were appointed, starting their roles on 1 January 2012.

The Chairman's first term of office also expired at the end of December 2011. At the recommendation of the Nominations Committee, the Governing Council gave its full support to Stephen Wragg being reappointed for a second three year term, from 1st January 2012.

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.

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.

Dr Jugnu Mahajan, Medical Director
Dr Jugnu Mahajan became the Trust's new 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.

Juliette Greenwood, Chief Nurse (until 30th September 2011)
Juliette joined the Trust in January 2005 from Great Ormond Street Hospital for Children NHS Trust, London, where she was the deputy chief nurse. Her career in the NHS started in 1980 and she has held a variety of roles in nursing and management. Her specific areas of interest are patient safety, leadership development, improving patient experiences and professional standards.

Heather Mcnair, Chief Nurse (from 5th December 2011)
Heather joined the hospital from Calderdale & 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.

She 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.

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 in 2008 having been deputy

director of finance at Leeds Partnerships NHS FT, a mental health/learning disability trust, where she was part of a team that successfully achieved Foundation Trust status.

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.

Non-executive directors

Stephen Wragg, Chairman
Stephen was 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.

Stephen's current term of office runs to 31 December 2014.

Anne Arnold
Anne joined the Trust in December 2004. She has extensive experience working with the NHS as a senior manager and as a management consultant. She now works primarily in education and is a carer. Anne is an MBA graduate and qualified accountant. She is Chair of the Trust's Audit Committee, a member of the Finance Committee and was the Senior Independent Director until January 2012, at which point she opted to pass on this role in the run up to the end of her term of office. Anne was reappointed as a Non Executive Director in 2009 and her current term of office runs until 31 October 2012, although she will leave in August 2012 to pursue a new role in education.

Suzy Brain England
Ms 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, 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 Board in January 2010, for a three year term of office. Linda 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.

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. Cllr Houghton is also chair of the Barnsley Local Strategic Partnership, 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.

Francis was appointed on 1 January 2008 until 31 December 2009 and was subsequently reappointed. Francis' current term is until December 2012. He is the Deputy Chairman and, since January 2012, senior independent director (SID). He also chairs the Trust's Non Clinical Governance & Risk Committee.

Paul Spinks
Paul joined the Trust in January 2007 and chaired the Trust's 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 Reporting Panel at the ICAEW and the Public Audit Forum Working Group on Whole of Government Accounts. His appointment was until 31 December 2011**.**

Sarah Wildon
Sarah joined the Trust in August 2006. Sarah is a public relations consultant with more than 30 years public and private sector practice. Her public sector experience includes working directly to Ministers, policy development, governance and marketing.

She runs her own public relations company, based in Huddersfield, and is a member of the Chartered Institute of Public Relations. Sarah is also a Trustee of the Yorkshire Building Society Charitable Foundation and has been an Advisor to the Board of the Health Informatics Service (THIS) since July 2009.

Sarah served as Chair of the Clinical Governance Committee. Her appointment was until 31 December 2011**.**

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 2011/12 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 Governing Council 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	12	10	6	6			1	0			7	6
Brain Engla	Suzy	Non Executive Director	3	2	1	1	1	1					1	0
Christon	Linda	Non Executive Director	12	12	6	6	7	7			6	6	6	5
Houghton	Stephen	Non Executive Director	3	3							1	0	1	1
Patton	Francis	Non Executive Director	12	12							7	7	7	4
Spinks	Paul	Non Executive Director	9	9	4	3			3	3			6	5
Wildon	Sarah	Non Executive Director	9	7			6	6					6	6
Wragg	Stephen	Chairman	12	12					4	4			7	7
Greenwood	Juliette	Chief Nurse	8	8			6	4						
Hanwell	Dawn	Director of Finance & Information	12	11	6	6			4	4	7	6		
Mahajan	Jugnu	Medical Director	12	10			7	5	4	1				
Mcnair	Heather	Chief Nurse	4	4			1	1						
O'Connor	Paul	Chief Executive	12	11					4	3			6	6
Peverelle	David	Chief Operating Officer	12	12					4	3	7	7		

Shading denotes Committee Chair.

Ms Wildon was Chair of CGC until 31st December 2011; Mrs Christon was Chair thereafter.

Mr Spinks was Chair of the Finance Committee until 31st December 2011; Mr Wragg was Chair thereafter

CEO attendance by invitation

Governing Council meetings

Governors (& 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 = 6	Staff & Environment Total = 6	Strategy & Performance Total = 6	Total eligible	Attended
Public Governors						**Public Constituency**					Attended	Attended	Attended		
Keith	Hinchliffe	01.09.2010	31.12.2012	first		A: Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham	6	4		✓	1	1	4		
Bruce	Leabeater	01.01.2008	31.12.2013	second			6	4	✓	✓	4	1	3	9	9
Carol	Robb	01.01.2006	31.12.2014	third			6	3	✓		5	3			
Joseph	Unsworth (Lead Governor)	01.01.2005	31.12.2013	third			6	6	✓	✓	5	6	5	9	9
Tony	Alcock	01.01.2011	31.12.2013	first		B: Darton East, Darton West and Old Town	6	5	✓	✓	4	5	1		
Pauline	Buttling	01.01.2010	31.12.2012	first			6	4	✓	✓			5		
Eric	Livesey	01.01.2009	31.12.2011	first			5	2							
Margaret	Richardson	01.01.2012	31.12.2014	first			1	1	n/a	n/a	2	1	2		
Ann	Frost	01.09.2010	31.03.2012	first	1	C: Stairfoot, Central, Kingstone and Worsbrough	5	2	✓	✓	4				
Sharon	Hodgson	01.01.2005	31.12.2012	third			6	5							
Bob	Ramsay	01.01.2005	31.12.2014	fourth			6	5			6	6	4	9	7
Derek	Carpenter	01.01.2012	31.12.2014	first		D: St Helens, North East, Cudworth, Monk Bretton and Royston	1	1	n/a	n/a					
Michael	Dunlavey	01.01.2010	31.12.2012	first			6	1							
Glyn	Etherington	01.01.2008	31.12.2013	second			6	4		✓	6				
Dillon	Sykes	01.01.2012	31.12.2014	first			1	1	n/a	n/a	1				
David	Thomas	01.01.2005	31.12.2014	fourth			6	4				5	4		
Denis	Gent	01.01.2005	31.12.2013	third		E: Darfield, Dearne North, Dearne South and Wombwell	6	4	✓		1		2		
Wayne	Kerr	01.01.2005	31.12.2012	third			6	4		✓					
Trevor	Smith	01.09.2010	31.12.2012	first			6	3	✓	✓					
Bill	Joice	01.01.2005	31.12.2011	third	1	O: Out of area/England & Wales	5	2	✓				1		
							Chairs denoted by shading								

Name		Term of office				Constituency	General Meetings		Annual General Meeting	Joint meeting with Board	Sub Groups			Nominations Committee	
		1st appointed	Expiry date	Term	Note		Total eligible	Attended	Attended	Attended	Patients & Access Total = 6 Attended	Staff & Environment Total = 6 Attended	Strategy & Performance Total = 6 Attended	Total eligible	Attended
Staff Governors						**Staff Constituency**									
Mr Ray	Raychaudhuri	01.09.2010	31.12.2012	first		Medical & Dental	6	6		✓	3			9	5
Jill	Marshall	01.01.2007	21.12.2012	second		Non Clinical Support	6	6	✓			4			
Viv	Mills	01.01.2005	31.12.2014	fourth		Clinical Support	6	4	✓	✓		2	3		
Debby	Horbury	01.01.2008	31.12.2013	second		Nursing & Midwifery	6	4			2	3			
Gwyn	Morritt	01.01.2012	31.12.2014	first			1	1	n/a	n/a		1	1		
Ann	O'Brien	01.01.2009	31.12.2011	first		Nursing & Midwifery	5	1							
Joyce	Rhodes	01.01.2009	31.12.2014	second		Volunteers	6	3	✓	✓	3	3	4		
Partner Governors						**Partner Organisation**									
Pauline	Acklam, MBE	October 2006				NHS Barnsley	6	4	✓	✓					
Prof Nigel	Bax	Jan 2005				University of Sheffield	6	1	✓	✓			6		
David	Brannan	Jan 2005				Voluntary Action Barnsley	6	5	✓	✓	4	5		9	8
Cllr Jenny	Platts	Oct 2009				Barnsley MBC	6	5		✓					
Jim	Holliday	Mar 2010	March 2011		2	Barnsley Arena	1	0	n/a	n/a					
Steve	Kirk	June 2011	Sept 2011		2	Barnsley Arena	1	1		n/a					
Martin	Jackson	Jan 2008				Joint Trade Unions Committee	6	3	✓	✓		2			
Harshad	Patel	Sept 2010	Oct 2011		3	Barnsley Black & Ethnic Minority Iniative (BBEMI)	3	2	✓	n/a			1		
Kay	Philips	June 2007				Hallam Sheffield University	6	5						9	7
Alex	Whitely	Sept 2010				Barnsley College	6	1		✓					
Plus															
Wragg	Stephen	01.12.2009	31.12.2014	second	4	Chairman	6	6	✓	✓	5	5	6	7	7

Chairs denoted by shading

Name				General Meetings		Annual General Meeting	Joint meeting with Board	Sub Groups			Nominations Committee	
								Patients & Access	Staff & Environment	Strategy & Performance		
				Total eligible	*Attended*	*Attended*	*Attended*	*Total = 6*	*Total = 6*	*Total = 6*	*Total eligible*	*Attended*
Board and Management Team attendance:								*Attended*	*Attended*	*Attended*		
Anne	Arnold		Non Executive Director & Senior Independent Director (to January 2012)			✓	Recorded within Board meeting attendance data			1	2 (as SID)	2
Hilary	Brearley		Director of Human Resources & Organisation Development		5	✓			2		9 *	8
Suzy	Brain England OBE		Non Executive Director (from January 2012)		2	n/a						
Linda	Christon		Non Executive Director			✓			1			
Juliette	Greenwood		Chief Nurse (to September 2011)			✓						
Dawn	Hanwell		Director of Finance & Information		2	✓			1	1		
Stephen	Houghton CBE		Non Executive Director (from January 2012)			n/a						
Sharon	Linter		Director of Quality, Standards & Governance		3			1		1		
Jugnu (Dr)	Mahajan		Medical Director		1					1		
Heather	Mcnair		Chief Nurse (from December 2011)		2	n/a						
Paul	O'Connor		Chief Executive		5	✓					2 **	2
Francis	Patton		Non Executive Director			✓		1		1		
David	Peverelle		Chief Operating Officer		1	✓			1			
Paul	Spinks		Non Executive Director (to December 2011)		1	✓						
Helen	Stevens		Associate Director of Communications & Marketing			✓						
Sarah	Wildon		Non Executive Director (to December 2011)		2	✓						

** professional support*
*** by invitation*

Notes

1 Resigned due to personal reasons (health and/or family commitments)
2 Mr Holliday left Barnsley Arena in 2011 and Mr Kirk was appointed in his stead as partner governor until the organisation was dissolved at the end of September 2011
3 Mr Patel resigned due to health and/or family commitments; due to internal reviews at BBEMI no further representative was, or has been appointed, at this time
4 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
5 Whilst appointed by nomination rather than election, Partner Governors are subject to re-appointment/nomination at 3 year intervals
6 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 Governing Council) 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
7 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.
8 There were two further sub-groups of the Governing Council: the Funding & Finance Committee (met once in 2011/12) and a Task & Finish group focussed on membership development. The latter is a sub-committee of the Strategy & Performance Sub-group and not shown separately. Members included Mrs Pauline Buttling, Mr David Brannan (group Chair), Mr Glyn Etherington, Mrs Joyce Rhodes, Mr Joe Unsworth and Mr Stephen Wragg (Trust Chair). The group met several times in 2011/12 to develop and lead the success pilot series of community-based membership engagement events.

Integrated governance – committees of the Board

Good governance is about making sure our Board 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.

What achievements have there been in 2011/12

- 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 – now providing a robust infrastructure to support and deliver effective integrated governance
- Developed strengthened and standardised the divisional governance arrangements
- Fully embedded the systematic monthly review of Trust wide risk registers, improving content and consistency of the trusts' electronic risk repository
- Introduced a number of different incident reports to ensure that front line staff have detailed incident information, can pinpoint trends and improve trust wide learning.

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 2011/12 comprised the following non-executive directors:

- Miss Anne Arnold, (*Committee Chair*)
- Mrs Linda Christon
- Mr Paul Spinks (to December 2011)
- Mrs Suzy Brain England OBE (from January 2012)

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 & Information.

The Trust's internal Audit function is provided by Assure (formerly known as South Yorkshire and North Derbyshire Audit Service)

The Trust's External Auditors are Pricewaterhouse Coopers and were appointed by the governing Council from 1 April 2007 and then re-appointed for the five-year period starting 1 April 2011. The audit fee for the statutory audit was £41, 500 (2011/12) excluding VAT. This was the fee for an audit in accordance with the Audit code issued by Monitor in 2011.

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 Governing Council 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

It is chaired by a non-executive director with its membership drawn from both the executive and non-executive directors.

In 2011/12 membership comprised:

- Miss Anne Arnold, non-executive director (*joined the Committee in January 2012*)
- Ms Dawn Hanwell, Director of Finance & Information

- Dr Jugnu Mahajan, Medical Director
- Mr David Peverelle, Chief Operating Officer
- Mr Paul Spinks, non-executive director (*Committee Chair*, to December 2011
- Mr Paul O'Connor, Chief Executive
- Mr Stephen Wragg, Chairman (*and Committee Chair from January 2012*)

Governance Committees

Both the Clinical Governance Committee and the Non-clinical Governance & Risk Committee are chaired by non-executive directors and include executive and non-executive directors amongst their members, as well as key managers from across the Trust to ensure that they have face-to-face liaison with the pertinent staff 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*)
- Juliette Greenwood, Chief Nurse (to September 2011)
- Mrs Sharon Linter, Director of Quality & Standards (to December 2011)
- Dr Jugnu Mahajan, Medical Director
- Ms Heather Mcnair, Chief Nurse (from December 2011)
- Ms Sarah Wildon, non-executive director (*Committee Chair, to December 2011*)

Membership of this Committee is extended to include staff from across the Trust, giving it direct input from a range of key disciplines. Further members include:

- Divisional Directors
- Chief Pharmacist
- Clinical Effectiveness representative
- Director of Education/College Tutor
- Risk representative
- Senior clinical representatives from each of the three core service divisions
- Head of Corporate Governance

Non Clinical Governance & Risk Committee

Members:

- Mrs Linda Christon, non-executive director (left Committee at end of December 2011)
- Ms Dawn Hanwell, Director of Finance & Information
- Mr Stephen Houghton CBE, non-executive director (from January 2012)
- Mr Francis Patton, non-executive director (Committee Chair)
- Mr David Peverelle, Chief Operating Officer

This Committee also has a broader membership to include a diverse range of staff from across the Trust, who bring a wealth of professional knowledge and experience to the meetings. Further members include:

- Chief Information Officer
- Director of Human Resources & Organisational Development
- Associate Director of Estates & Facilities
- Risk representative
- Head of Corporate Governance
- Representatives from each of the three service divisions

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 seven times in 2011/12. 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
- Mrs Suzy Brain England OBE, non-executive director (from January 2012)
- Mrs Linda Christon, non-executive director

- Mr Francis Patton, non-executive director
- Mr Stephen Houghton CBE, non-executive director (from January 2012)
- Mr Paul Spinks, non-executive director (to December 2011)
- Ms Sarah Wildon, non-executive director (to December 2011)

Attendances are shown on the table of Board and committee meetings on page 134.

During 2011/12 the Committee was responsible for the appointment of a new Chief Nurse, who commenced in December 2011. The appointment was subject to open competition, supported by staff, governor and partner organisation participation in the stakeholder focus groups. The interview panel also included an inde[3]pendent party, Ms Libby McManus, Chief Nurse at York Hospital, whose support was greatly appreciated.

The Committee is supported by the Chief Executive* and Director of Human Resources & 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 has no policy statement on the remuneration of senior managers** but its standing financial instructions state that the committee will make such recommendations to the Board on the remuneration and terms of service of ExecutiveDirectors (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 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.

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.

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* except where discussions relate to the appointment or appraisal of the Chief Executive

** Senior managers are defined as the Executive and Non Executive Directors of the Trust.

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 Governing Council. 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

Name and Title	Year ended 31 March 2012			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	120-125	20-25	0	120-125	20-25	0
Mrs J Greenwood, Chief Nurse [1]	45-50	0	0	80-85	0	0
Mrs H Mcnair, Chief Nurse [2]	30-35	0	0	0	0	0
Mr P O' Connor, [7] Chief Executive	145-150	0	0	10-15	0	0
Mr D Peverelle, Chief Operating Officer	90-95	0	0	90-95	0	0
Ms D Hanwell, Director of Finance & Information	90-95	0	0	90-95	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	10-15	0	0	10-15	0	0
Ms S Wildon, Non Executive Director [3]	5-10	0	0	10-15	0	0
Mr P Spinks, Non Executive Director [4]	5-10	0	0	10-15	0	0
Mrs S Brain England OBE, Non Executive Director [5]	0-5	0	0	0	0	0
Mr S Houghton CBE, Non Executive Director [6]	0-5	0	0	0	0	0
Mr F Patton, Non Executive Director	10-15	0	0	10-15	0	0

[1] Mrs J Greenwood resigned from post of Chief Nurse wef 30th September 2011
[2] Ms H Mcnair was appointed as Chief Nurse wef from 5th December 2012
[3] Ms S Wildon left the Trust on 31st December 2011.
[4] Mr P Spinks left the Trust on 31st December 2011.
[5] Mrs S Brain England OBE commenced as a Non Executive Director on 1st January 2012
[6] Mr S Houghton CBE commenced as a Non Executive Director on 1st January 2012
[7] 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 2011/12 and any future remuneration or fees that might become payable would be for the Trust's receipt, not Mr O'Connor.

Notes to the remuneration report:

Band of Highest Paid Director's total Remuneration £' 000s	145-150
Median Total £' s	21,798
Ratio	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 2011/12 was £145,000 to £150,000. This was 6.8 times the median remuneration of the workforce which was £21,798.

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 ISS, 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 2012.

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 2011/12: 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 2012 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 2012 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 1 April 2011 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mr P O' Connor, Chief Executive	7.5-10.0	155.0-160.0	782	654	108	0
Mr D Peverelle, Chief Operating Officer	0.0-2.5	155.0-160.0	851	775	52	0
Ms D Hanwell, Director of Finance & Information	2.5-5.0	110.0-115.0	485	400	72	0
Mrs J Greenwood, Chief Nurse	5.0-7.5	145.0-150.0	645	505	61	0
Dr J Mahajan, Medical Director	0.0-2.5	105.0-110.0	517	449	54	0
Mrs H Mcnair, Chief Nurse	2.5-5.0	115.0-120.0	490	0	34	0

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:

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 & Wales, who elect the governors on the Governing Council 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 2012 was 12,546 members - made up of 9,340 public and 3,206 staff and volunteers.

Membership at the end of the year breaks down as:

Public
Constituency A – 2087
Constituency B – 1492
Constituency C – 1748
Constituency D – 2109
Constituency E – 1293
Constituency O – 611

Staff
Medical & Dental – 235
Nursing & Midwifery – 1548
Clinical Support – 528
Non Clinical – 685
Volunteers – 210

The governors and the Trust have continued 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 engagement events held in 2011/12, with the BBEMI women's focus group (to reach women and children from minority backgrounds), with Barnsley College (to promote liaison with young people), and at Darfield Road WMC, based in an area of lower representation.

In 2011/12, public members received quarterly editions of the members' newsletter, Barnsley Hospital News. As mentioned earlier, governors now 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 communications.

Membership is spread across the constituencies, largely mirroring the overall constituency populations. Membership levels had dropped slightly in 2010/11 but the increased focus on membership engagement (by the governors and the membership office) throughout 2011/12 has maintained membership as well as promoting greater engagement in the community. Monitoring of membership activity takes place every quarter .

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 2011/12 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
The main assets of the Trust in value terms are the Land and Buildings and these have been revalued at 31/03/2012 as the building indices and location indices between 31/3/2011 and 31/3/2012 have changed, as advised by the District Valuer (see page 54 for further details). The change in value has been reflected in the accounts (see section 12 in the accounts).

Political or charitable donations
There have been no political or charitable donations in the year.

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 2011/12 were green for governance (including mandatory services) and 3 for finance. This is an improvement on the annual plan for the year (amber/red for governance), which was impacted by the CQC report at the beginning of 2011/12 but quickly returned to green in the second quarter. 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 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Amber-Green	Green

Q3 "dip" due to breaches in A&E target (winter pressures) and 62 day wait for first treatment from consultant screening service referral: all cancers (two patients). Robust action plans instigated to ensure swift return to compliance including, for the latter, liaison with regional network to enable earlier referral to the Trust.

	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 mentioned earlier. 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.

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 November 2011 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

Within the last year Occupational Health has lost and gained contracts; NHS Barnsley gave notice and new contracts have been signed with Barnsley Metropolitan Council and local schools.

There was an average uptake of influenza vaccinations (1,690 given overall – 759 to BHNFT staff) and following a review a different approach will be taken this year. Support will be requested from senior managers to try to increase uptake.

Ongoing Projects:

- ESR and Cohort (Occupational Health computer system) to interface.
- National Audit for Depression.
- Aim to register for SEQOHs (Occupational Health Service Standards for Accreditation) to gain registration.

- Participate in MoHaWK, the national clinical registry of Occupational Health – audits, benchmarking – Yorkshire & the Humber NHS Health at Work

The Occupational Health Manager post now incorporates the Trust Stress Champion role.

The Health and Wellbeing Team continue to provide diverse therapies for the 249 referrals and 1125 follow up appointments (increase of 284 from last year). The Senior Health and Wellbeing Practitioner is involved in the Healthy Workplace Group. Audits are carried out of all aspect of the service. They continue to offer stress management training.

The Manual Handling Team continue to deliver training for staff who have no direct patient contact (1570 staff) and those with direct patient contact (1584 staff). 706 staff received training via e-learning.

The Occupational Health Service will continue to support staff in improving their health and wellbeing at work.

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, 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 (LCFS) carrying out a range of activities that are overseen by the Audit Committee. A fraud risk assessment is carried out annually and proactive fraud exercises are undertaken based on this risk assessment. Where fraud is identified or suspected an investigation is carried out in accordance with the Trust's Fraud Policy and Response Plan.

Compliance with Secretary of State's directions on fraud and corruption is evaluated on an annual basis by NHS Protect who this year have improved the assessed rating from Level 2 to Level 3. The Trust is deemed to be performing well.

This year, proactive counter fraud work has focussed on preventative action to ensure the Trust does not fall victim to the current and real threat of organised high value NHS fraud. In the last year the LCFS has formally investigated four cases of alleged fraud at the hospital. The LCFS also changed its name to NHS Assure.

The Annual Counter Fraud Report concludes that staff, management and executives have continued to strongly support counter fraud work across the whole organisation in what has been a positive year for counter fraud work at the Trust. The LCFS and Counter Fraud Team look forward to the future.

The Trust is also aware of and has acted on the Bribery Act 2010. Registers on hospitality are held centrally, with information available on request; work is progressing to enable this information to be provided on our website in 2012 reflecting our ethos of transparency and openness.

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: 33837
Number of Bills paid within 30 days: 32288
Percentage of bills paid within 30 days: 95.42%

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
In March 2012 the Trust was informed by a healthcare contractor that they had inadvertently collected items of personal patient information along with items of product performance data they routinely downloaded from a diagnostic scanner they had provided to the Trust. The Trust was one of a number of NHS organisations where this process had inadvertently taken place and therefore the incident investigation and management was undertaken by the Department of Health (DH).

The incident has been notified to the Information Commissioners Office (ICO) and the joint view of the DH and ICO is that the risk of harm to patients is negligible. The data is held in a complex format and is not readily accessible and the contractor has given assurance, independently verified, that the data remains secure, has not been subject to loss, hacking, misuse or theft and will be destroyed on the completion of the investigation.

Signed .....
Chief Executive

Date: .....

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.

Signed
Chief Executive

Date ……

Annual Governance Statement (AGS)

By Paul O'Connor, Chief Executive

ANNUAL GOVERNANCE STATEMENT (AGS) 2011/12

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 ongoing 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 2012 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's Governance infrastructure was comprehensively reviewed in 2009 and the revised arrangements were effected in January 2010. These structures were strengthened and supported through the appointment of a Head of Corporate Governance from July 2010. An interim review and full evaluation of these revised governance arrangements was undertaken in 2010/11 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. A further annual review has been undertaken in 2011/12 to ensure that the infrastructure continues to meet the Trust's governance requirements; this review was positive and confirmed effective governance processes were in place.

This review also included the development of the Director of Quality and Performance function, increasing this roles portfolio to improve Board Assurance processes by linking quality, business planning and performance reporting.

The Trust continually reviews best practice advice as outlined in; Monitor guidance, HMFA 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 & 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 Committee, Safeguarding Adults and Children's Committees, the Health and Safety and Information Governance Committees. 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 2011 by the Head of Corporate Governance and the Trust's Risk Manager and was approved in August 2011. The updated document clearly differentiates between the Trust's risk management arrangements and the governance and assurance framework, and also details the Divisional governance infrastructure, which has been both strengthened and standardised.

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. A Quality Assurance Officer has 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 post also provides an interface with the Clinical Effectiveness Department, which monitors ongoing 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 divisional governance forums.

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
- Divisional Governance meetings
- Corporate Governance Committees

4. The risk and control framework

Governance Structure and Risk Management

The revised governance arrangements introduced in January 2010 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 of 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 Board 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 August 2011 and January 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 that are 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 each quarterly public Board meeting. The framework is subject to specific detailed review at every meeting of the Board's governance 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 Board of Directors takes an overarching role in assurance and monitoring of performance and has monitored the delivery of the 2011/12 Business Plan throughout the year. Further assurance is given through ongoing 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 2011/12 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 significant 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 introduced in 2008 in order to assess the likelihood and consequences of identified risks. Risk awareness training on the use of this matrix has been 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 of 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.

In March 2011 the Trust introduced an electronic system of incident reporting, to further refine incident information, identify emerging risks, pinpoint trends, improve organisational transparency and improve access to incident information. As with any new processes there is often a time lapse to fully embed the revised system. The introduction of this development did result in a reduction of reported incidents for a short period of time but this quickly recovered and reporting of incidents continues to increase through improved awareness across all staff groups and enhanced reporting processes.

The Trust's Annual Quality Report is prepared to ensure that it presents a balanced view of the risks to quality governance that have faced the Trust throughout the year. To deliver this perspective and understanding the Board of Directors and the Governing Council receive regular quality reports and quality dashboards to track quality performance and the risk to achieving quality objectives are openly discussed at both Board and Governing Council Meetings. Key members of the Executive team also meet with the NHS Barnsley, the Trust's host 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.

Our Major Risks

In 2011/12 the Board took a range of actions to support both ongoing assurance and scrutiny and specific actions to reduce risks; examples being:

- Undertaking an annual review of the revised governance arrangements and evaluating the effectiveness of these arrangements
- Closely monitor 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
- Ongoing review and testing of emergency preparedness and 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 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
- Channelling 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 re-admission and intermediate care drivers that will impact significantly across the interfacing health care providers

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
- Development of the IT capacity and capability to deliver a comprehensive new patient information system
- Failure to achieve Trust targets would impact on financial and operational performance
- Although the Trust has achieved the challenging HCAI targets at the year end the risk associated with maintaining this performance has been highlighted at each Board Meeting, acknowledging the additional risk of managing the profile of C.Difficile cases against a defined quarterly trajectory
- The variable, high levels of unscheduled care have continued to add risk to the delivery of the < 4 hours in Accident and Emergency 95% target

This list is not exhaustive and more details can be found on pages 56-57 of the Annual Report.

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.

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 Governing Council and Patient Partnership Initiative (PPI), and other interested bodies/organisations
- Collaborative working between the Governing Council 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 host 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 Governing Council are actively involved in monitoring of the Trust's risks and performance through information and discussions at Governing council 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.

The Trust received an unannounced visit from the Care Quality Commission on 31 March 2011. This was as part of their national assessment programme assessing Dignity and Nutrition in NHS hospitals, looking at whether older people were treated with respect and how they were helped with food and drink should they need assistance. The Trust received an initial draft report in May 2011 and then received a final report at the end of May 2011. The CQC report confirmed that the Trust was fully compliant against outcome 1: respecting and involving people who use services. The Trust did however; receive an improvement action highlighting moderate concerns in terms of outcome 5: meeting nutritional needs. As a consequence of these findings the Trust developed a comprehensive action plan incorporating all the compliance requirements identified, but also included a number of enhancement or best practice actions to further improve patient outcomes. These workstreams and all the associated actions have been delivered and the Trust was revisited in December 2011. The subsequent report confirmed the Trust's compliance with all the essential standards.

The CQC visited the hospital on the 21st March 2012 as part of a National Responsive Review, to examine records associated with termination of pregnancy; the Trust are still awaiting the outcome of this latest visit.

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 pages 48-50 in 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, 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. Monthly performance reviews are undertaken with each divisional and corporate team where their performance is assessed across a full range of financial and quality matrices, which 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 as effectiveness of the use of resources are well monitored and any identified issues are acted upon.

Good governance is about making sure that the Board is well informed and assured that the right systems and processes are in place. The Trust does this through its five committees; 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.

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 Governing Council. The formulation commenced in August 2011, 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 2011/12 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 divisional 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. Additionally the CQC quality outcomes are monitored and controlled through identified CQC outcome leads; compliance against the requirements is routinely reported to the Executive Team and to the Board of Directors.

All proposed efficiency/cost saving initiatives are clinically and quality impact assessed by the Board with leadership and guidance from the Medical Director and Chief Nurse against an evaluation matrix, in order to ensure that implementation of proposed schemes will not directly impact on patient safety or quality of services. 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
- The Productive Ward Programme – releasing time to care

- The Productive Operating Theatre
- Enhanced recovery patient pathways
- Mental health care pathway within maternity services
- The World Health Organisation (WHO) surgical safety check list

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 Performance Board, Quality Safety Improvement and Effectiveness Board and the Quality Commissioning Group meetings. Detailed reports are then reported to the Board 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. Non Executive Directors also actively engage with staff on quality by visiting wards and departments on a monthly rotation.

Data Security

In March 2012 the Trust was informed by a healthcare contractor that they had inadvertently collected items of personal patient information along with items of product performance data they routinely downloaded from [e.g. 2 diagnostic scanners] they had provided to the Trust. The Trust was one of a number of NHS organisations where this process had inadvertently taken place and therefore the incident investigation and management was undertaken by the Department of Health (DH).

The incident has been notified to the Information Commissioners Office (ICO) and the joint view of the DH and ICO is that the risk of harm to patients is negligible. The data is held in a complex format and is not readily accessible and the contractor has given assurance, independently verified, that the data remains secure, has not been subject to loss, hacking, misuse or theft and will be destroyed on the completion of the investigation.

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 Group. 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.

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.

6. 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 & 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 significant 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
- Governing Council reports and
- Clinical audit reports

The Trust has proactively recognised the need for ongoing 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 2011/12, the Trust's Assurance Framework and governance processes identified gaps in control in the following areas:

- 62 Day Cancer Target for patients requiring to be seen following attending a cancer screening service was narrowly missed in the 1st quarter. Actions were taken to revise the monitoring and performance in respect of this target and compliance with this target was delivered across the year from the second quarter onwards.
- An in depth review of the procurement processes undertaken within the Trust highlighted some governance and controls assurance weaknesses, all of which are being addressed through a comprehensive targeted action plan.
- The Trust identified a need to improve the management and governance of subcontracting and service level agreements processes where there is a need to utilise such arrangements. A considerable amount of work has been undertaken in this area developing umbrella agreements to manage provider to provider service commitments and further work is on going to further strengthen the governance infrastructure.
- The Government's Transparency Agenda in Procurement presented a challenge for the Trust in 2011 and 2012. A steering group was quickly established in order to progress a number of workstreams to deliver the compliance requirements. Considerable progress has been made in this area, the outstanding publication scheme arrangements are currently being finalised.
- Safeguarding adults and children are high on both the national and Trust's agenda and a number of improvements have been implemented in this area in order to increase controls assurance processes, particularly around training and HR checking processes.

7. 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.

……. Signed

Chief Executive

Date:……

Financial Statements

Foreword to the Accounts for the year ending 31 March 2012

Insert foreword (accounts team written)

Signed .....
Chief Executive

Date:

- Insert Independent Auditors' report
- Insert accounts in full